Biosocial Realities and Right to Health: From Behavioral to Structural Interventions

Mahmood Monshipouri *

Kaveh Khoshnood **[1]

> We live in a world threatened by unlimited destructive force, yet we share a vision of creative potential.... AIDS shows us once again that silence, exclusion, and isolation—of individuals, groups, or nations—creates a danger for us all.[(1)]
>
> Jonathan Mann, 1998

> [w]hen medicine and public health are explicitly placed at the service of the poor, it provides even greater insurance against their perversion.[(2)]
>
> Paul Farmer, 2003

---

* Prof. Dr. Mahmood Monshipouri is Professor of Department of Political Science at Quinnipiac University. (Monshipour@quinnipiac.edu)

** Prof. Dr. Kaveh Khoshnood is Assistant Professor at Yale School of Public Health. (Kaveh.Khoshnood@yale.edu)

1. This paper was delivered at the *American Political Science Association Meetings* in Chicago, IL, September 1-4, 2004.

ISJ, Vol. 2, No. 1, Summer 2005, pp. 19-37.

INTRODUCTION

HIV/AIDS poses the greatest threat to global public health and is now widely regarded as one of the most formidable challenges to human rights. The attempt to globalize public health by enabling developing countries progressively achieve the right to health has spawned a plethora of arguments. Some public health scientists view individual human rights as the key to preventing this pandemic, arguing that "only by assuring the individuals that their interests would be protected could they be recruited to join in a public health effort by modifying their behavior."[(3)] Others argue that the right to health concerns not only a government's duty to its own people, but also the obligations of rich states to provide resources to low-income countries in order to help them combat HIV/AIDS, malaria, and TB.[(4)] Still others point out that the right to health is so fundamental that individuals are unable to exercise any other rights if they cannot maintain their health.[(5)]

It is imperative to move away from definitions having to do with individually-focused lifestyle toward context-sensitive notions if we are to get at the root causes of an epidemic like HIV/AIDS. Human rights framework, we submit, provides a potent method of discourse and assessment to do so. Moreover, as some experts argue, embedding health issues in the rights framework may prove more pragmatic than approaching the problem as one of penal reform alone.[(6)] Thus far, human rights actions and practices in their preoccupation with treatment have failed to properly address those at the risk of the abuse.

Obviously, the focus on health gives the human rights struggle a new dimension, while at the same time underscoring the importance of social and economic rights. We argue that the minimum standard of health care as a definition of right to health falls short of any meaningful analysis. The definition of right to health must be expanded to include entitlements such as basic and adequate health conditions.

The main theme of this paper is that protecting the rights of HIV infected individuals must be seen as a central strategy for the fight against this epidemic. The health and human rights nexus has entered a new phase, as the social and economic costs of HIV/AIDS are becoming prohibitively high. Local and Global disparities mean that proven therapies as well as the fruits of science and public health are stockpiled for some and denied to others.[(7)]

Whether one can take the article twenty-five of the Universal Declaration of Human Rights (1948) to mean that there is a universal right to health in the case of a global epidemic like HIV/AIDS has become the subject of an intense debate. In the developing world, the economic impact of HIV/AIDS has been substantial, crippling development and dashing hopes for economic prosperity and progress. AIDS will divert resources away from development investment to rising health and social welfare needs.[(8)]

We argue the need for the right to health by focusing on "structural interventions" aimed at changing the social determinants of risk. While we do not deny the importance of the individually-focused "behavioral interventions," we concur with those experts who argue that "Because HIV is no longer an automatic death sentence, we must anticipate behavioral shifts and explain the benefits and limits of current therapies."[(9)] It is also important to realize that many conditions and factors render regulating private behaviors via intervention difficult.[(10)]

We insist, however, that health and human rights are interconnected and their promotion fundamentally interlinked and that social justice is the foundation of public health. The broadest social determinants of health—such as income and class inequality, gender inequality, discrimination, and social stigmatization—must be viewed in this context. The invisible, marginalized people—largely at risk and not counted for—must be taken

into account in any serious attempt to address public health issues via structural interventions.

