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Universal Access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans

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Abstract

Rhetorical acknowledgment of the value of human rights for the AIDS response continues, yet practical application of human rights principles to national efforts appears to be increasingly deficient. We assess the ways in which international and national strategic plans and other core documents take into account the commitments made by countries to uphold human rights in their efforts towards achieving Universal Access. Key documents from the Joint United Nations Programme on HIV and AIDS (UNAIDS), the World Health Organization (WHO), the World Bank, the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the US President's Emergency Plan for AIDS Relief (PEPFAR) were reviewed along with 14 national HIV strategic plans chosen for their illustration of the diversity of HIV epidemic patterns, levels of income and geographical location. Whereas human rights concepts overwhelmingly appeared in both international and national strategic documents, their translation into actionable terms or monitoring frameworks was weak, unspecific or absent. Future work should analyse strategic plans, plans of operation, budgets and actual implementation so that full advantage can be taken, not only of the moral and legal value of human rights, but also their instrumental value for achieving Universal Access.

Keywords

global health; health policy; HIV/AIDS; human rights

Introduction

The current global framework for confronting HIV is Universal Access; intended to mean 'the scaling up of HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of Universal Access to treatment by 2010 for all those who need it' [1]. Looking back in time, countries where the initial response to HIV achieved the greatest strides, including Australia, Brazil, the Netherlands, Switzerland, Thailand, and Uganda, are those where human rights principles such as participation, non-discrimination and access to information, essential services and life-saving technologies inspired policies

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and programmes [2–4]. Countries that failed in their early responses to HIV, such as China, Russia and South Africa, are those where inequality, persisting discrimination and denial of access and of participation of affected communities aggravated the risk of acquiring HIV infection [5,6]. Twenty-seven years and 23 million deaths [7] after the emergence of AIDS, these facts are known, the evidence is abundantly available, and yet across the globe, while rhetorically continuing to acknowledge the value of attention to human rights, strategies appear to be increasingly deficient in their application of human rights principles to the implementation of policies and programmes.

The ‘3 by 5’ initiative, launched in 2003 by the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS), was billed as a step towards ensuring that HIV/AIDS treatment was universally accessible to all who needed it as a ‘human right’ [8]. Although rights existed in the rhetoric of ‘3 by 5’, neither its policy nor its operational documents included concrete attention to rights or provided guidance as to how human rights principles might actually support strategies to reach its objectives [8]. Furthermore, the primary focus of ‘3 by 5’ was treatment with little attention to prevention or to the links between the two. In addition to being a laudable goal, Universal Access is a big step forward with its integration of prevention with treatment and care, as well as its focus on national level targets. Human rights are touched upon in Universal Access commitments, with reference made in core documents to how their application can help ensure acceptable and equitable implementation, generate trust between providers and clients, encourage ongoing engagement with health services and stimulate accountability against national benchmarks and targets [9]. Against this background, this article explores the ways and extent to which global and national policy and programmatic commitments towards Universal Access integrate human rights concerns in meaningful ways.

The role of human rights in HIV efforts

No single analytical framework – whether grounded in economics, social sciences, ethics or human rights – can determine to everyone’s satisfaction who should benefit from services first, second or last, what levels of prevention, care and support should be provided to each affected population and who, as a result, may benefit less or later from the highest attainable standard of services. What a human rights framework distinctively contributes is an array of principles, norms, standards and instruments conducive to shaping policy and enhancing accountability. The application of a human rights framework can help ensure that the processes of setting agendas and priorities, as well as the expected outcomes, are based on justice, dignity and fairness and that a level of accountability is built into decision-making processes.

The first global strategy on AIDS launched by WHO in 1987 [10] emphasized the critical importance of a supportive environment for effective prevention and impact mitigation and the need to put into place structures and services to serve the needs of vulnerable populations. Strongly focused on information, education, access to services and the creation of a supportive environment, attention to human rights was largely grounded in the pragmatic recognition that the human rights violations occurring around the world in relation to HIV, including mandatory testing and detainment of vulnerable populations, violence within families and communities denial of inheritance and property rights, as well as violations in access to food, housing, marriage, education, medical care, international travel, health insurance, employment etc. [11–14] were undermining the public health impact of prevention initiatives [15].

