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Rhianna M. Fronapfel

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# AIDS PREVENTION AND THE RIGHT TO HEALTH UNDER INTERNATIONAL LAW: BURMA AS THE HARD CASE

Rhianna M. Fronapfel<sup>†</sup>

*Abstract:* Many commentators suggest that states have a human rights obligation to prevent the spread of HIV/AIDS within their borders. Specifically, state HIV/AIDS prevention obligations are often premised on the “right to health” contained within many international human rights documents. Other approaches encourage states to implement AIDS prevention measures by emphasizing the detrimental effects of AIDS on economies and national and international security instead. Many commentators who adhere to the health-and-human-rights model, however, reject such other approaches as overly concerned with the interests of developed countries and lacking the ethical focus that underlies health and human rights. Implicit in such arguments is the suggestion that the health-and-human-rights approach is, or should be, the exclusive or preeminent way to encourage states to comply with suggested AIDS prevention measures.

The health-and-human-rights approach, however, is not universally relevant to the development of AIDS prevention measures. This is particularly evidenced by Burma, a country that has failed to take any significant steps to abate its quickly accelerating HIV/AIDS crisis despite the government’s official statements and actions manifesting an intent to combat the epidemic. Burma’s failure is especially disquieting in light of the proven success of measures suggested by international health and AIDS organizations, and models offered by countries such as Thailand with similar epidemics and winning prevention strategies. International human rights law lacks the binding or enforcement power to compel the state’s compliance with international HIV/AIDS agreements, and the abysmal health and human rights record of the Burmese government suggests that Burma is unlikely to be swayed by the ethical call of a health-and-human-rights approach. Thus, Burma serves as an example of where the health-and-human-rights approach fails to bring about compliance with HIV/AIDS prevention measures, highlights the weaknesses of the approach, and compels the conclusion that the right to health is not a model that is universally applicable or useful in encouraging state compliance with AIDS prevention measures.

## I. INTRODUCTION

The HIV/AIDS pandemic is a problem of international concern.<sup>1</sup> As the severity of the disease increased to epidemic proportions over the last two decades, developed states and the international community began to explore ways to aid and encourage developing states to treat and prevent the spread of the disease within their borders. A host of approaches arose that aimed at encouraging developing states to implement HIV/AIDS prevention

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<sup>†</sup> The author would like to thank Professor Veronica Taylor for her advice and guidance in the development of this Comment.

<sup>1</sup> Lawrence O. Gostin, *The Global Reach of HIV/AIDS: Science, Politics, Economics and Research*, 17 EMORY INT’L L. REV. 1, 1 (2003) (“HIV/AIDS affects people throughout the world—their health, their communities, and their countries’ economic structures. It is truly a global epidemic, imposing a burden on all countries and regions, leaving none immune to its devastating impact.”).

measures and to dedicate the resources necessary to do so. Many such approaches encourage states to prevent the spread of AIDS in order to dampen the disease's detrimental impact on economic stability and international and national security.<sup>2</sup>

Accompanying the rising prominence of human rights in international law, many commentators have promoted an alternate approach that conceptualizes the duty of states to prevent the spread of HIV/AIDS within the health-and-human-rights paradigm. Such an approach focuses on the duty of states to prevent the spread of HIV/AIDS in order to comply with the "right to health" provisions found within many international human rights documents.<sup>3</sup> The right-to-health approach is not necessarily incompatible with those approaches that focus on factors such as economics and security. Nonetheless, a tension exists between them.<sup>4</sup> The very existence of non-human-rights-based approaches implies that the right-to-health model is not always adequate, standing alone, to encourage resistant states to implement HIV/AIDS prevention measures. The suggestion that human rights is not always the most viable way to conceptualize state health and HIV/AIDS obligations, however, has proven controversial among some health-and-human-rights adherents, a number of whom reject the other approaches altogether. For example, a leading opponent of non-human-rights-based approaches argues that issues such as HIV/AIDS prevention are best conceptualized within a health-and-human-rights paradigm focused on health justice and equity rather than the "self-serving relativism" of a security-based approach.<sup>5</sup>

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<sup>2</sup> See, e.g., David P. Fidler, *Caught Between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness*, 35 MCGEORGE L. REV. 45 (2004).

<sup>3</sup> See *infra* Part II.B. See generally International Covenant on Economic, Social, and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR]; International Convention on the Elimination of All Forms of Racial Discrimination, Jan. 4, 1969, 660 U.N.T.S. 195 [hereinafter ICERD]; Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW]; and United Nations Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3.

<sup>4</sup> Compare PAUL FARMER, *PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR* 195 (Univ. of Cal. Press 2005) (2003) (promoting a human rights approach to improving health and criticizing security-based approaches), with DAVID P. FIDLER, *INTERNATIONAL LAW AND INFECTIOUS DISEASES* (Oxford Univ. Press 1999) (questioning the feasibility of a human rights approach to infectious disease treatment and prevention, and discussing alternative approaches such as ones based on trade and security).

<sup>5</sup> FARMER, *supra* note 4.