THE HIV/AIDS ISSUE AND BIOSOCIAL REALITIES

HIV/AIDS as a global problem is in dire need of a global solution and the costs of inaction are simply too great to ignore. Approximately 60 million people have been infected and 22 million people have died from AIDS since its identification in the 1980s, with a further 68 million people projected to die from the disease by 2020.[11] The United Nations Children's Fund (UNICEF) has estimated that more than 20 million children have been orphaned by the AIDS epidemic, with this figure expected to rise to 25 million by 2010, while many facing poverty and starvation as a result. Moreover, an increasing number of children are born HIV-positive as more women are infected and drugs available to reduce transmission to the children are prohibitively expensive.[12]

South Africa has 5 million people living with HIV, the highest absolute figure of any country in the world. Botswana and Swaziland have reached HIV prevalence levels of approximately 40%, and other countries have passed 30%, levels far beyond what could been guessed a few years ago.[13] Injecting drug use is the most cited cause of the epidemic but unsafe sex is increasingly a factor among the youth. Young people are particularly badly affected, most of all in Eastern Europe and Central Asia, where 80% of those living with HIV are under 30 years of age. The increases in new HIV infections, the number of young people affected, and the changing pattern of infection from injecting drug use to sexual transmission demonstrate that prevention efforts have been utterly insufficient.[14]

Too often, the cause of death is not determined or revealed largely owing to stigma and its social implications for the infected people. Disastrous impacts on infrastructure of African states are varied and many. In many of

these states, for example, people are reluctant to invest in higher education. They send, as Paula Tavrow notes, their children abroad. “In Botswana,” Tavrow writes, “50% of girls age 15-29 are HIV positive. Parents send their children abroad and don’t want them to come back.”[15]

Experts argue that AIDS in developing countries, especially in Sub-Saharan Africa, is primarily a welfare and education issue, not merely a medical one. Hence, attacking poverty, discrimination, and oppression may be the best way to prevent the epidemic. Of the 48 countries in Sub-Saharan Africa, Botswana, Lesotho, Swaziland, and Zimbabwe show the highest percentage of prevalence of HIV among adults. Income disparities are not surprisingly among the highest in these countries.[16] In 1998, the director of the World Health Organization declared: “The developing world carries 90 percent of the disease burden, yet poor countries have access to only 10 percent of the resources that go to health.”[17]

Social Epidemiology and Political Analysis

The fields of epidemiology and political analysis have become increasingly interconnected. These fields both illustrate the way poverty, discrimination, marginalization, social stigmatization, inappropriate criminalization, oppression, exploitation, and degradation of human dignity have all detrimental effects on health. For many in developing countries, life choices are structured by racism, sexism, political violence, and grinding poverty.[18] In both disciplines, rethinking has become imperative.

HIV/AIDS pandemic has forced the public health community to reexamine its assumptions and approaches to the control of diseases. The focus on changing individual risk behaviors using predominantly psychologically driven theoretical frameworks have proven to have little or modest success at curbing the spread of HIV/AIDS around the globe. This is

particularly true for the most deprived, marginalized and stigmatized populations in the United States and abroad.

While not denying that proximal risk factors such as unprotected sex and sharing of drug injection equipment with HIV infected individuals are directly associated with acquisition and spread of HIV infection, the new public health thinkers have raised the question of what factors put entire populations "at risk of risk?" Instead of demonstrating and re-demonstrating these direct associations between HIV infection and risk behavior at the individual level, the new paradigm asks why HIV/AIDS is so often concentrated in groups of people who have been historically marginalized and oppressed, in various cultural settings.

On the other hand, there is increasing evidence that structural interventions can have more profound impacts on reducing the burden of HIV/AIDS. As defined by Blankenship et al, structural interventions are those that attempt to alter the context in which health is produced and reproduced. In contrast to the individually oriented interventions that are driven by psychological theories of behavior change, structural interventions are predominantly influenced by social sciences and championed by social scientists who are much more concerned by the *conditions* that produce risk and risky environments and not individuals risk behaviors.