Largely the result of strong advocacy by civil society, WHO, and then UNAIDS, global and national HIV policies and plans since that time have largely incorporated human rights

norms and considerations [16]. Every country in the world is party to at least one human rights treaty, and all have made rights-related commitments in relation to HIV including the 2000 Millennium Development Goals [17], the 2001 Declaration of Commitment on HIV/AIDS [17] and the 2006 UN General Assembly Resolution on Universal Access [18].

Early on, even with the best of intentions, it was not clear what a commitment to human rights actually meant in practice for implementation of HIV policies and programmes. We know now that anchoring HIV strategies in human rights principles is more than simply pretty statements, or even simply responding to violations after they occur, but that there are practical implications for the ways in which work is to be carried out [19,20]. Human rights are now understood to offer a framework for action and for HIV programming, and a rights-based approach, as the name implies, constitutes the adoption of an approach that is explicitly shaped by human rights principles.

Initially conceptualized in the mid-1990s as a 'human rights-based approach to development programming' by the United Nations Development Programme (see Table 1) [21], the understanding of what a rights-based approach actually means for HIV efforts has varied across sectors, disciplines and organizations. A human rights-based approach to HIV calls for attention to processes as well as outcomes, for example, as an outcome, an increase in the uptake of HIV testing services could equally be caused by an increase in the availability of high quality voluntary counselling and testing services as by the introduction of mandatory testing for certain population groups. Although the short-term outcome is the same, from a human rights perspective, the processes used to achieve this outcome are entirely different. The first is appropriate in both public health and human rights terms, whereas the second may, in the long term, be detrimental from both human rights and public health perspectives.

The principal components of a rights-based approach to HIV programming include: examining the legal and policy environment in which programmes take place; systematically integrating core human rights principles into policy and programmatic responses at local, national and international levels, for example, non-discrimination, participation, core components of the right to health, including the availability, accessibility, acceptability and quality of the services delivered, ensuring the most vulnerable populations are reached with the services they need (see Table 2 for a definition of these terms); and ensuring transparency and accountability for how policies and programmes are carried out [12,22–31].

As resources around the response to HIV have increased, there is a deepening gap between rhetorical statements touting the integration of human rights in the AIDS response and actual operational and programmatic commitment to do so. A number of reasons can be posited for these lacunae. In stark terms, on the one hand there is the distortion that can occur as a result of inadequate resources, training or other factors between the conceptualization of a rights-based approach at the policy level and what happens by the time it is translated into programming, and on the other there is the use of rights language by organizations to justify their work as it is politically useful to do so even if their approach remains the same. Finally, as ever larger amounts of money are brought to the AIDS response, increasingly donors are tying future funding into outcome indicators with short time frames, leaving little room for attention to the issues raised by application of a rights-based approach [32]. Driven by these concerns, this review set out to consider the extent and ways in which current international and national level commitments in relation to HIV prevention, care and treatment under the rubric of Universal Access integrate human rights norms and standards in their approaches. Although such an assessment is, at this initial stage, limited to the review of publicly available documents, planned efforts by UNAIDS and other actors, in the future, should

open opportunities for expanding the scope of assessment to include a comparison between plans and actual implementation in countries.

A human rights assessment of HIV strategic plans

To ascertain the availability of practical guidance and support for countries on how to integrate human rights into their efforts, a review was first conducted to determine how and the extent to which human rights principles were dealt with in key documents published by leading international agencies and initiatives concerned with Universal Access. These include UNAIDS, WHO, the World Bank, the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the US President's Emergency Plan for AIDS Relief (PEPFAR). A convenience sample of 14 countries was then retained for the second part of this analysis. Countries were chosen to ensure the inclusion of: (i) all regions in the world; (ii) different prevalence/incidence rates within both generalized and concentrated epidemics; (iii) places that host the majority of people currently living with HIV (thus a deliberate over-representation of African countries); (iv) a mix of high, medium and low income countries; (v) those that benefit from the support of the Global Fund, PEPFAR and other major sources of HIV funding; and (vi) importantly, those whose information was readily available from published documents and websites. This sample represents a diverse panel, allowing a general picture to emerge as to how, in different circumstances, countries both rhetorically and operationally incorporate human rights principles into their HIV strategies. Multi-year strategic national HIV plans were systematically examined for their use of rights language and concepts, as they provide the inspiration for annual and biannual plans of operations.