Burma<sup>6</sup> serves as an interesting lens through which to view this debate because of the severity of the country's AIDS epidemic and the particular failure of the Burmese leadership to take any significant steps to implement prevention measures.<sup>7</sup> The country is facing a major health crisis as the AIDS epidemic steadily increases largely unabated within its borders. The last official report by the World Health Organization ("WHO") puts the HIV prevalence rate in Burma at 0.77% as of the end of 2001, fourth behind those countries with the highest rates of infection in Asia: Cambodia, Thailand, and India.<sup>8</sup> According to a 2004 estimate of the Joint United Nations Programme on HIV/AIDS ("UNAIDS"), the rate of HIV/AIDS among adults is approximately 1.2% and as high as 2.2%.<sup>9</sup> Other estimates put the current rate of infection in Burma as high as 4%, just behind Cambodia's.<sup>10</sup> Given the prevention successes in the other high-prevalence countries, Burma is poised to become the country with the highest HIV infection rates in Asia if current trends continue.<sup>11</sup> UNAIDS has recognized the seriousness of Burma's AIDS situation and identified Burma as one of the three highest-priority countries in Southeast Asia, stating that "there is a genuine potential for this very serious epidemic to grow out of control unless an effective coordinated response is urgently implemented."<sup>12</sup> Burma's government has exhibited a commitment to combat the epidemic by finally acknowledging its existence after a long period of denial,<sup>13</sup> and engaging in a five-year

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<sup>6</sup> This Comment refers to the country in question as "Burma." It should be noted that the Burmese government changed the country's name to the ostensibly more ethnically inclusive name "Myanmar" in 1989. Many ethnic groups, however, reject the name "Myanmar" itself as ethnically exclusive, and while the United Nations and the business community usually employ the "Myanmar" designation, many Western governments (including the United States), non-governmental organizations, and commentators continue to refer to the country as "Burma." The use of "Burma" in this Comment is for the sake of consistency and expediency, and is not meant to signal an allegiance to either side of this debate. See Myint Zan, *Judicial Independence in Burma: Constitutional History, Actual Practice and Future Prospects*, 4 S. CROSS U. L. REV. 17 n.1 (2000).

<sup>7</sup> See *infra* Part III.B.

<sup>8</sup> World Health Organization ("WHO"), HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, at 11 (2003).

<sup>9</sup> Joint United Nations Programme on HIV/AIDS ("UNAIDS")/WHO, *Myanmar: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2004 Update* at 2 (2004), available at [http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS\\_PDFs/EFS2004\\_MM.pdf](http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS_PDFs/EFS2004_MM.pdf).

<sup>10</sup> Chris Breyer et al., *Assessing the Magnitude of the HIV/AIDS Epidemic in Burma*, 32 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 311, 311 (2003); Jeremy Sarkin & Marek Pietschmann, *Legitimate Humanitarian Intervention under International Law in the Context of the Current Human Rights and Humanitarian Crisis in Burma (Myanmar)*, 33 HONG KONG L.J. 371, 384 (2003).

<sup>11</sup> See ELISABETH PISANI, MONITORING THE AIDS PANDEMIC NETWORK, AIDS IN ASIA: FACE THE FACTS 23 (2004), available at [http://www.fhi.org/en/HIVAIDS/pub/survreports/aids\\_in\\_asia.htm](http://www.fhi.org/en/HIVAIDS/pub/survreports/aids_in_asia.htm) (follow "Chapter 1" hyperlink).

<sup>12</sup> UNAIDS, JOINT PROGRAMME FOR HIV/AIDS: MYANMAR 2003-2005 1 (Apr. 1, 2004), available at [http://www.unaids.org/html/pub/una-docs/jpmyanmar\\_15jul04\\_en.pdf](http://www.unaids.org/html/pub/una-docs/jpmyanmar_15jul04_en.pdf).

<sup>13</sup> *Myanmar: Sickening*, THE ECONOMIST, Nov. 9, 2000.

UNAIDS plan, which includes guidelines for the government to increase prevention efforts.<sup>14</sup> Despite these representations, the Burmese government has failed to respond to the AIDS epidemic in any significant way,<sup>15</sup> largely preferring official denial of the severity of the crisis to serious abatement efforts.<sup>16</sup>

This Comment argues that the health-and-human-rights approach is not universally useful in encouraging states to prevent the spread of AIDS, as evidenced by Burma's situation. The right-to-health approach is an inadequate mechanism to encourage Burma's compliance because the Burmese government is unlikely to be swayed by the ethical call of the health-and-human-rights approach, and international human rights law lacks the enforcement mechanisms or binding power necessary to compel Burma's compliance with international HIV/AIDS prevention agreements. Examining the health-and-human-rights approach through the Burmese lens demonstrates that the approach is not sufficient to persuade all states to prevent the spread of AIDS.

Part II of this Comment examines the various approaches to HIV/AIDS prevention and the tensions between them. Part III observes that the overall rate of HIV/AIDS infection is steadily increasing in Burma as a result of the government's failure to institute prevention measures. Part IV argues that the right to health is an inadequate mechanism with which to enforce Burma's compliance with AIDS prevention measures. Finally, Part V argues that Burma is unlikely to voluntarily implement AIDS prevention measures in order to fulfill the ethical call of a health-and-human-rights approach.

## II. BACKGROUND: HEALTH AND HUMAN RIGHTS AND OTHER APPROACHES TO HIV/AIDS PREVENTION

Within the human rights discourse, many commentators suggest that states have an obligation to prevent the spread of HIV/AIDS in order to comply with the right to health found in many international human rights treaties.<sup>17</sup> Other more pragmatic approaches exist that encourage compliance with prevention measures by focusing on the detrimental

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<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> Tony Broadmoor, *Edging Towards Disaster*, 11 THE IRRAWADDY, May 2003, <http://www.irrawaddy.org/database/2003/vol11.4/cover.html>.