This rethinking of the approach to identifying and responding to ill health is consistent with the call by some public health professionals for a return to the roots of modern public health. These individuals remind us that modern public health has its roots in movements for social justice. In the early years of public health, illness and health were clearly understood as social phenomena directly related to social factors such as poverty, sanitation, employment, housing, discrimination, etc.

The rethinking among public health community is not restricted to the HIV/AIDS pandemic but is occurring in many other areas of public health such as cancer, smoking, heart disease, etc. and can be broadly categorized as "social epidemiology." This is in contrast to the so called "risk factor epidemiology" that often locates the risk of disease in *individual behavior* and advocates individual behavior change as the solution to controlling various diseases.

Social epidemiology on the other hand, has a *population-based* perspective and locates the risk of diseases in the social environment of populations. As such, social epidemiologists identify social factors, such as poverty, employment, housing, discrimination, and criminalization of certain behaviors, as the root causes of multiple diseases. There are two consequences of this perspective: 1) the solutions proposed by social epidemiologists by necessity have to include the modifications of larger societal factors, and 2) social epidemiologists must engage with the political systems to get support for their proposed interventions, something they are often ill equipped to tackle.

The reassessment of the mission of public health has coincided historically with a new awareness of the inextricable link between health and human rights. Championed mostly by human rights oriented lawyers, clinicians and public health professional, they have argued that the key to curbing the spread of HIV/AIDS is to protect the human rights of those affected by this epidemic.

The health and human rights proponents are distinct from the new public health advocates and social epidemiologists in two ways: a) their emphasis on individual human rights (and not rights of entire communities or societies) and b) their focus on ensuring the human rights of people *with*

HIV/AIDS and not those *at risk* of HIV/AIDS, such as uninfected drug users.

In some sense, one can argue that social epidemiologists and advocates of structural interventions are more intentionally concerned with Social, Economic and Cultural Rights compared to the advocates of the health and human rights who are more keenly focused on Civil and Political Rights of person with HIV/AIDS. Moreover, in principle, the social epidemiologists would be equally concerned with the social factors that put populations "at risk of risk" *before* they are infected with a disease as they would be with social factors that impact the progression of disease in populations that are already infected and as such depart from the health and human rights advocates.

HEALTH AND HUMAN RIGHTS

We borrow two assumptions from the field of social epidemiology: (1) that modern concepts of health takes full account of the underlying "conditions" that establish the foundation for realizing physical, mental, and social well-being[(19)] and (2) that health is a precondition for the capacity to realize and enjoy human rights and dignity.[(20)] Increasingly, social scientists elucidate how human rights provide the necessary tools to rectify the adverse effects of inequalities on the health and welfare of the individuals, groups, and communities. Civil-political rights as well as economic, social, and cultural rights are directly linked to the prevention of disease and the promotion of health. Public policies must take a hard look at biosocial realities in a global context of our times.

To better understand the right to health in the context of the AIDS pandemic, it is essential that we define this right in terms of norms and obligations. A good place to start is to focus on the *Article 25 of the Universal Declaration of Human Rights* (1948):

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[21]

General Comment No. 14 of the UN Committee on Economic, Social, and Cultural Rights (CESCR) proclaims that "health is a fundamental human rights indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity." That right, however, is interdependent with many other human rights. Good health is the prerequisite for exercising other individuals' rights, including the exercise of right to equal participation in the community. This capacity for participation in turn enhances their health status.[22] Seen from this perspective, the right to health covers wide-ranging socioeconomic conditions necessary for living a life in dignity. This means that everyone should have access to appropriate medical care and adequate legal remedies.

Perhaps the most problematic aspect of the right to health, as defined in terms of the "enjoyment of the highest attainable standard of physical and mental health," relates to state duties and responsibilities.[23] Not only are states responsible for providing effective health services, their actions must also be transparent.

