

# Guiding Principles

## 2.1 Introduction

This chapter sets out the guiding principles – human rights, public health and development – that provide the overarching framework for the Code. These principles are then applied in specific terms both to how we do our work (Chapter 3 – Organisational Principles) and to what we do (Chapter 4 – Programming Principles). The guiding principles and organisational principles are relevant to all NGO signatories to the Code. The programming principles are more specific and therefore may apply to different NGOs depending on the nature of their work.

## 2.2 Core values

The motivation for, and commitment to, responding to HIV/AIDS is underscored by core values that guide both what we do and how we work.

At the centre of our work is our commitment to:

- valuing human life
- respecting the dignity of all people
- respecting diversity and promoting the equality of all people without distinction of any kind, such as sex, race, colour, age, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation or civil, political, social or other status
- preventing and eliminating human suffering
- supporting community values that encourage respect for others and a willingness to work together to find solutions, in the spirit of compassion and mutual support, and
- addressing social and economic inequities and fostering social justice.

These values are common to our work as NGOs in responding to HIV/AIDS, whether we are HIV/AIDS, health, development, human rights or humanitarian NGOs.<sup>1</sup> Many of these same values also find expression in the Universal Declaration of Human Rights.<sup>2</sup>

## 2.3 Involvement of PLHA and affected communities



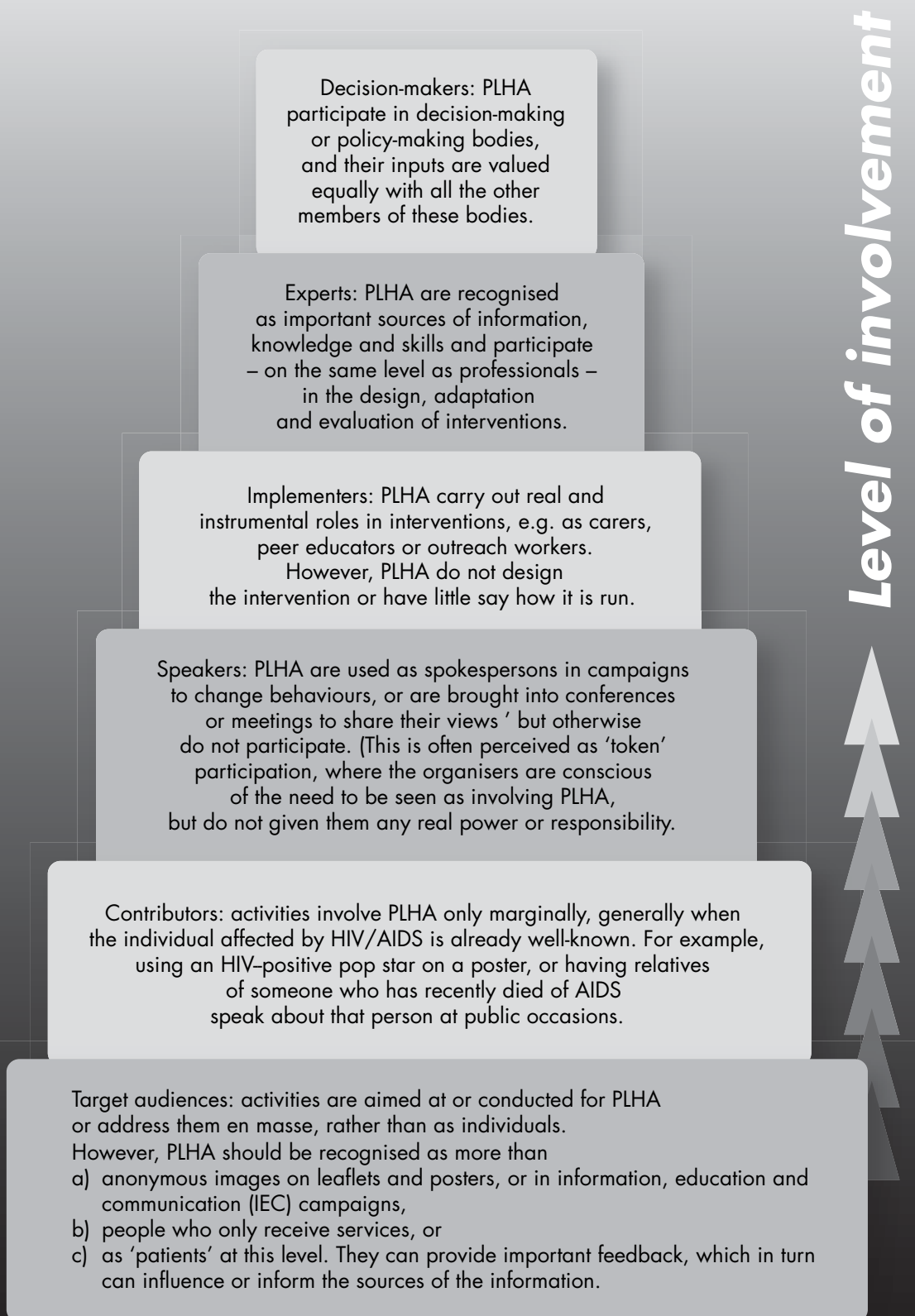
We advocate for the meaningful involvement of PLHA and affected communities in all aspects of the HIV/AIDS response.