<sup>17</sup> *See, e.g.*, Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 181-182 (1994) (noting that states should address the AIDS epidemic in order to comply with their right to health obligations).

security and economic effects of AIDS.<sup>18</sup> Many proponents of health and human rights characterize such other approaches as being overly preoccupied with the interests of developed countries, while lacking an appropriate emphasis on ethics.<sup>19</sup> Implicit in that argument is the suggestion that health and human rights are, or should be, the exclusive or pre-eminent mechanism with which to encourage state compliance with AIDS prevention measures.<sup>20</sup>

A. *Many Commentators Suggest That States Have a Human Rights Obligation to Prevent the Spread of HIV/AIDS Within Their Borders*

Ever since Jonathan Mann, the first director of the World Health Organization's Global Program on AIDS, identified HIV/AIDS as a human rights issue,<sup>21</sup> many commentators have framed the obligation of states to deal with the AIDS epidemic with reference to international human rights law.<sup>22</sup> HIV/AIDS and the international human right to health have developed symbiotically over the past two decades.<sup>23</sup> Not only has HIV/AIDS served as a catalyst for bringing the right to health to the forefront of human rights law,<sup>24</sup> but framing HIV/AIDS as a right-to-health issue allowed it to be "anchored in international law," whereby governments are publicly accountable, at least theoretically, for their actions toward people affected by the disease.<sup>25</sup> HIV/AIDS is the first worldwide epidemic to arise in the modern era of human rights,<sup>26</sup> and has, in a sense, become a test case for human rights in the context of public health.<sup>27</sup>

In keeping with this trend, UNAIDS frames HIV/AIDS prevention and treatment largely as a health-and-human-rights issue. According to

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<sup>18</sup> David P. Fidler, *Public Health and National Security in the Global Age: Infectious Diseases, Bioterrorism, and Realpolitik*, 35 GEO. WASH. INT'L L. REV. 787 (2003) (advocating a security-based approach).

<sup>19</sup> See, e.g., FARMER, *supra* note 4.

<sup>20</sup> *Id.* at 199.

<sup>21</sup> Jonathan Mann, *Human Rights and AIDS: The Future of the Pandemic*, 30 J. MARSHALL L. REV. 195, 203-206 (1996).

<sup>22</sup> See, e.g., David Patterson & Leslie London, *International Law, Human Rights and HIV/AIDS*, Bulletin of the World Health Organization 2002 80(12), at 965 (2002); UNAIDS Global Reference Group on HIV/AIDS and Human Rights, *Issue Paper: Monitoring a Rights-Based Approach*, Fourth Meeting, August 23-25, 2004; and, UNAIDS Global Reference Group on HIV/AIDS and Human Rights, *Public Report*, Second Meeting, August 25-27, 2003.

<sup>23</sup> Sofia Gruskin & Daniel Tarantola, *Health and Human Rights 1* (Francois-Xavier Bagnoud Center for Health Hum. Rts., Working Paper No. 10, 2000).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*; LAWRENCE O. GOSTIN, *THE AIDS PANDEMIC: COMPLACENCY, INJUSTICE, AND UNFULFILLED EXPECTATIONS* 62 (2004).

<sup>26</sup> FIDLER, *supra* note 4, at 198.

<sup>27</sup> *Id.*

UNAIDS, in order for states to combat the AIDS epidemic, “the right to health care, information and other social and economic rights inscribed in United Nations Human Rights conventions and the Universal Declaration of Human Rights must be realized.”<sup>28</sup>

In addition, a number of international guidelines address the obligation of states to deal with HIV/AIDS under international human rights law. While not legally binding,<sup>29</sup> such documents clarify the right to health as it operates within the context of HIV/AIDS and the human rights of those living with the disease.<sup>30</sup> For example, in 1996, the United Nations prepared a set of guidelines called the International Guidelines on HIV/AIDS and Human Rights.<sup>31</sup> These guidelines not only called on states to ensure that their AIDS policies were consistent with “international human rights obligations,”<sup>32</sup> and the principle of non-discrimination,<sup>33</sup> but also to ensure the “widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.”<sup>34</sup> Thus, many human rights adherents conceptualize the obligation of states to prevent the spread of HIV/AIDS within their borders as a human rights issue, and many international documents reflect this perceived link between AIDS prevention and human rights.

*B. State HIV/AIDS Prevention Obligations Are Often Premised on the Right to Health*

Within the health-and-human-rights paradigm, the duty of states to deal with HIV/AIDS within their borders, including preventing its spread, is often conceptualized as a state’s duty to comply with the right to health

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<sup>28</sup> U.N. General Assembly Special Session on HIV/AIDS, June 25-27, 2001, *Together We Can: Leadership in a World of AIDS* 16, UNAIDS/01.34E (June 2001), available at <http://www.unaids.org/en/resources/publications/corporate+publications.asp>.

<sup>29</sup> Such instruments are referred to as “soft law,” and include international documents, declarations, reports, or other instruments which “may be loosely defined as declared norms of conduct understood as legally nonbinding by those accepting the norms.” JEFFREY L. DUNOFF ET AL., *INTERNATIONAL LAW: NORMS, ACTORS, PROCESS: A PROBLEM-ORIENTED COURSEBOOK* 32 (2002). While nonbinding, such documents “are meant to, and in fact do, influence government behavior.” *Id.* at 24.