Globalization and Access to Pharmaceuticals

The right to produce and import medicines that are prohibitively expensive in today's market has become much more pronounced in a globalizing world. The access of people with HIV/AIDS to adequate medical treatment has generated a contentious debate over who should, in an increasingly global economy, rip the benefits of science and technology and how such benefits should be distributed.

Under the World Trade Organization (WTO), the TRIPS Agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights) sets minimum standards for levels of intellectual property protection that all WTO member states must observe. This entails 20-year patent protection on all products, including pharmaceutical products. All members of the WTO are required to pass national patent legislation in conformance with the TRIPS agreement. Although developing countries are given a longer time to implement such legislation, all should comply by 2006.(24)

Many developing countries have been intimidated out of pursuing generic importation or production. These countries' governments cannot afford to supply HIV/AIDS drugs, even if they are sold at their marginal cost.(25) The World Trade Organization (WTO) has been partly responsible for the failure of developing countries to allow generic competition on patented medicines.(26)

In some developing countries (India and Brazil) generic manufacturers have produced these drugs at rather cheap prices without permission from the patent holders. This practice, considered legal under TRIPS, has become known as "compulsory licensing."(27) TRIPS also allows for the importing of medicines from countries other than the country of manufacture. This practice is called "parallel importing." Although both compulsory licensing and parallel importing are widely practiced by Western countries, some developing countries have been pressured by Western governments to ban such practices.(28)

The central issue under debate relates to the prohibitive price of many patented drugs when compared to generic drugs. Antiretroviral drugs are cost-effective in developing countries. Thailand's Government Pharmaceutical Organization has supplied generic zidovudine since 1993.

The ensuing competition has led to a decrease in monthly cost (600 mg per day) from $US324 in 1992 to $US87 in 1995.[29]

The pharmaceutical industry tends to argue that any weakening of patent rights will undermine research and development. Many NGOs, including Médecins Sans Frontières (Doctors Without Borders), OXFAM, the US-based group Consumer Project of Technology (a Ralph Nader—backed group in Washington, DC), and AIDS activists, argue that "higher prices for drugs under patent do not in fact stimulate research and development for drugs for neglected diseases, including tropical diseases."[30] Additionally, they point, "with a pharmaceutical market of less than 6% in the developing world, low drug prices—mostly for drugs that are hardly sold now—will not themselves affect the research and development capacity of the drug companies."[31]

The HIV/AIDS epidemic in turn holds serious implications for globalization, including threatening global health, retarding development, undermining productivity, and posing new threats to global security. The flow of refugees living with HIV and searching for treatment may flood developed countries. This so-called "therapeutic pilgrimage" is a significant part of migration unfolding in a globalizing context. The epidemic clearly signifies the emerging global public health crisis.[32]

Neoliberal globalization has led to increased reliance on the market forces, giving priority to growth over equity while masking socioeconomic disparities. The latter has, in substantial degree, determined the distribution of not just the risk but also of outcome in highly complex and evolving contexts. The privatization of state-run social programs in developing countries will surely have negative consequences for upholding certain rights such as the right to health. The privatization of health services in developing countries affects rich and poor differently. About half of the Peruvian

population survives on less than two dollars per day. They have very limited say in determining social policy and certainly not much stamina to endure the negative consequences of the privatization of the health care system.[33]

The interconnected world of globalization tends to heighten health risks. The grip of globalization and corporate mentality on the global economy has exacerbated the health issues for the vast majority of the poor people around the world, raising profound ethical questions of how to curtail and ultimately eradicate human suffering. Large pharmaceutical, biotechnology, for-profit health-care providers, and health insurance corporations have played an enormous role in the corporatization and commodifications of health. Obtaining higher returns for shareholders has become a greater priority than safeguarding the public health.[34] The commercial interests of pharmaceutical TNCs override the goal of combating diseases that routinely afflict the world's poor. Few transnational pharmaceutical firms have attempted to develop new treatments for the world's most threatening infectious disease, such as malaria, hepatitis, or tuberculosis.[35]