At the Paris AIDS Summit in 1994, the principle of greater involvement of people living with or affected by HIV/AIDS (GIPA) was a cornerstone of the Summit's Declaration.<sup>3</sup> GIPA is a specific expression of the right to active, free and meaningful participation.<sup>4</sup> In emphasising GIPA and the right to participation, we recognise that the meaningful involvement of PLHA and affected communities makes a powerful contribution by enabling individuals and communities to draw on their lived experiences in responding to HIV/AIDS. In turn, this contributes to reducing stigma and discrimination and to increasing the effectiveness and appropriateness of the HIV/AIDS response and of our own programmes<sup>5</sup> (see section 3.2 Involvement of PLHA and affected communities).

It is important to acknowledge that many people living with and affected by HIV/AIDS are actively involved in responding to the pandemic – not only within NGOs, but also as policy-makers, activists, healthcare workers, educators, scientists, community leaders and public servants, to name just a few. Nonetheless, there remains a long way to go in fully realising GIPA worldwide. We have a significant role to play in advocating with governments, donors and private and public sector agencies for the meaningful involvement of PLHA and affected communities, as well as in achieving GIPA within our own organisations.

## A pyramid of involvement by PLHA

*This pyramid models the increasing levels of involvement advocated by GIPA, with the highest level representing complete application of the GIPA principle. Ideally GIPA is applied at all levels of organisation.*



## 2.4 A human rights approach to HIV/AIDS

The AIDS pandemic is destroying the lives and livelihoods of millions of people around the world. The situation is worst in regions and countries where poverty is extensive, gender inequity is pervasive and public services are weak.<sup>6</sup>

In recent years, the devastation caused by HIV/AIDS in many developing countries has brought into stark relief the need to strengthen the link between furthering development goals and addressing the causes of vulnerability to HIV/AIDS and its impacts. HIV/AIDS-specific approaches alone, such as targeted HIV prevention programmes, do not address the underlying causes of vulnerability. Addressing the inequities that drive the epidemic must be an integral part of an effective response.

Poverty both causes vulnerability to HIV infection and increases the severity of the impacts of HIV/AIDS on individuals, households and communities.<sup>7</sup> Gender inequities often affect the capacity of women and girls to negotiate safer sex and compound the impact of the epidemic on them. Many of the impediments to an effective response to HIV/AIDS are linked to the denial of human rights: the rights to equality, information, privacy, health, education and an adequate standard of living. Failure to protect the human rights of PLHA and affected communities has devastating consequences and undermines prevention efforts and access to treatment, care and support. Discrimination against PLHA and affected communities often affects access to employment, housing, health and other services, in turn deepening the personal and social impacts of the epidemic.

The Declaration of Commitment on HIV/AIDS recognises that the realisation of human rights is essential to reducing vulnerability to HIV/AIDS and sets time-bound targets for realising these rights.<sup>8</sup> Experience has shown that public health strategies and human rights protection are mutually reinforcing.<sup>9</sup> A human rights approach provides a common framework for translating international human rights obligations into practical programming, at international and national level, strengthening the effectiveness of both HIV/AIDS-specific programmes and broader health, development and humanitarian responses.<sup>10</sup>

Human rights laws protect individuals and groups from actions that interfere with fundamental freedoms and human dignity.<sup>11</sup> Protecting and promoting human rights has obvious merit intrinsically; however, there is also an increasing recognition that public health often provides an added and compelling justification for safeguarding human rights.<sup>12</sup>

Human rights encompass civil, political, cultural, economic and social rights. It is clear that these rights are interrelated and interdependent. The right to health, for example, cannot be viewed in isolation from the rights to education, housing and employment.

Every country in the world is now party to at least one human rights treaty that addresses health-related rights, including the right to health and a number of rights related to conditions necessary for health.<sup>13</sup> International human rights instruments impose obligations on governments ratifying them to respect, protect and fulfil the rights they set out. While the principle of progressive realisation of human rights acknowledges that the capacity of developing countries to ensure the full realisation of these rights is often constrained by limitations on resources, it also requires governments to take deliberate, concrete and targeted action towards that goal.<sup>14</sup>

Human rights obligations can be used by NGOs to advocate for concrete action by governments. The *HIV/AIDS and Human Rights: International Guidelines*<sup>15</sup> provide detailed and specific guidance on how human rights should be promoted and protected in the context of the specific challenges posed by HIV/AIDS.