The full list of documents reviewed is attached (Appendix). Emphasizing the core human rights principles noted in the components of a rights-based approach above, the following words were systematically searched: Universal Access; human rights; rights; stigma; discrimination; participation; vulnerable groups; and with regard to the right to health (the 3AQ) – availability, accessibility, acceptability and quality. When these words were found in the documents reviewed, attention was devoted to understanding their meaning in context.

International documents were reviewed in English. The majority of national documents first published in languages other than English (China, Vietnam, Brazil) were searched in the English translation posted on the government website, creating some uncertainty as to the total coherence between the English words searched and their actual meaning in the original versions. The Peru plan was searched in its original Spanish version. When several documents of apparently equivalent significance were available for a single country, the most recent document was chosen.

Reviewers compiled their findings and annotations were then entered in tabular form to indicate whether the key words were present (Yes) or not (No) in the documents reviewed. Strong efforts were made to distinguish between rhetorical and operational use of these terms but with limited success for reasons noted below. Section (a) of Table 3 summarizes the results garnered from international agencies and section (b) those of the national sample. Below is a summary of findings emerging from the review of documents, presented according to the key search terms noted above.

Universal Access

All international documents reviewed were created after the launch of Universal Access, thus not surprisingly the term can be found throughout the documents of each organization. PEPFAR appears to limit its focus to treatment, whereas all other institutions reviewed seem to adopt the broader intended vision encompassing both prevention and treatment. National plans varied in the time of their creation. The Brazil and Nigeria documents date before the

launch of the initiative, but nonetheless use the term in relation to HIV treatment. Of those created after 2006, all but China use the term explicitly.

Human rights and rights

As can be expected all international documents referred to human rights but most often in connection with stigma, discrimination, participation, vulnerability and confidentiality and, at times, in relation to access. Interestingly, most countries also explicitly referred to human rights in their plans, including not only countries that are party to scores of international human rights treaties (e.g. Botswana, Brazil, Germany, India, Kenya, Nigeria, Pakistan, Peru, South Africa), but also those that are not (e.g. Indonesia, Myanmar, Papua New Guinea). China, even as it has ratified several international human rights treaties, avoids this language completely, but gives different levels of attention to selected rights concepts as noted below. Differences also exist across countries in the ways human rights are referred to, ranging from over-arching sets of commitments to direct reference to the right to treatment and care, but in general at the country level there is far less attention to programmatic activity in the use of this term than by the international players.

Stigma and discrimination

Even as these are different concepts that are best addressed through different sorts of mechanisms, they are often referred to jointly in both international and national documents as barriers to Universal Access. Stigma and discrimination are most concretely referenced by the international organizations of any of the human rights search terms, and are often included in both the indicators proposed for monitoring and evaluation as well as in human rights-related sections of strategic planning guidance. The international documents tend also to discuss the importance of the participation of vulnerable groups to eliminate stigma and discrimination. Within national documents, there is also mention of ensuring confidentiality and privacy in order to prevent stigma and discrimination (e.g. Vietnam, Myanmar). Less frequent are references on how to respond to either stigma or discrimination operationally.