While scientific R&D is necessary to develop medicines and vaccines, public-private sector coordination is required to establish a delivery system and infrastructure. Merck and CO., USA, has sponsored an Enhancing Care Initiative with Harvard University in Brazil and South Africa, and Botswana. In Botswana, Merck is collaborating with the Bill and Melinda Gates Foundation and other partners. Some US $100 million, including free anti-retroviral medicines, will be made available over five years.[36]

A broader consensus holds that structural inequities are among the most formidable obstacles to a universal right to health. Thus far, globalization has had exacerbating effects on the economically and socially disadvantageous classes both in developed and developing countries, deepening poverty, racism, and income and educational inequalities. Many

questions remain relevant: How might such disparities be addressed in the context of a sustainable development? What accounts for such discrepancies: individual behaviors, beliefs, and attitudes or larger social structural factors?

GENDER AND HIV/AIDS

Women are more vulnerable than men to HIV/AIDS because of such conditions as socioeconomic inequalities, discrimination, and the threat of coerced and unwanted sex and women's inability to negotiate safe sex. Women's low status is the key explanatory factor in HIV infections. Gender-related inequalities threaten the right to good health. Sex work, which is poverty-driven, is likely to enhance risk-taking behaviors, such as non-use of condoms with clients.[(37)] In most settings, Paul Farmer reminds us, gender alone fails to define risk for assaults such as rape and physical abuse and battering. "It is poor women," Farmer insists, "who bear the brunt of these assaults."[(38)]

The most obvious aspect of HIV/AIDS in Africa today is the feminization of the epidemic.[(39)] Many married, monogamous women in parts of Africa and Asia are infected with HIV. Although these women are aware of HIV and have access to condoms, their risk factor is their inability to control their husbands' sexual behavior or to refuse unprotected or unwanted sexual intercourse.[(40)] Under such circumstances, refusal may result in physical punishment or divorce. One implication of the latter is socioeconomic deprivation for the woman. Promoting women's rights, including legal and social changes upholding those rights, would bolster their ability to negotiate sexual practice and protect themselves from HIV infection.[(41)]

In many developing countries, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs). When combined with traditional beliefs about women, these perceptions provide a basis for

the further stigma of women within such societies. Moreover, HIV-positive women are treated differently from men. While men are likely to be "excused" for their behavior that resulted in their infection, women are not. In some African countries, women, whose husbands have died from AIDS-related infections, have been blamed for their death.[42] Women widowed AIDS suffer the injustice of both statutory and customary law that militates against their being able to retain marital property.[43]

Application of human rights law can provide a remedy, resulting in improvements in women's health status. Feminists identify the private law, including family relationships and functioning, as costly to women's health. Laws permitting younger marriage of girls than boys, they argue, "promote the stereotyping of women in childbearing and service roles, and exclude them from the education and training that boys receive to fulfill their masculine destiny as family and social leaders."[44]

CONCLUSION

At the beginning of the third millennium, HIV/AIDS has become the greatest transnational health crisis as well as the most serious infectious disease in terms of threats to human security. This pandemic has forcefully and painfully shown us that interventions that focus solely on altering individual behavior while ignoring social context of risk are doomed to fail. There exists a fertile ground for the cooperation between political scientists and epidemiologists. While epidemiologists are primarily concerned with the treatment of the epidemic, political scientists are keen on filling a crucial gap by providing their expertise and knowledge of political structures, political process, and policymaking process.

Structural interventions are an example of these types of interventions proposed by social epidemiologists that aim to reduce the burden of HIV/AIDS. Structural interventions are focused on altering the social

context of risk and hold the promise of a more profound impact on reducing burden of HIV/AIDS globally. The implementation and success of structural interventions to a large degree hinges on the ability of its proponents to engage the political systems and obtain their support. ❖

NOTES:

1. Lawrence O. Gostin, “Remembrance of Jonathan Mann,” available at <http://www.iapac.org/advohaf2.asp?artid=35.>. Last visited on June 11, 2004.

2. Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Berkeley: University of California Press, 2003, p. 236.

3. Daniel Wikler and Richard Cash, “Ethical Issues in Global Public Health,” in Robert Beaglehole, ed., *Global Public Health: A New Era*, NY: Oxford University Press, 2003, pp. 226-242; see p. 231.

4. David P. Fidler, “A Globalized Theory of Public Health Law,” *The Journal of Law, Medicine & Ethics*, Vol. 30, No. 2, Summer 2002, pp. 150-161; see p. 156.

5. Carol Devine, Carol Rae Hansen, and Ralph Wilde, *Human Rights: The Essential Reference*, Phoenix, Arizona: The Oryx Press, 1999, p. 107.

6. Paul Farmer (2003), *Pathologies of power* Ibid., p. 236.

7. Paul Farmer (2003), *Pathologies of Power*, Ibid. p. 221.

8. Keith Hansen, “A Plague’s Bottom Line,” *Foreign Policy*, No. 137, July/August 2003, pp. 26-27.

9. See comments made by Dr. Helene Gayle of the Bill and Melinda Gates Foundation, an NGO committed to fighting epidemics such as HIV/AIDS, in Lawrence K. Altman, “Report Urges More H.I.V. Prevention Along With Treatment,” *The New York Times*, June 11, 2004, p. A9; see also Helen Epstein, “The Fidelity Fix,” *The New York Times Magazine,* June 13, 2004, pp. 54-59. She argues that increased faithfulness seems to have been crucial to the precipitous decline of H.I.V. rates in Uganda. (p. 56).

10. Kim M. Blankenship, Sarah J. Bray, and Michael H. Merson, “Structural Interventions in Public Health,” in *AIDS*, Vol. 14, Supplementary 1, 2000, pp. 11-21; see p. 19.

11. See “World AIDS Summit Warns of Challenges Ahead,” CSIS Globalization 101, available at <http://www.globalization101.org/news.asp?NEWS_ID=35>. Last visited on June 19, 2004.

12. *Ibid.*

13. See comments made by Mary Robinson, “Breaking Barriers: Partnership to Fight HIV/AIDS in Europe and Central Asia Conference for Ireland’s EU Presidency,” available at <http://www.eginitiative.org/documents/breakingbarriers.html.>. Last visited on June 19, 2004.

14. *Ibid.*

15. Leslie Evans, “AIDs in Africa Devastates Economies and Destabilizes States,” UCLA International Institute: Educating Global Citizens, available at <http://www.international.ucla.edu/article.asp?parentid+4208>. Date posted: 6/10/2003. Last visited on June 23, 2004.

16. See The World Bank, *2004 World Development Indicators*, Washington, D.C.: The International Bank for Reconstruction and Development, 2004, pp. 60-63 and 104-106.

17. Quoted in Mahmood Monshipouri, “Promoting Universal Human Rights: Dilemmas of Integrating Developing Countries,” *Yale Human Rights and Development Law Journal*, Vol. 4, 2001, pp. 25-61; see p. 56.

18. Paul Farmer, “On Suffering and Structural Violence: A View From Below,” *Daedalus*, Vol. 125, No. 1, Winter 1996, pp. 261-283; see p. 263.

19. Jonathan M. Mann. Lawrence Gostin, Sofia Gruskin, Troyen Brennan, Zita Lazzarini, and Harvey Fineberg, “Health ad Human Rights,” in Jonathan M. Mann. Sofia Gruskin, Michael A. Grodin, and George J. Annas, *Health and Human Rights: A Reader*, NY: Routledge, 1999; pp. 7-20; see p. 16.

20. *Ibid.,* p. 18.

21. Center for the Study of Human Rights, *Twenty-Four Human Rights Documents*, NY: Columbia University, 1992, pp. 6-9; see especially p. 8.