We must also be guided by a human rights approach in:

- the way we do our work
- the design, development and implementation of programmes responding to HIV/AIDS, and
- advocating for an environment, including reform of laws and public policy, that protects and promotes the rights of PLHA and affected communities and supports effective programmes (an ‘enabling environment’; see section 3.8 Advocacy).

The human rights principles and public health principles outlined below are embodied in the good practice principles outlined in chapters 3 and 4. The human rights principles outlined below identify the principles of particular relevance in responding to HIV/AIDS.

## Human rights



We protect and promote human rights in our work.

### The right to health

All people have the right to the enjoyment of the highest attainable standard of physical and mental health. The International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR) provides that states party to the Covenant take steps to achieve the full realisation of this right, including prevention, treatment and control of epidemic, endemic, occupational and other diseases.<sup>16</sup>

The Committee on Economic, Social and Cultural Rights, which monitors the ICESCR convention, has interpreted the ‘right to health’ to include not only timely and appropriate access to health care, but also as addressing the underlying determinants of health, such as access to safe water, food, nutrition, housing and health-related education and information, including on sexual and reproductive health.<sup>17</sup> In 2003 and 2004, the Commission on Human Rights passed resolutions recognising that access to HIV treatment is fundamental to progressively achieving the right to health and called on governments and international bodies to take specific steps to enable such access.<sup>18</sup>

## The right to equality and non-discrimination

The cornerstone of the Universal Declaration of Human Rights 1948 (UDHR) is that 'All human beings are born free and equal in rights and dignity'. This statement of equality of all human beings is closely linked to the right of all people to equal protection of the law and from discrimination.<sup>19</sup> For example, ICESCR prohibits discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of adversely affecting the equal enjoyment or exercise of the right to health.<sup>20</sup>

In addition to the above, there are a range of other human rights principles that are relevant in responding to HIV/AIDS.

## The right to privacy

No-one shall be subject to arbitrary or unlawful interference with his/her privacy.<sup>21</sup>

## The right to information

Everyone has the right to freedom of expression; this right includes freedom to seek, receive and impart information and ideas of all kinds.<sup>22</sup>

## The right of participation

Everyone has the right to active, free and meaningful participation.<sup>23</sup>

## The right to enjoy the benefits of scientific progress

Everyone has the right to enjoy the benefits of scientific progress and its applications.<sup>24</sup>

## Freedom from torture

No-one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no-one shall be subjected to medical or scientific experimentation without free consent.<sup>25</sup>

## Freedom of association

Everyone shall have the right to freedom of association with others, including the right to form and join trade unions.<sup>26</sup>

## The right to work

Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.<sup>27</sup>

## The right to education

Everyone has the right to education, directed to the full development of the human personality and the sense of its dignity, enabling all persons to participate effectively in a free society and promoting understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups.<sup>28</sup>

## The right to an adequate standard of living

Everyone has the right to an adequate standard of living, including adequate food, clothing, housing, medical care and necessary social services.<sup>29</sup>

## The right to development

Everyone is entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realised.<sup>30</sup>

# Public health



We apply public health principles in our work.

## Broad definition of health

The goal of public health is to promote the health of communities. A broad definition of 'health' is required to take into account the social determinants of health, which so significantly affect the achievement of this goal. WHO defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.<sup>31</sup>

## Addressing population vulnerability

In order to promote the health of communities at a population level, it is critical to understand the array of factors that place particular populations at risk of HIV transmission or exacerbate the impact of HIV/AIDS, including the social factors that underscore such vulnerability.

Understanding the causes of vulnerability and developing service and programme responses that address the needs of specific communities is essential in an effective response to HIV/AIDS.

## Evidence-informed approaches

A comprehensive and participatory assessment of populations' needs, in order to identify, understand and address population vulnerability, requires an approach that is informed by evidence.

Surveillance, monitoring and risk assessment, encompassing the collection of data related to health status, epidemiological analysis and population health research, provide an essential evidence base for the development and delivery of programmes (see also sections 2.5 Cross-cutting issues: addressing population vulnerability; 3.6 Programme planning, monitoring and evaluation; and 3.9 Research).

## Prevention

Public health response to HIV encompasses three levels of prevention activities:

- primary prevention measures to prevent HIV transmission
- secondary prevention measures to ensure early detection and successful management and treatment for PLHA
- tertiary prevention measures to limit the further negative effects of HIV and increase the quality of life of PLHA.