Participation

Interestingly, whereas all international documents reviewed give concrete attention to the participation of affected communities, this is an elusive concept in many national plans. In particular, international initiatives tend to give great emphasis to participation in both their strategic planning and operational guidance, as well as monitoring and evaluation indicator guides. Most emphasize participation by people living with HIV/AIDS (PLWHA) and other vulnerable groups. Mention of participation is entirely absent in a surprisingly high number of countries (e.g. Papua New Guinea, China, South Africa, India, Nigeria). In several countries, participation by stakeholders including PLWHA is addressed generally although groups are not named explicitly (e.g. Botswana, Brazil, Germany, Indonesia, Myanmar, Kenya, Pakistan, Vietnam). Peru is an exception, naming specific 'vulnerable' groups including adolescents, sex workers, PLWHA, men who have sex with men and drug users. Even when participation is noted as requiring the inclusion of communities in consultative and governance processes, attention to specific affected communities, mechanisms of involvement and requirements as to the extent and quality of participation are often absent in national documents.

Vulnerable groups

Documents, both international and national, commonly provide a list of those vulnerable groups thought to be at greatest risk of not accessing prevention, care or treatment, but rarely are approaches to addressing their specific needs noted. PEPFAR tends to focus most on the vulnerability of children, especially orphans. In contrast, it is worth noting that virtually all

countries reviewed refer directly to sex workers, injecting drug users and men who have sex with men as populations needing special attention to ensure their equal access to HIV-related services. Despite the lack of clarity as to what this special attention means in all cases, even just the mere acknowledgment that these populations exist is a huge step forward from the rampant denial earlier in the epidemic when many countries claimed some or all of these populations did not exist within their societies [33–35]. In some plans named vulnerable groups also include women, young people, children and uniformed personnel. With the exception of Germany, with its clear recognition of the vulnerability of migrants and prisoners, these groups as well as populations suffering from mental and other disabilities are often absent. Across the documents reviewed, even if named as vulnerable, the priority afforded these populations is inconsistently translated in the magnitude of effort or resources allocated. The mainstay of many plans remains the ‘general population’ or young people, even if in the country at issue these populations remain at relatively low risk (e.g. India, China, Indonesia, Vietnam). In Papua New Guinea, ‘high-risk groups with high-risk vulnerability’ are noted but without reference to specific populations, including a warning against identifying specific populations, rather than specific behaviors, as this may exacerbate stigma and discrimination.

Availability

The availability of services and goods was explicitly noted in all international and national plans with the exception of Germany, where the brief mention of availability presumes availability is guaranteed to all through existing health systems. In general, across the plans discussion focused on limitations to availability, reasons for these limitations, inequity in availability and the need to scale-up availability. Language often focused on antiretroviral therapy, with little attention to prevention or care more generally. For example, the Global Fund recommends the use of an indicator regarding the availability of human resources, equipment, drugs and other commodities specifically required for the treatment of HIV. Few national plans are explicit about policies, strategic approaches or the resources needed to ensure the availability of any HIV-related structures, services and goods (e.g. Brazil, Peru, Botswana, Kenya, Myanmar, Nigeria, South Africa, Pakistan and Vietnam). India proposes to address unequal availability through research and development. All documents generally fail to discuss availability in relation to vulnerable groups.

Accessibility

Accessibility to services and goods is the mainstay of all international and national documents, but the use of this term varies widely raising additional questions as to the coherence between the rhetorical use of the term access and its practical application. Achieving improved, equitable access to treatment and care is perhaps the most common usage. Depending on the plan, to varying degrees, this can be about prevention commodities including condoms or sexually transmitted infection programmes, and in the case of Papua New Guinea, Myanmar, China and Vietnam, voluntary counselling and testing. General goals to enhance access for all PLWHA are occasionally noted but there is wide diversity as to whether targets are set for the HIV-positive population as a whole (e.g. China, Pakistan, Papua New Guinea, South Africa and Vietnam), or with reference to specific subpopulations such as pregnant women or sub-national geopolitical areas (e.g. districts in Botswana). Vietnam and Peru are the only two countries in the sample to mention access for specific vulnerable sub-populations. In Vietnam, documents identify sex workers, drug users, street children, working young people, school drop-outs, disabled young people, ethnic minorities, young people and ‘other groups’, whereas Peru specifically mentions adolescents, sex workers, drug users and men who have sex with men.