22. Rebecca Cook, “Gender, Health, and Human Rights,” in Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, eds., *Health and Human Rights: A Reader*, NY: Routledge, 1999, pp. 253-264; see p. 263.

23. Richard Lewis Siegel, “AIDS and Human Rights,” *Human Rights Quarterly*, Vol. 18, No. 3, August 1996, pp. 612-640; see p. 633.

24. H. David Banta, “Worldwide Interest in Global Access to Drugs,” *JAMA*, Vol. 285, No. 22, June 13, 2001, pp. 2844-2846; see p. 2845.

25. Nathan Geffen, “Applying Human Rights to the HIV/AIDS Crisis,” *Human Rights Dialogue*, Series 2, No. 6, Spring/Summer 2001, pp. 13-14; see especially p. 14.

26. *Ibid.*

27. *Ibid.,* p. 2846.

28. David Wilson, Paul Cauthorne, Nathan Ford, Saree Aongsonwang, "Global Trade and Access to Medicines: AIDS Treatments in Thailand," *The Lancet*, November 27, 1999, pp. 1893-1895; see p. 1893.

29. *Ibid.,* p. 1894.

30. H. David Banta, *op. cit.,* p. 2845.

31. H.David Banta, *op. cit.,* p. 2845.

32. Tony Barnett, "HIV/AIDS and Globalization: What is the Epidemic Telling Us about Economics, Morality, and Pragmatism?" pp. 9-14; see p. 13.

33. Jim Yong Kim, Aaron Shakow, Jaime Bayona, Joe Rhatigan, Emma L. Rubin de Celis, "Sickness Amidst Recovery: Public Debt and Private Suffering in Peru," in *Dying for Growth: Global Inequality and the Health of the Poor*, in Jim Yong Kim, Joyce V. Millen, Alec Irwin, and John Gershman, eds., *Dying for Growth: Global Inequality and the Health of the Poor*, Monroe, Maine: Common Courage Press, 2000, pp. 127-153; see p. 129.

34. Mahmood Monshipouri, "Promoting Universal Human Rights: Dilemmas of Integrating Developing Countries," *Yale Human Rights and Development Law Journal*, Vol. 4, 2001, pp. 25-61; see p. 58.

35. Joyce V. Millen and Timothy H. Holtz, Dying for Growth, Part I: Transnational Comparatives and the Health of the Poor, in Jim Yong Kim, Joyce V. Millen, Alec Irwin, and John Gershman, eds., *Dying for Growth: Global Inequality and the Health of the Poor*,Monroe, Maine: Common Courage Press, 2000, pp. 177-223; see p. 184.

36. See "The Globalization of AIDS," *World Economic Forum*, Annual Meeting, January 29, 2001, available at <http://www.weforum.org/site/knowledgenavigator.nsf/Content/The%20Globalization%20of%20AIDS_2001?open&topic_id=500270000&theme_id=500>. Last visited on June 19, 2004.

37. Elhadj Sy, "Gender, HIV/AIDS, and Human Security," available at <http://www.un.org/womenwatch/daw/csw/Sy2001.htm.> Last visited on June 5, 2004.

38. Paul Farmer, "On Suffering and Structural Violence: A View From Below," *Daedalus*, Vol. 125, No. 1, Winter 1996, pp. 261-283; see p. 275.

39. African Women's Media Center, available at <<http://www.awmc.com/pub/p-4680?e-4681/ch-4696. Last visited on June 9, 2004.

40. Lawrence O. Gostin, *The AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations*, Chapel Hill, NC: The University of North Carolina Press, 2004, p. 67.

41. *Ibid.,* p. 67.

42. See "HIV & AIDS Stigma and Discrimination," available at <http:///www.avert.org/aidsstigma.htm>. Last visited on June 5, 2004.

43. *Human Rights Watch*, "Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girds in Africa," December 2003, pp. 1-96; see p. 4.

44. Rebecca Cook, "Gender, Health, and Human Rights," in Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, eds., *Health and Human Rights: A Reader*, NY: Routledge, 1999, pp. 253-264; see p. 262.