The public health model of primary, secondary and tertiary prevention may not be the language that all NGOs use. Nonetheless, this approach reflects what we do. We work to prevent HIV transmission, provide treatment, care and support, and address the underlying causes of HIV/AIDS and its impacts.

## Community organisation

Communities are a vital part of the HIV/AIDS response. Communities must be mobilised, informed and empowered to enable them to increase control over, and to improve, their health. This means that communities must be involved in setting priorities, making decisions, and planning and implementing strategies to achieve better health. At the heart of this process is the empowerment of communities, and their ownership and control of their own endeavours.<sup>32</sup>

## Public policy

Public health policy seeks to influence the social conditions that affect health by promoting the use of a scientific knowledge base and an understanding of the determinants of health in the development of public policy, legislation and health systems to provide an enabling environment for effective responses to HIV/AIDS.

# Development



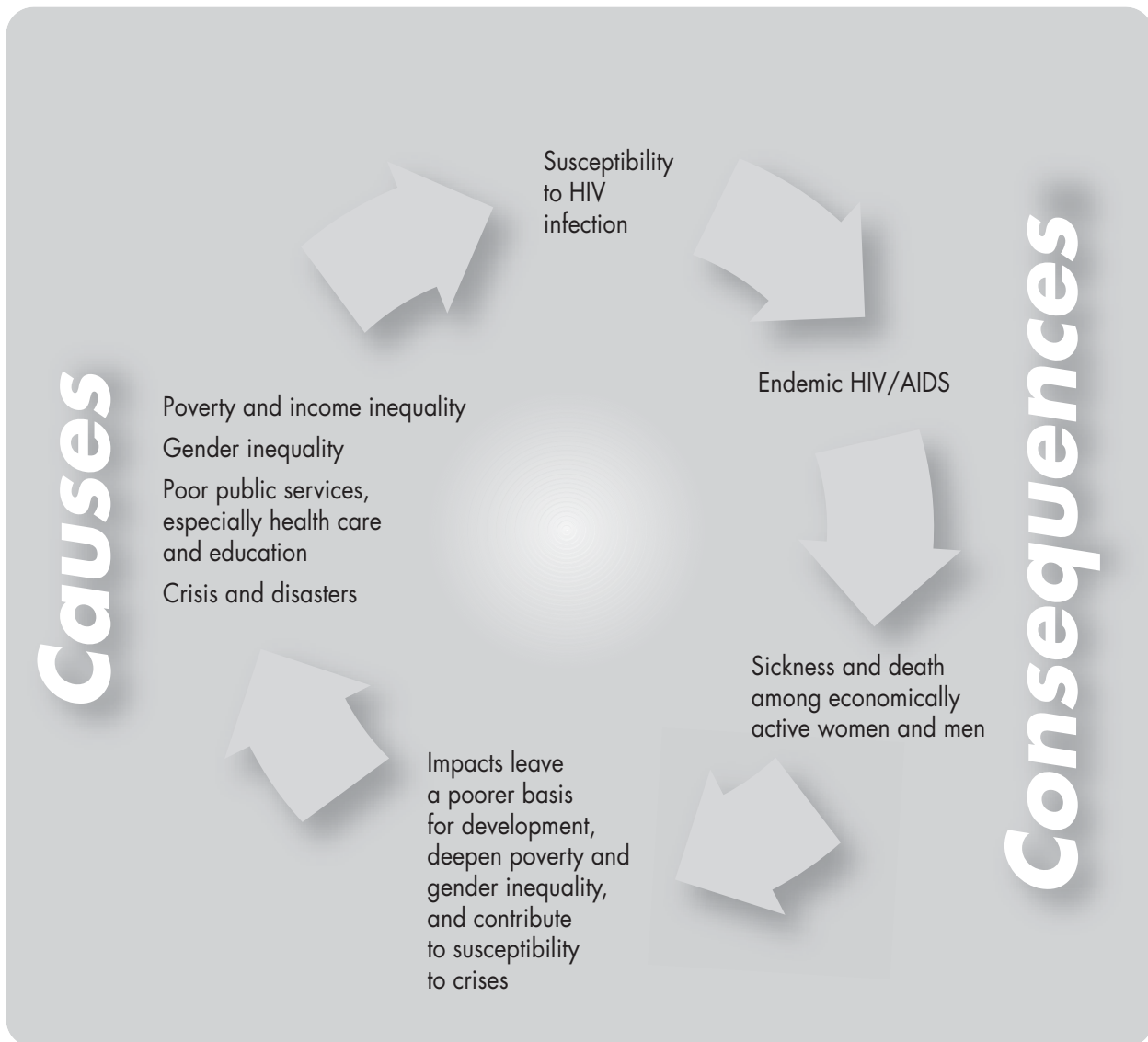
We address the causes of vulnerability to HIV infection and the impacts of HIV/AIDS.