Acceptability

Strikingly, acceptability as defined by the human rights community does not appear in any of the international documents reviewed and is mentioned in only a limited number of country plans (India, Papua New Guinea, Pakistan, South Africa, Botswana), and in very different ways. The cultural acceptability of HIV interventions is mentioned by India and Papua New Guinea but for Pakistan and Botswana it is simply part of the more general goal of ensuring that sexually transmitted infection and HIV interventions are accessible, affordable and acceptable. Finally, in the case of South Africa, acceptability is used in the context of standards for laboratory testing. Even in the few documents in which acceptability was noted, no mention was made of measures within or outside the health sector that could help to make services 'acceptable' socially, culturally and otherwise.

Quality

Quality is noted in three distinct ways in the documents reviewed: quality of life; quality of services and goods; and quality of data, data collection, and monitoring and evaluation. This stands in interesting contrast to the human rights definition that is limited to the quality of services and goods. Of the international documents, PEPFAR has the most specific discussion of quality, going so far as to describe specific components of quality treatment. The quality of prevention, care and treatment commodities is usually missing from national documents. Plans from Myanmar and Kenya state the need to ensure quality of blood, but with insufficient information about how this is to be achieved. Germany is the only country whose plan mentions quality assurance systems and the need to ensure the quality of generic medicines. Even as these plans are not necessarily the best place to set quality standards, few, with the exception of PEPFAR, even go so far as to suggest how quality standards will be set, monitored and evaluated.

Coming together

This review confirms that attention to human rights continues to exist in the global response to HIV. The positive impacts of this attention will not, however, be achieved simply through what is said on paper but through implementation and ongoing monitoring and evaluation. Despite the rhetoric of Universal Access being about prevention as well as treatment, this review suggests that in most countries access remains primarily equated with treatment. This suggests efforts are needed to ensure that prevention concerns are part of the mainstay of Universal Access. The congruence between commitments to Universal Access and to human rights was widely recognized across the international actors and panel of countries chosen for this review regardless of their geopolitical characteristics and overall human rights records. Differences exist, however, between what is suggested through the international documents reviewed and what appears within country-level documents. The guidance extended by international agencies around Universal Access brings attention to human rights concerns, even if the lack of attention to acceptability is a noticeable gap. Within national documents, however, statements on human rights overwhelmingly appear in strategic documents, but their translation into operational terms or into monitoring frameworks is most often weak or absent. A review to determine whether relevant policy and legislation within these same countries is consistent with the pronouncements made, or whether some present obstacles to an effective response, such as by requiring parental consent for access to HIV prevention information or by criminalizing sex work or same-sex sex, could help to ensure that the inclusion of human rights language in national documents reflects more than simply the fact that this language is part of the global discourse around HIV.

Overall, from the countries reviewed it appears that national strategic documents contain many of the ingredients of a rights-based approach to HIV, but that full advantage is not

taken of the instrumental value human rights can offer. In addition, a human rights analysis of the documents reviewed highlights that law reform, ensuring confidentiality protection, preventing violence against women and other interventions beyond traditional health sector approaches relevant to an effective HIV response still receive insufficient attention. Taken together, these findings have direct implications for the ways obstacles to Universal Access can be addressed.

The practical value that the human rights concepts noted here can provide to effective strategies has not been sufficiently explored. Of critical importance is documentation of the effectiveness of rights-based approaches to HIV/AIDS when they are occurring. Presentation of solid evidence on how rights-based approaches to HIV initiatives have actually strengthened those initiatives and informed sound public health practice will be useful tools to close the gap between rhetoric and operational commitment. New technologies and resources are still needed to bring the HIV epidemics under control, but this is not enough. A rights-based approach is strongest when used in conjunction with empirical assessment of the complex epidemiological, economic, management and other information relevant to deciding how resources can most effectively be used. Universal Access must ensure sufficient attention to prevention, as well as to care and treatment. Beyond theory and semantics, human rights bring human values into the equation while projecting a vision of greater justice, fairness and dignity as fundamental rights and requisites for a successful response to the global pandemic.