<sup>30</sup> See, e.g., Patterson & London, *supra* note 22, at 965 (discussing what is required from states by the International Guidelines on HIV/AIDS and Human Rights).

<sup>31</sup> The Secretary-General, *Report of the Secretary General on the Second International Consultation on HIV/AIDS and Human Rights*, Annex 1, delivered to the U.N. Commission on Human Rights, U.N. Doc. E/CN.4/1997/37 (Jan. 20, 1997), available at <http://www.hri.ca/fortherecord1997/documentation/commission/e-cn4-1997-37.htm>.

<sup>32</sup> *Id.* at Guideline 3.

<sup>33</sup> *Id.* at Guideline 5.

<sup>34</sup> *Id.* at Guideline 6.

found in many international human rights instruments.<sup>35</sup> For example, prominent commentators Lesley Stone and Lawrence Gostin argue that government policies focused on respecting and protecting the right to health, such as the promotion of scientifically proven prevention measures like condom use and needle exchange programs, “will best curb the spread of HIV/AIDS.”<sup>36</sup> Thus, understanding how HIV/AIDS prevention fits within the health-and-human-rights schema requires an understanding of the meaning of the right to health.

The international right to health was first enshrined in the 1948 Universal Declaration of Human Rights (“UDHR”),<sup>37</sup> which is regarded as the first major international human rights document and the “cornerstone of the modern human rights movement.”<sup>38</sup> In addition to recognizing the right to be free from cruel, inhuman, or degrading treatment,<sup>39</sup> the right to equal protection of the law,<sup>40</sup> and the right to freedom of religion,<sup>41</sup> Article 25 of the UDHR expressly recognizes the right to health as an element of the right to an adequate standard of living:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of 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.<sup>42</sup>

Despite the widespread recognition of the UDHR pronouncements, this declaration itself is not a legally binding document.<sup>43</sup>

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<sup>35</sup> See Mary Ann Torres, *Public Health and International Law: The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: a Case Study from Venezuela*, 3 CHI. J. INT’L L. 105 (2002) (examining Venezuela’s obligations to treat those with HIV/AIDS within their obligations to honor their right to health); see also Roger Phillips, *South Africa’s Right to Health Care: International and Constitutional Duties in Relation to the HIV/AIDS Epidemic*, 11 HUM. RTS. BRIEF 9 (2004) (examining South Africa’s duties in regard to treatment and prevention of HIV/AIDS within its obligations to honor the right to health); Jamar, *supra*, note 17 (discussing the right to health in general and noting that states should address the AIDS epidemic in order to comply with their right to health obligations).

<sup>36</sup> Lesley Stone & Lawrence O. Gostin, *Using Human Rights to Combat the HIV/AIDS Pandemic*, 31 HUM. RTS. 2, 3 (2004).

<sup>37</sup> Universal Declaration of Human Rights, G.A. Res. 217A at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter UDHR].

<sup>38</sup> Gruskin & Tarantola, *supra* note 23, at 313.

<sup>39</sup> UDHR, *supra* note 37, art. 5.

<sup>40</sup> *Id.* at art. 7.

<sup>41</sup> *Id.* at art. 18.

<sup>42</sup> *Id.* at art. 25 (1).

<sup>43</sup> Patterson & London, *supra* note 22, at 964; see also explanation of “soft law,” *supra* note 29.



Since the inception of the UDHR, many of its provisions have been incorporated into numerous state constitutions and more than twenty binding multilateral treaties.<sup>44</sup> The two most important of these treaties are the 1966 International Covenant on Economic, Social, and Cultural Rights (“ICESCR”)<sup>45</sup> and the International Covenant on Civil and Political Rights (“ICCPR”).<sup>46</sup> Together with the UDHR, these two major treaties are often referred to as the “International Bill of Human Rights.”<sup>47</sup> While the ICCPR does not refer to health, the ICESCR specifically recognizes the right to health. Article 12 provides that “the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”<sup>48</sup> and “[t]he steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for . . . [t]he prevention, treatment, and control of epidemic, endemic, occupational and other diseases.”<sup>49</sup> As of April 2005, 142 countries have ratified the ICESCR.<sup>50</sup> Burma, however, has not yet signed or ratified the treaty, and is therefore not bound by its provisions.<sup>51</sup>

Other multilateral human rights treaties with right-to-health provisions focus on specific populations.<sup>52</sup> Two that similarly include a right to health within their provisions are the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (“CEDAW”)<sup>53</sup> and the 1989 Convention on the Rights of the Child (“CRC”).<sup>54</sup> Article 12 of CEDAW provides that “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning.”<sup>55</sup> Article 24 of CRC addresses the right to health more directly, providing that states “recognize the right of the child to the enjoyment of the highest attainable standard of health and to

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<sup>44</sup> Gruskin & Tarantola, *supra* note 23, at 313.

<sup>45</sup> ICESCR, *supra* note 3.

<sup>46</sup> U.N. International Covenant on Civil and Political Rights, Dec. 16, 1996, 999 U.N.T.S. 302 [hereinafter ICCPR].

<sup>47</sup> Gruskin & Tarantola, *supra* note 23, at 313.

<sup>48</sup> ICESCR, *supra* note 3, art. 12(1).

<sup>49</sup> *Id.* at art. 12(2).