HIV/AIDS has devastating and far-reaching implications for individuals, families, communities and societies. Epidemic diseases are not new, but what sets HIV/AIDS apart is its unprecedented negative impact on the social and economic development of nations most affected by it. In high-prevalence countries, skilled personnel in public, social, education and health care services are becoming ill and dying, undermining the capacity of services to meet demands that continue to escalate as a consequence of HIV/AIDS. The pandemic is reducing labour forces and agricultural productivity, thus exacerbating global poverty and vulnerability to HIV/AIDS infection. Millions of children in developing countries are without adequate care and support, which places additional pressures on families and communities to care for orphans and children made vulnerable by HIV/AIDS (OVC). As parents and care-givers become ill or die, children are increasingly shouldering the burden of generating an income, producing food and taking care of family members who are ill.<sup>33</sup> Women and girls bear a large proportion of the burden of AIDS care, both in the formal care sector and informally in communities. This often leads to girls having to leave school, women having diminished opportunities for economic independence, and women living with HIV/AIDS struggling to meet their own as well as their families' care needs, all of which further entrenches gender inequities.<sup>34</sup>

A human rights approach to HIV/AIDS encompasses the right to development, where all people are entitled to participate in, contribute to, and enjoy economic, social, cultural and political

development. It also supports efforts to address the underlying causes of vulnerability to HIV/AIDS and its impacts. The Declaration of Commitment on HIV/AIDS provides explicit commitments to invest in sustainable development in order to alleviate the social and economic impacts of HIV/AIDS, and calls for multi-sectoral strategies, including:

- developing and accelerating the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic;
- reviewing the social and economic impact of HIV/AIDS at all levels of society, especially on women and older people, and particularly on their role as care-givers in families affected by HIV/AIDS, to address their special needs; and
- adjusting and adapting economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, the provision of essential economic services, labour productivity, government revenues and deficit-creating pressures on public resources<sup>35</sup> (see also section 4.3 Mainstreaming HIV/AIDS).



## 2.5 Cross-cutting issues: addressing population vulnerability



Our programmes are informed by evidence in order to respond to the needs of those most vulnerable to HIV/AIDS and its consequences.

Given the significant differences between HIV/AIDS epidemics around the world, population priorities will vary depending on the nature of the epidemic, including whether there is high, medium or low HIV prevalence and whether the epidemic is widespread or concentrated within specific populations, such as people who inject drugs or men who have sex with men.

One of the key aims of this Code is to articulate the principles, practices and evidence base that underscore successful NGO work in responding to HIV/AIDS and that have global applications. It is not within the scope of the Code to provide detailed programming responses for the diversity of epidemics worldwide. Nonetheless, this section aims to highlight some of the key population groups that need to be considered in our work, depending on the context.

Priority must be given, and resources allocated, to meet the needs of those most vulnerable to HIV/AIDS and its impacts. While PLHA, their families and carers are a consistent priority, populations particularly vulnerable to HIV/AIDS and its impacts will vary from country to country, depending on the nature of the epidemic. This demands that our responses to HIV/AIDS be based on context-specific evidence. We need to understand the epidemiology, the social patterns of sexual activity and injecting drug use and the nature of the impact of HIV/AIDS in any given context.

Attention needs to be paid to the gender dimensions of HIV/AIDS. HIV/AIDS is not only driven by gender inequity – it entrenches it.<sup>36</sup> Women and girls are becoming increasingly vulnerable to HIV infection and bear the overwhelming burden of AIDS care, both informally in their families and communities and in the formal care sector.<sup>37</sup> The ‘feminisation’ of epidemics is starkest where heterosexual sex is the dominant mode of transmission. Women also figure significantly in many countries with epidemics that are concentrated in key populations such as injecting drug users, mobile populations and prisoners.<sup>38</sup>

The population groups considered in this section are clearly not mutually exclusive. This requires that we understand and take account of the multiple factors, such as gender, age, sexuality, ethnicity and socio-economic status, that shape people's lives in ways that influence their vulnerability to HIV/AIDS. Section 5.3 Key resources provides tools that can support the application of these programming principles when working with specific populations.

## People living with HIV/AIDS

The impact of HIV/AIDS is felt most strongly, and understood most profoundly, by those living with the disease. The meaningful involvement of PLHA and affected communities makes a powerful contribution to the HIV/AIDS response by empowering people living with HIV/AIDS to draw on their lived experiences. In turn this contributes to reducing stigma and discrimination and increasing the effectiveness and appropriateness of programmes (see section 3.2).