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Appendix: International agencies and initiatives documents list

The Global Fund (TGF) <<http://www.theglobalfund.org/en/>>

1. TGF Technical Review Panel Terms of Reference
2. Monitoring and Evaluation Toolkit: HIV/TB
3. CCM Basic Principles
4. Revised Guidelines on CCM and Grant Eligibility
5. CCM Minimum Requirements
6. Guidelines for Round 7 Proposals
7. Report of TGF Partnership Forum 2006
8. M&E Guidelines for Reporting to the Global Fund
9. A Strategy for the Global Fund: Accelerating the Effort to Save Lives
10. Funding the Global Fight Against HIV/AIDS, Tuberculosis and Malaria Strategy
11. Guide to PLHIV Involvement in Country Coordinating Mechanisms
12. A Synthesis and Analysis of Findings from CCM Case Studies, Tracking Study, GNP+ and Other Surveys
13. 2006 Partnership Forum Report: Celebrating Successes and Overcoming Challenges
14. Resource Needs: Funding the Global Fight Against HIV/AIDS, TB and Malaria
15. Investing in Impact: Mid-Year Results Report 2006
16. Partners in Impact: Results Report 2007
17. Measuring the Systems Effects of the Global Fund
18. The Global Fund Brochure
19. Sustaining Performance, Scaling Up Results: Third Progress Report 2005
20. Making Performance-based Funding Work: Mid-Year Progress 2005
21. Investing in the Future: The Global Fund at 3 Years
22. A Force for Change: The Global Fund at 30 Months
23. An Evolving Partnership
24. The Global Fund Annual Reports 2005 and 2006

UNAIDS <<http://www.unaids.org/en/>>

1. The Outcome Document from the 2005 World Summit Committing to Universal Access
2. Technical Meeting for the Development of a Framework for Universal Access to HIV/AIDS Prevention, Treatment and Care in the Health Sector
3. Proceedings of a Technical Meeting for the Development of a Framework for Universal Access to HIV/AIDS Prevention, Care, Treatment and Support in the Health Sector
4. National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluation of National Antiretroviral Programmes
5. Guidelines on Construction of Core Indicators: 2008 Reporting
6. Guide to the Strategic Planning Process for a National Response to HIV/AIDS: Strategic Plan Formulation
7. Scaling-up Towards Universal Access: Considerations for Countries to set their National Targets for HIV Prevention, Treatment, Care and Support
8. Setting National Targets for Moving towards Universal Access, Operational Guidance
9. Towards Universal Access by 2010
10. Supporting National HIV/AIDS Responses: An Implementation Approach

PEPFAR <<http://www.pepfar.gov/>>

1. PL 108-25
2. US Five-Year Global HIV/AIDS Strategy
3. The Power of Partnerships: Third Annual Report to Congress on PEPFAR: Critical Intervention in the Focus Countries (Chapters 1, 2, and 3 – Prevention, Care and Treatment)
4. PEPFAR Fiscal Year 2007 Operational Plan – Update
5. PEPFAR Fiscal Year 2006 Operational Plan – Update
6. PEPFAR Fiscal Year 2005 Operational Plan – Update
7. Indicators Reference Guide for Focus Countries
8. Orphans and Other Vulnerable Children Programming Guidance
9. HIV/AIDS Palliative Care Guidance No. 1 for the United States Government in-Country Staff and Implementing Partners
10. ABC Guidance No. for United States Government In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually Transmitted HIV Infections within the President's Emergency Plan for AIDS Relief
11. The Power of Partnerships: Third Annual Report to Congress on PEPFAR
12. Bringing Hope: Supplying Antiretroviral Drugs for HIV/AIDS Treatment
13. Report on Refugees and Internally Displaced People – PEPFAR

14. Focusing on our Future: Prevention, Diagnosis and Treatment of Pediatric HIV/AIDS
15. Building Hope and Saving Lives: Building Sustainable HIV Treatment
16. Annual Report on Prevention of Mother to Child Transmission
17. M&E Systems Strengthening Tool
18. Data Quality Assurance Tool for Program-level Indicators