<sup>50</sup> Gruskin & Tarantola, *supra* note 23, at 313.

<sup>51</sup> Office of the United Nations High Commissioner for Human Rights, *Status of the Ratifications of the Principal International Human Rights Treaties As of 09 June 2004*, at 7, available at <http://www.unhchr.ch/pdf/report.pdf>.

<sup>52</sup> Gruskin & Tarantola, *supra* note 23, at 313; ICERD, *supra* note 3, art. 5(e)(iv).

<sup>53</sup> CEDAW, *supra* note 3, art. 12.

<sup>54</sup> CRC, *supra* note 3, art. 24.

<sup>55</sup> CEDAW, *supra* note 3, art. 12(1).

facilities for the treatment of illness and rehabilitation of health.”<sup>56</sup> Burma is a party to both CEDAW and the CRC, the only two major human rights treaties to which it is a party.<sup>57</sup> While there are a number of regional human rights treaties that also contain right-to-health provisions,<sup>58</sup> there is no such treaty for Asia, and therefore Burma is not bound by a regional human rights treaty.<sup>59</sup>

In addition to these binding treaties, human rights conference participants have passed a number of non-binding resolutions elaborating on the right to health.<sup>60</sup> For example, the 1978 Alma Alta Declaration called upon nations to provide for the availability of essential health care, including education concerning the prevention and control of health problems and diseases.<sup>61</sup>

### C. *Non-Human-Rights Approaches Similarly Serve to Encourage States to Implement AIDS Prevention Measures*

While the health-and-human-rights approach to AIDS prevention has gained prominence, many commentators instead emphasize approaches that have roots pre-dating the origin of the health-and-human-rights model, and that focus on pragmatic concerns such as the detrimental effect of the AIDS epidemic on economic and security factors.<sup>62</sup>

<sup>56</sup> CRC, *supra* note 3, art. 24(1).

<sup>57</sup> Officer of the United Nations High Commissioner for Human Rights, *supra* note 51.

<sup>58</sup> *See, e.g.*, African Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), art. 16, (*entered into force* Oct. 21, 1986); Organization of American States, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (“Protocol of San Salvador”), art. 10, *opened for signature* Nov. 17, 1988, O.A.S.T.S. No. 69, (*entered into force* Nov. 16, 1999); *and*, European Convention on the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 222 (*entered into force* Sept. 3, 1953, *as amended by* Protocols Nos 3, 5, 8, and 11 *which entered into force* on 21 September 1970, 20 December 1971, 1 January 1990, and 1 November 1998 *respectively*).

<sup>59</sup> Gruskin & Tarantola, *supra* note 23, at 313.

<sup>60</sup> *Id.* at 314; *see, e.g.*, 1993 World Conference on Human Rights (U.N. 1993c, 1998a); 1995 World Summit for Social Development (U.N. 1995b).

<sup>61</sup> Gruskin & Tarantola, *supra* note 23, at 320.

<sup>62</sup> *See, e.g.*, Fidler, *supra* note 18 (examining the linkage between public health issues, including HIV/AIDS, and national security); David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy*, 17 HARV. HUM. RTS. J. 99 (2004) (examining HIV/AIDS as a U.S. national security issue); J.M. Spectar, *The Olde Order Crumbleth: HIV-Pestilence As a Security Issue & New Thinking About Core Concepts in International Affairs*, 13 IND. INT'L & COMP. REV. 481 (2003) (examining the link between HIV/AIDS and national, regional, and global security); International Crisis Group, *HIV/AIDS as a Security Issue, ICG Report* (Washington, D.C./Brussels June 19, 2001), *available at* [http://www.icg.org/library/documents/report\\_archive/A400321\\_19062001.pdf](http://www.icg.org/library/documents/report_archive/A400321_19062001.pdf); Alex de Waal, *Why the HIV/AIDS Pandemic is a Structural Threat to Africa's Governance and Economic Development*, 27 FALL FLETCHER F. ON WORLD AFF. 6 (2003); Susan K. Sell, *Trade Issues and HIV/AIDS*, 17 EMORY INT'L L. REV. 933 (2003).

1. *The HIV/AIDS epidemic is seen as a threat to national security*

Various nations and commentators conceptualize HIV/AIDS as a national and international security threat because the severity of the epidemic correlates to national and international unrest.<sup>63</sup> According to the International Crisis Group,<sup>64</sup> “AIDS can no longer be understood or responded to as primarily a public health crisis. It is becoming a threat to security.”<sup>65</sup> Likewise, in January of 2000, the U.N. Security Council addressed the disease in terms of security implications,<sup>66</sup> and for the first time passed a unanimous resolution relating to HIV/AIDS.<sup>67</sup> The resolution recognized that an unchecked HIV/AIDS pandemic could pose a risk to stability and security, and encouraged interested member states to assist with the creation and execution of policies for HIV/AIDS prevention and treatment.<sup>68</sup> Beginning with the administration of U.S. President Clinton, who “claimed that emerging and re-emerging infectious diseases, especially HIV/AIDS, constituted a national security threat and foreign policy challenge for the United States,”<sup>69</sup> U.S. policy has similarly conceptualized HIV/AIDS as a security issue.<sup>70</sup>

While the health-and-human-rights regime focuses on the ethical duties of states to deal with HIV/AIDS, conceptualizing HIV/AIDS as a security issue encourages states to take action to further their own individual and collective interests. Conceptualizing HIV/AIDS as a security issue encourages high-prevalence states to deal with the AIDS epidemic within their borders in order to preserve national security.<sup>71</sup> In the hardest-hit countries in Africa, for example, “the devastating impact of HIV/AIDS on the military forces, economies, and governance systems . . . represents a direct national security threat . . . because HIV/AIDS is destroying the material sources of state power.”<sup>72</sup> The fact that HIV/AIDS is harmful to the power and stability of a regime is a factor likely to encourage a state

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<sup>63</sup> International Crisis Group, *supra* note 62, at i.