## Women and girls and men and boys

Programmes need to recognise and respond to the variety of ways in which gender inequities expose women and girls to the risk of HIV infection, undermine women's access to information, services and programmes, and entrench the subordination of women. In many cultures, unequal power in sexual relationships undermines the capacity of women and girls to exercise control over their sexual choices. One of the most serious manifestations of this inequity is gender-based violence, which can expose women to HIV infection, and fear of which can prevent them from protecting themselves against infection. Legislation often restricts the right of women to own or inherit property, entrenching their economic dependence on men, and limiting their capacity to refuse sex or negotiate condom use. A gendered approach to HIV/AIDS requires advocating for a legislative and policy environment that promotes the rights of women and girls, in order to shift the dynamics that underscore women's subordinate position in society and sexual relationships (see good practice principles in advocating for an enabling environment in sections 4.2 HIV/AIDS programming on page 63 and 4.3 Mainstreaming HIV/AIDS on page 83).

To reduce the spread and minimise the impact of HIV/AIDS, inequities between men and women must be reduced. This must necessarily involve men and boys as well as women and girls. Given the power men often have in society, communities, families and sexual relationships, there is a growing recognition of the need for programmes for men and boys that challenge gender roles and norms, enabling them to change their attitudes and behaviours that affect the vulnerability of women and girls. There is also a need to address the ways in which gender roles and norms undermine men's ability to access health programmes, including sexual health, HIV prevention and treatment, care and support.<sup>39</sup>

## Children and young people

Young people continue to make up a significant proportion of new infections each year, with 38 per cent of PLHA worldwide now under the age of 25.<sup>40</sup> We need to recognise and meet the needs of the growing population of young people living with HIV/AIDS. Sub-populations of young people are particularly vulnerable to infection, including young women, young men who have sex with men, young people who inject drugs, and sexually exploited children.<sup>41</sup> Many young people do not know how to protect themselves from HIV, and there are significant social and cultural barriers that impede the widespread availability of appropriate sexual health and HIV education for young people.<sup>42</sup>

There is also a clear cycle of vulnerability in relation to orphans and children affected by HIV/AIDS. An estimated 14 million children worldwide have lost one or both parents to AIDS.<sup>43</sup> A holistic response, including care in the community, is needed to address their needs, and this in turn can reduce their vulnerability to HIV infection.<sup>44</sup>

## Older people

Older people are both infected and affected by HIV/AIDS, but far too often their specific needs are overlooked. Data on infection rates among people over 50 are inadequate, yet the data that are available indicate rising infection rates among older people. With the expanding availability of ARVs, more people will be living with HIV/AIDS and their needs are likely to change as they grow older. In high-prevalence countries in particular, older people are often the primary carers for their adult children who have HIV/AIDS and/or children orphaned or made vulnerable by their parents' ill health or untimely death. Age-, gender- and HIV/AIDS-related stigma plays a role in older men and women being overlooked in programming.<sup>45</sup>

## Men who have sex with men (MSM), including gay men

Sex between men has been the predominant mode of transmission in some countries. However, it is also a factor in all HIV epidemics, though it is often statistically hidden and officially denied.<sup>46</sup> In recent decades there have been significant advances in decriminalising sex between men in many countries. Nonetheless, laws that criminalise or otherwise stigmatise or discriminate against MSM are contrary to human rights law and continue to drive the spread of HIV by alienating such men from access to prevention, treatment, care and support programmes.<sup>47</sup> Programmes need to be appropriate for MSM and enable them to protect themselves from HIV infection and respond to discrimination. Advocacy efforts need to be directed to law reform and addressing the social stigmatisation that increases the vulnerability of MSM.

Generally, the term 'men who have sex with men (MSM)' is used throughout the Code to include gay men. However, it is important to note that the needs and experiences of gay men and men who have sex with men but who may not identify as gay are different, and require responses that are appropriate to those differing needs and experiences.

## Sex workers and their clients

The stigma associated with sex work in many countries around the world creates significant barriers to sexual health and HIV prevention efforts among sex workers and their clients. While sex work has been decriminalised in some countries, it remains illegal in many more. Even where knowledge about safe sex practices is high among sex workers, the prevailing power dynamics, entrenched by gender, legal and social inequities, make it difficult to put that knowledge into practice. With this in mind, programmes, services and advocacy efforts need to be appropriate for sex workers and their clients. Strategies are required to promote an environment which supports access to treatment for HIV and other sexually transmitted infections (STIs). Supporting sex workers, including through collective action, empowers them to negotiate transactions, and address the health and social contexts that increase their vulnerability to HIV infection.