The World Bank <http://www1.worldbank.org/hiv_aids/publications.asp>

1. The World Bank Global HIV/AIDS Program of Action
2. TGF/World Bank HIV/AIDS Programs Comparative Advantage Study
3. Planning and Managing for HIV/AIDS Results: A Handbook
4. Legal Aspects of HIV/AIDS: A Guide to Policy and Law Reform
5. Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance
6. HIV/AIDS Strategic Self-Assessment Tool (SAT)
7. Key Steps in Preparing a National Strategic Plan
8. AIDS Strategic Action Plan – Business Plan

Country Documents List

Brazil: English Website Text from Ministry of Health of Brazil's (Ministero de Saude) STD/HIV page – <http://www.aids.gov.br/data/Pages/LUMISB9C1F777ENIE.htm>

Botswana: Botswana National HIV/AIDS Strategic Framework 2003–2009

China: China's Action Plan (2006–2010) for Reducing and Preventing the Spread of HIV/AIDS – State Council Office Document (2006) No. 13

Germany: Action Plan to implement the Strategy of the Federal Government to fight HIV/AIDS (2007)

India: National AIDS Prevention and Control Policy (2003–2007)

Indonesia: Indonesia National HIV/AIDS Strategy 2003–2007

Kenya: The Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/6–2009/10 (2003–2006)

Myanmar: Myanmar National Strategic Plan on HIV and AIDS 2006–2010

Nigeria: Federal Government of Nigeria National Policy on HIV/AIDS 2003

Papua New Guinea: Papua New Guinea National Strategic Plan on HIV/AIDS (2004–2008)

Pakistan: National HIV/AIDS Strategic Framework (2001–2006)

Peru: MultiSectoral Strategic Plan (2007–2011) for the Prevention and Control of STI and HIV/AIDS in Peru

(Aprueban Plan Estratégico Multisectorial 2007–2011 para la Prevención y Control de las ITS y VIH/SIDA en el Perú – Decreto Supremo No. 005-2007-SA)

South Africa: HIV and AIDS and STI Strategic Plan for South Africa, 2007–2011

Vietnam: National Strategy on HIV/AIDS Prevention and Control in Vietnam till 2010 with a Vision to 2020

Table 1

United Nations statement of common understanding of the human rights-based approach to development.

| | |
|---|---|
| 1 | All programmes of development cooperation, policies and technical assistance should further the realisation of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments. |
| 2 | Human rights standards contained in and principles derived from the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process. |
| 3 | Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights. |

From United Nations [21].

Table 2

Definitions of search terms.

| | |
|--|---|
| Human rights/rights | Human rights are legally guaranteed under international human rights law. They protect against actions that interfere with fundamental freedoms and human dignity and support the agency of individuals and populations [12,22,23]. |
| Stigma and discrimination | HIV/AIDS-related stigma is the process of devaluing people because of their real or perceived HIV/AIDS status or that of their family and community. HIV/AIDS-related discrimination refers to the legal institutional and procedural ways people are denied access to their rights because of their real or perceived HIV/AIDS status, or based on their real or perceived membership within already stigmatized and vulnerable groups such as sex workers and injecting drug users [24,25]. |
| Participation | Under human rights law, everyone is entitled to active, free and meaningful participation and inclusion in, contribution to, and enjoyment of civil, economic, social, cultural and political development. Ensuring the inclusion and full participation of all key stakeholders and affected communities, with particular attention to the greater involvement of people living with HIV and AIDS (GIPA), at every stage of HIV policy-making and programming is recognized as essential to an effective response [26,28] |
| Vulnerable/marginalized groups | Vulnerable and marginalized groups are broadly defined in the majority of human rights documents as comprising simply the most vulnerable or marginalized segments of the population. In HIV, increasingly, these groups are called 'most at risk populations'. Variation exists but in all cases these are understood to include injecting drug users, men who have sex with men, sex workers, and increasingly prison inmates, migrants/mobile populations, as well as women and young people. Questions exist about this more inclusive definition, which seems to leave out only adult men [29,30]. |
| The Right to Health in Relation to Goods and Services (The 3AQ) | The right to health has been defined by the Committee on Economic, Social and Cultural Rights to include the availability, accessibility, acceptability and quality of the goods and services provided. This is commonly known as the '3AQ' and the meaning of each of these terms is defined below: Availability: This requires making available in sufficient quantity functioning healthcare facilities, goods and services, as well as programmes to address HIV and AIDS. Although these facilities, goods and services will vary by context, they should address the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs [28]. Accessibility: The concept of accessibility encompasses four distinct components: <ul style="list-style-type: none"> i. Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable and affected populations; ii. Physical accessibility: health facilities, goods and services must be physically accessible to all sections of the population, especially vulnerable or marginalized groups; iii. Affordability: health facilities, goods and services must be affordable for all. Payments have to be based on the principle of equity, ensuring accessibility of needed services, whether privately or publicly provided; and iv. Access to information: accessibility also includes the right to seek, receive and impart information and ideas concerning health issues but this does not impair the right to have personal health data, including the results of HIV tests, treated with confidentiality [28]. Acceptability: Acceptability requires that all health facilities, goods and services be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to sex and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned [28]. Quality: Goods and services must be scientifically and medically appropriate and of good quality. Good quality services should include, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation [28]. |