<sup>64</sup> The International Crisis Group is a “private, multinational organization committed to strengthening the capacity of the international community to anticipate, understand and act to prevent and contain conflict.” *Id.* at Appendix A.

<sup>65</sup> *Id.* at i.

<sup>66</sup> Fidler, *supra* note 18, at 792.

<sup>67</sup> S.C. Res. 1308, U.N. Doc. S/RES/1308 (July 17, 2000), available at [http://www.state.gov/www/regions/africa/000717\\_unsc\\_hiv aids.html](http://www.state.gov/www/regions/africa/000717_unsc_hiv aids.html).

<sup>68</sup> *Id.*

<sup>69</sup> Fidler, *supra* note 18, at 792.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 843.

<sup>72</sup> *Id.*

concerned with its own survival to take measures proven successful to quell the spread of the epidemic.

Conceptualizing HIV/AIDS as a security issue also encourages wealthier states to channel resources into high-prevalence states in order to prevent the global spread of the disease and further international and collective security.<sup>73</sup> A former U.S. Ambassador to the U.N. responded to the Security Council resolution regarding HIV/AIDS: "We have to recognize that while interdependence gives economic opportunities, it also can pose global threats. You cannot deny AIDS a visa; you cannot embargo it or quarantine it; you cannot stop it at a border. That is why we must work together."<sup>74</sup> Conceptualizing HIV/AIDS as a security issue encourages states to funnel resources into high prevalence countries in order to serve their own security interests.<sup>75</sup>

## 2. *The HIV/AIDS epidemic is also seen as a threat to national economy*

Likewise, various nations and commentators attempt to promote the implementation of prevention measures by focusing on HIV/AIDS as a threat to economic vitality and stability.<sup>76</sup> Like the security approach, an economics approach to HIV/AIDS prevention encourages states to take action not out of an obligation to respect the fundamental right to health, but to further their own individual and collective interests.<sup>77</sup> Simply put, employing AIDS prevention measures benefits a developing nation because the economic impact of AIDS is greater than the economic cost of implementing such measures.<sup>78</sup> AIDS has the cumulative effect of decreasing productivity and increasing costs.<sup>79</sup> The impact of the disease reduced the gross domestic product ("GDP") of Africa's hardest-hit countries by one percent.<sup>80</sup> HIV/AIDS also decreases business investment as the consumer-base diminishes and becomes more impoverished.<sup>81</sup>

AIDS' ability to weaken national economies may also have international implications because "AIDS-fuelled economic disintegration, if

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<sup>73</sup> Spectar, *supra* note 62, at 513.

<sup>74</sup> *Id.* (quoting Richard C. Holbrooke, U.S. Permanent Representative to the United Nations, Remarks Following the Security Council Vote Approving Resolution 1308, Regarding HIV and Peacekeepers (July 17, 2000), available at [http://www.casy.org/engdocs/holbrooke\\_00.htm](http://www.casy.org/engdocs/holbrooke_00.htm)).

<sup>75</sup> Fidler, *supra* note 2, at 75-77.

<sup>76</sup> See, e.g., De Waal, *supra* note 62.

<sup>77</sup> World Bank, *Optimizing the Allocation of Resources for HIV Prevention: The Allocation by Cost-Effectiveness (ABC) Model: Guidelines*, July 2002.

<sup>78</sup> *Id.*

<sup>79</sup> International Crisis Group, *supra* note 62, at 10.

<sup>80</sup> *Id.* at 9.

<sup>81</sup> *Id.* at 12.

left unchecked, could cut severely into world supplies of key natural resources.”<sup>82</sup> The international economic effects of AIDS therefore motivate developed nations, at least to some extent, to funnel resources into high prevalence developing nations in order to protect their own economic interests.<sup>83</sup>

*D. Many Commentators Reject Non-Human Rights Approaches to HIV/AIDS Prevention as Overly Concerned With the Interests of Developed Countries and Lacking an Ethical Focus*

While such pragmatic approaches to HIV/AIDS prevention are not necessarily incompatible with an approach that focuses on AIDS prevention as a right-to-health duty, a tension exists between them. Prominent commentator David Fidler suggests, for example, that “the universalist, right-to-health ideology that guided international public health in the WHO’s first five decades is, controversially, giving way to arguments centered again on the self-interests of the great powers.”<sup>84</sup> He further questions why many public health officials consider human rights law the “crown jewel” of global public health strategy in the first place.<sup>85</sup>

On the other hand, many health-and-human-rights commentators disparage security and economic approaches as lacking the fundamental rights focus of the health-and-human-rights model, criticizing the “self-serving relativism” of the non-human-rights-based approaches.<sup>86</sup> Implicit in such arguments is the suggestion that the health-and-human-rights approach is, or should be, the exclusive or preeminent way to encourage states to comply with suggested AIDS prevention measures. Jonathan Mann, former director of WHO’s Global Programme on AIDS, and the founding father of the health-and-human-rights approach to HIV/AIDS prevention and treatment, stated that “the human rights framework offers public health a more coherent, comprehensive, and practical framework for analysis and action on the societal root causes of vulnerability to HIV/AIDS than *any* framework inherited from traditional public health or biomedical science” (emphasis added).<sup>87</sup> Such statements suggest that health and human rights should be the approach taken to HIV/AIDS prevention in place of, rather than in addition to, approaches that focus on the detrimental effect of AIDS

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<sup>82</sup> *Id.* at 14.