## People who inject drugs

HIV transmission through injecting drug use accounts for approximately 10 per cent of HIV infections globally and is a dominant factor driving HIV infection rates in many countries.<sup>48</sup>

Injecting drug use is a major factor in epidemics in Asia, North America, Western Europe, parts of Latin America, and in the Middle East and Northern Africa. In some Eastern European countries, especially the countries of the former Soviet Union, injecting drug use is driving an epidemic among young people.<sup>49</sup>

The illegality and stigma associated with injecting drug use invariably lead to discrimination against people who use drugs and create barriers to accessing services.<sup>50</sup> Failure to protect the human rights of people who inject drugs makes them afraid to access health and related support services, leading to negative health outcomes and undermining HIV prevention efforts.<sup>51</sup> A comprehensive range of services and programmes is needed in order to respond effectively to the harms associated with injecting drug use, including education programmes that reduce the risk of HIV infection among those who inject drugs (as well as those that deter people from drug use), access to clean needles and syringes, drug treatment programmes, and appropriate healthcare services. Concerted efforts must be made to ensure support for, and availability of, the full complement of services and programmes that reach and involve people who inject drugs.

## Transgender people

Transgender people face stigma and discrimination, which exacerbate their HIV risk. There are few transgender-sensitive HIV/AIDS programmes. Social marginalisation can result in the denial of health, education, employment and housing opportunities. Access to treatment, care and support is often limited due to fear of a person's transgender status being revealed, lack of knowledge about the healthcare needs of transgender people, and discrimination.<sup>52</sup>

## Prisoners

Correctional facilities, such as adult gaols and juvenile detention centres, are commonly characterised by concentrated populations of people living with HIV/AIDS, where injecting drug use, tattooing and consensual and forced sex commonly occur, in an environment where there is limited and often no access to the means of preventing the spread of HIV or to education programmes on HIV prevention.<sup>53</sup> This has significant consequences not only for prisoners themselves but also for the families and communities to whom they return, often after relatively short terms of imprisonment. Attempts to reduce drug use by mandatory drug screening have often had counter-productive results.<sup>54</sup> Programmes need to address the specific risks of HIV infection in prisons and meet the often complex health needs of prisoners, including those living with HIV/AIDS.<sup>55</sup>

## Mobile populations: internally displaced people, refugees, migrant and mobile workers

The spread of HIV/AIDS across communities, countries and continents is testimony to linkages between population movement and the growing epidemic. There is increasing recognition that the mobility of people, whether displaced by conflict or natural disasters, or to access work, can create particular kinds of vulnerability to HIV/AIDS and its consequences.<sup>56</sup> People move, voluntarily and involuntarily; temporarily, seasonally and permanently.

Mobility increases vulnerability to HIV/AIDS, both for those who are mobile and for their partners back home. Migrant and mobile workers<sup>57</sup> are often more vulnerable to HIV infection because of isolation resulting from stigma and discrimination and differences in language and culture; separation from regular sexual partners; lack of support and friendship; and lack of access

to health and social services.<sup>58</sup> Where these factors are combined with lack of legal protection, vulnerability to HIV infection is further increased. Effective responses to the vulnerability of mobile populations must include cross-border and regional responses, involving partners in source, transit and destination countries; culturally and linguistically appropriate outreach programmes; and advocacy efforts to protect and promote the human rights of, and where necessary improve the legal status of, migrant and mobile workers.<sup>59</sup>

At the end of 2001, over 70 different countries were experiencing an emergency situation of some kind, resulting in over 50 million people being affected worldwide.<sup>60</sup> The conditions that arise in emergencies such as armed conflict and natural disasters – social instability, poverty, displacement of populations, gender-based violence – are also the conditions that favour the spread of HIV infection. There is increasing recognition that humanitarian programmes need to both integrate HIV/AIDS-specific responses, such as making condoms available, and adapt interventions to better address the underlying causes of vulnerability to HIV/AIDS and its consequences in emergency settings<sup>61</sup> (see section 3.4 Mainstreaming HIV/AIDS).