Table 3

Results of search for key words or their equivalent in documents reviewed.

| Documents reviewed | Key words and principles | | | | | | | | | |
|--------------------|--------------------------|------------|--------------------|-------------------|---|---|---------------------------|-------------------------------|--------------|-----|
| | Human rights (1) | | | | | Right to health: structures, goods and services | | | | |
| | Rights (2) | Stigma (3) | Discrimination (4) | Participation (5) | Attention to vulnerable populations (6) | Availability (7) | Accessibility/ access (8) | Acceptability/ acceptable (9) | Quality (10) | |
| (a) International | | | | | | | | | | |
| Global Fund | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| PEPFAR | Yes | Yes | Yes | Yes | Yes | No | Yes | No | Yes | Yes |
| World Bank | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No |
| UNAIDS | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| (b) National | | | | | | | | | | |
| Botswana | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Brazil | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| China | No | No | No | No | No | Yes | Yes | No | Yes | Yes |
| Germany | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No | No |
| India | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes |
| Indonesia | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Kenya | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Myanmar | Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Nigeria | Yes | Yes | Yes | No | Yes | Yes | Yes | No | No | No |
| Papua New Guinea | Yes | Yes | Yes | No | No | Yes | Yes | Yes | Yes | Yes |
| Pakistan | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Peru | Yes | Yes | Yes | Yes | Yes | No | Yes | No | Yes | Yes |
| South Africa | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes |
| Vietnam | No | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |

UNAIDS, Joint United Nations Programme on HIV and AIDS; PEPFAR, US President's Emergency Plan for AIDS Relief.

Explanatory notes on columns headings: 1. Human Rights: Reference to human rights violations, or the need for the strategy to meet human rights norms and standards. 2. Rights: Reference to the need for the strategy to fulfill people's rights or to violations of rights. 3. Stigma: Acknowledgement of stigma as a barrier to effective prevention, care and/or treatment, and/or intended actions to reduce HIV-related stigma. 4. Discrimination: Acknowledgement of discrimination as a barrier to effective prevention, care and treatment, and/or intended actions to reduce HIV-related discrimination. 5. Participation: Acknowledgement of need for participation of populations at greatest risk or vulnerability in strategic process, and/or in governance. 6. Attention to vulnerable populations: Acknowledgement of specific vulnerable populations consistent with local epidemiological, social or behavioral evidence. 7. Availability: Acknowledgement of the lack of HIV-related structures, services or goods and/or intent to

provide these. 8. Accessibility: Acknowledgment of legal, social, economic or geographic barriers to access sources of prevention, care and treatment and/or actions to overcome these barriers. 9. Acceptability: Acknowledgment of social or cultural concerns impeding access to HIV prevention, care and support and/or intended action to overcome these concerns. 10. Quality: Reference to the poor quality of services being provided and/or the intent for prevention, care and treatment to meet set quality standards.