<sup>83</sup> *Id.*

<sup>84</sup> Fidler, *supra* note 18, at 850.

<sup>85</sup> FIDLER, *supra* note 4, at 199.

<sup>86</sup> See FARMER, *supra* note 4, at 195.

<sup>87</sup> Mann, *supra* note 21, at 204.

on economies and security. As David Fidler states, “[m]any public health experts see human rights as . . . the *best* way to promote and protect public health” (emphasis added).<sup>88</sup>

### III. THE OVERALL RATE OF HIV/AIDS INFECTION IS STEADILY INCREASING IN BURMA AS A RESULT OF THE GOVERNMENT’S FAILURE TO INSTITUTE PREVENTION MEASURES

Successful strategies to prevent the spread of HIV/AIDS are clearly established, proven in practice by states such as Thailand with once-serious epidemics, and readily available for implementation.<sup>89</sup> While the similarity of Burma’s and Thailand’s AIDS epidemics suggest that the measures employed in Thailand would also be successful in Burma, the Burmese government has failed to employ such strategies to combat HIV/AIDS within its borders.<sup>90</sup> As a result, the rate of HIV/AIDS within Burma continues to increase.

#### A. *The International Community and Thailand Have Established Successful Prevention Strategies*

Strategies that work to dampen the spread of HIV/AIDS, especially those aimed at the sex industry, are no longer a mystery. According to a comprehensive 2004 report from the organization Monitoring the AIDS Pandemic (“MAP”), commercial sex remains the most common risk behavior and driving force of the epidemic in Asia, while needle-sharing between injection drug users (“IDUs”) also contributes significantly to the epidemic in many Asian countries.<sup>91</sup> Thus, it should come as little surprise that the recommended approaches for tackling the epidemic in these countries include prevention and education campaigns aimed at cutting the proportion of men who engage in commercial sex, promoting the use of condoms among those who do,<sup>92</sup> and promoting safe and consistent access to sterile injecting equipment for IDUs.<sup>93</sup> These HIV/AIDS prevention and

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<sup>88</sup> FIDLER, *supra* note 4, at 170.

<sup>89</sup> GOSTIN, *supra* note 25, at 301.

<sup>90</sup> *Myanmar: Sickening*, *supra* note 13.

<sup>91</sup> PISANI, *supra* note 11, at 2-3.

<sup>92</sup> Promoting condom use is generally thought to be the most necessary and successful way to tackle the AIDS epidemic, and has been central to all successful intervention measures. For example, Uganda’s program, which focused heavily on condom use, helped to lower its rate of infection from 14% in the early 1990s to 8% in 2000. *A Turning Point For AIDS?*, *The Economist*, July 13, 2004, [www.economist.com/displaystory.cfm?story\\_id=6095](http://www.economist.com/displaystory.cfm?story_id=6095).

<sup>93</sup> ELISABETH PISANI, *supra* note 11, at 23.

treatment strategies are well-accepted and have proven successful in practice.<sup>94</sup>

Burma's neighbor, Thailand, is widely regarded as a model of successful HIV/AIDS prevention.<sup>95</sup> While Thailand's prevention strategies have not yet had a significant impact on HIV/AIDS in the IDU population,<sup>96</sup> Thailand is nevertheless one of the few countries that has managed to curb the spread of a potentially serious AIDS epidemic.<sup>97</sup> The country has the second highest prevalence rate in Asia behind Cambodia, and was the first country in Asia to document HIV among IDUs, female sex workers ("FSWs"), and their clients.<sup>98</sup> Working with international organizations such as WHO and UNAIDS, Thailand responded to the epidemic early, focusing specifically on reducing the number of men visiting FSWs and promoting condom use in all sexual interactions.<sup>99</sup> As a result of these efforts, the percentage of adult men engaging in commercial sex annually fell from roughly 25% to 10%,<sup>100</sup> condoms are now used in 90% of commercial sex transactions,<sup>101</sup> the rate of HIV among FSWs declined from its peak of 33% in 1994 to 12% in 2002,<sup>102</sup> and the overall rate of AIDS in Thailand is steadily declining.<sup>103</sup> It is likely that Thailand's rate of infection would have been in the millions rather than the hundreds of thousands had Thailand not vigorously promoted condom use.<sup>104</sup>

#### *B. Burma Has Failed to Effectively Institute Any of the Proven Prevention Strategies*

The similarity of Burma's and Thailand's AIDS epidemics suggest that Burma could succeed in combating AIDS using some of the same measures implemented by Thailand. Like Thailand, Burma's AIDS

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<sup>94</sup> GOSTIN, *supra* note 25, at 302.