# Notes

- 1 See, for example, the outline of humanitarian values of the International Federation of Red Cross and Red Crescent Societies at [www.ifrc.org/WHAT/values/hvalues](http://www.ifrc.org/WHAT/values/hvalues)
- 2 The Universal Declaration of Human Rights (1948). [www.unhchr.ch/udhr/lang/eng.htm](http://www.unhchr.ch/udhr/lang/eng.htm)
- 3 The Declaration of the Paris AIDS Summit (1994) is set out in *From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA)*, UNAIDS Best Practice Collection, September 1999. [www.unaids.org](http://www.unaids.org), search by title
- 4 See Section 2.4 regarding the right to participation.
- 5 Levene, J., *Community Mobilisation and Participatory Approaches: Reviewing Impact and Good Practice for HIV/AIDS Programming*, International HIV/AIDS Alliance, November 2004.
- 6 Collins, J. and Rau, B., *AIDS in the Context of Development*, United Nations Research Institute for Social Development (UNRISD) Programme on Social Policy and Development, Paper Number 4, Geneva, UNRISD and UNAIDS, 2000, p.6.  
[www.unrisd.org/unrisd/website/document.nsf/\(httpPublications\)/329E8ACB59F4060580256B61004363FE?OpenDocument](http://www.unrisd.org/unrisd/website/document.nsf/(httpPublications)/329E8ACB59F4060580256B61004363FE?OpenDocument)
- 7 Holden, S., *AIDS on the Agenda: Adapting Development and Humanitarian Programmes to Meet the Challenges of HIV/AIDS*, ActionAid, Oxfam GB and Save the Children UK, 2003. For a detailed discussion of HIV/AIDS as a development issue, see pp.9-38.  
[www.oxfam.org.uk/what\\_we\\_do/issues/hivaids/aidsagenda.htm](http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm)
- 8 Declaration of Commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 25-27 June 2001.
- 9 *2004 Report on the Global AIDS Epidemic*, Joint United Nations Programme on HIV/AIDS (UNAIDS), pp.123-127. [www.unaids.org/bangkok2004/report.html](http://www.unaids.org/bangkok2004/report.html). For examples, see section 4.2 of the Code on voluntary counselling and testing and addressing stigma and discrimination.
- 10 Patterson, D., *Programming HIV/AIDS: A Human Rights Approach. A Tool for International Development and Community Based Organizations Responding to HIV/AIDS*, Canadian HIV/AIDS Legal Network, 2004.  
[www.aidslaw.ca/Maincontent/issues/discrimination/rights\\_approach/international.htm](http://www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach/international.htm)
- 11 *25 Questions and Answers on Health and Human Rights*, World Health Organisation (WHO), Health and Human Rights Publication Series Issue No.1, July 2002, p.9.  
[www.who.int/hhr/activities/publications/en/print.html](http://www.who.int/hhr/activities/publications/en/print.html)
- 12 *HIV/AIDS and Human Right: International Guidelines*, Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), 1998,  
[www.ohchr.org/english/issues/hiv/guidelines.htm](http://www.ohchr.org/english/issues/hiv/guidelines.htm)
- 13 *25 Questions and Answers on Health and Human Rights*, p.14.
- 14 International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 2(1); ICESCR General Comment 3 on the nature of state parties' obligations, Fifth Session 1990 (E/1991/23).
- 15 *HIV/AIDS and Human Right: International Guidelines*, OHCHR and UNAIDS, 1998 and *HIV/AIDS and Human Right: International Guidelines – Revised Guideline 6*, 2002, both at  
[www.ohchr.org/english/issues/hiv/guidelines.htm](http://www.ohchr.org/english/issues/hiv/guidelines.htm)
- 16 ICESCR, article 12. As of November 2003, 148 countries had ratified the ICESCR.

- 17 In May 2000 the Committee adopted a General Comment on the right to health. General Comments serve to clarify the nature and content of individual rights and the obligations of governments.  
[www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358b0e2c1256915005090be?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument)  
 Also see *The Protection of Human Rights in the Context of HIV/AIDS*, Commission on Human Rights resolution 2003/47:  
[www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/c73b1b5e18ebae52c1256d1f00419762?Opendocument](http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/c73b1b5e18ebae52c1256d1f00419762?Opendocument);  
 and the reports of the UN Special Rapporteur on the Right to Health:  
[www.unhchr.ch/Huridocda/Huridoca.nsf/0/306eaf7b4938ba9c1256dd70051435d/\\$FILE/N0356469.pdf](http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/306eaf7b4938ba9c1256dd70051435d/$FILE/N0356469.pdf)  
[www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/\\$FILE/G0310979.pdf](http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/$FILE/G0310979.pdf)
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[www.unhchr.ch/huridocda/huridoca.nsf/e06a5300f90fa0238025668700518ca4/7022446690f820cec1256e82003192f6/\\$FILE/G0413757.pdf](http://www.unhchr.ch/huridocda/huridoca.nsf/e06a5300f90fa0238025668700518ca4/7022446690f820cec1256e82003192f6/$FILE/G0413757.pdf)  
 Also see Access to Medication in the Context of Pandemics such as HIV/AIDS, Tuberculosis and Malaria, Commission on Human Rights resolution 2003/29, April 2003.  
[www.unhchr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.RES.2003.29.En?Opendocument](http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.RES.2003.29.En?Opendocument)
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