<sup>95</sup> UNAIDS/WHO, *AIDS Epidemic Update: December 2004*, UNAIDS/04.45 (English original December 2004), available at [http://www.unaids.org/wad2004/report\\_pdf.html](http://www.unaids.org/wad2004/report_pdf.html) ("Asian countries that have introduced large-scale prevention programmes addressing sexual transmission of HIV—notably Cambodia and Thailand—have seen significant reductions in risk behaviour, and have recorded declining levels of new HIV and other sexually transmitted infections . . . The combined effect has been a steep drop in sexually transmitted infections and a decline in HIV prevalence.").

<sup>96</sup> WHO, *supra* note 8, at 12.

<sup>97</sup> *Id.*; see also *AIDS in Asia: Ready for Take-Off?*, *The Economist*, July 15, 2004.

<sup>98</sup> WHO, *supra* note 8, at 11, 29.

<sup>99</sup> *Id.* at 31.

<sup>100</sup> *Id.*

<sup>101</sup> *AIDS in Asia: Ready for Take-Off?*, *supra* note 97.

<sup>102</sup> WHO, *supra* note 8, at 10.

<sup>103</sup> UNAIDS/WHO, *supra* note 95.

<sup>104</sup> WHO, *supra* note 8, at 31; *Myanmar: Sickening*, *supra* note 13.

epidemic is largely fuelled by the sex industry, with IDUs also playing a prominent role in the transmission of the disease.<sup>105</sup> Furthermore, the rates and general trends of HIV infections among IDUs and FSWs in Burma are similar to those in the early years of Thailand's epidemic, a factor that suggests that Burma could successfully combat its AIDS epidemic using Thailand's approach as a model.<sup>106</sup> Likewise, the first two objectives of the Joint Programme of Action engaged in by Burma and UNAIDS include preventative measures successful in Thailand and elsewhere.<sup>107</sup> The first, "[i]ndividual risk of sexual transmission of HIV reduced," recommends measures to promote the consistent use of condoms by making them more accessible and affordable, particularly in the context of paid sex.<sup>108</sup> The second, "[i]ndividual risk of HIV transmission among injecting drug users and their partners reduced," recommends measures to improve the access and quality of drug treatment measures aimed at lowering the rate of needle-sharing among IDUs.<sup>109</sup>

Burma has yet to effectively institute any of the measures suggested by the international community, the UNAIDS plan, or the Thailand model.<sup>110</sup> Burma's rate of HIV/AIDS reflects this failure. While Thailand's "100% condoms" program decreased the rate of HIV infection in the FSW community from 33% in 1994 to 12% in 2003, HIV prevalence among those FSWs tested in Burma increased from 4% in 1992 to 32% in 2003.<sup>111</sup> The overall rate of HIV/AIDS is steadily increasing in turn.<sup>112</sup>

The Burmese government has not only failed to allocate resources to implement the prevention measures outlined in the UNAIDS plan, but also maintains policies that actually impair prevention measures. For example, while Burma has publicly announced that condom use is now part of its prevention campaigns, women are still routinely arrested for possessing condoms on the assumption that those who carry them work in the sex trade.<sup>113</sup> Furthermore, Burma's Press Scrutiny Board ("PSB") still censors AIDS coverage and bans the word "condom" from appearing in literature.<sup>114</sup> Indeed, state media are largely banned from reporting about AIDS

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<sup>105</sup> WHO, *supra* note 8, at 36.

<sup>106</sup> *Id.*

<sup>107</sup> UNAIDS, *supra* note 12, at iii.

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Myanmar: Sickening*, *supra* note 13.

<sup>111</sup> WHO, *supra* note 8, at 36.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*; ELISABETH PISANI, *supra* note 11.

<sup>114</sup> Aung Zaw, *The AIDS Embargo*, 10 IRRAWADDY, January 2002, <http://www.irrawaddy.org/database/2002/vol10.1/cover1.html>.



altogether.<sup>115</sup> Similarly, while needles and syringes can be purchased with a prescription, they are illegal to carry and may result in a fine and up to six months in prison.<sup>116</sup> The HIV/AIDS prevention campaigns that have been implemented avoid any mention of sex or the need for drug addicts to use clean needles, instead urging people to “stay faithful to your spouse” and “respect family values.”<sup>117</sup> Recent news articles report that Burmese authorities threatened a youth member of the rival democratic party with arrest for advocating the prevention of HIV/AIDS, ordering him to take down a signboard on his house reading, “Let us prevent AIDS from spreading,”<sup>118</sup> and arrested a seventy-year-old man for possessing and reading an educational leaflet on the prevention of HIV/AIDS.<sup>119</sup> Thus, Burma’s restrictive policies towards condoms, syringes, and education regarding their use seriously hampers efforts to quell the spread of the epidemic.

#### IV. BURMA IS NOT BOUND TO IMPLEMENT HIV/AIDS PREVENTION MEASURES BY AN OBLIGATION TO PROTECT THE INTERNATIONAL HUMAN RIGHT TO HEALTH

Despite the contentions of many health-and-human-rights adherents, a health-and-human-rights approach to HIV/AIDS prevention is simply not workable in every situation. While the AIDS situation in Burma is dire, Burma has failed to implement even the most minimal of prevention measures.<sup>120</sup> The health-and-human-rights approach will not work to encourage Burma’s compliance with such recommendations because international human rights law lacks the binding or enforcement power necessary to compel Burma’s cooperation. The right to health is a vague concept, and the duties of states such as Burma under the right to health are unclear. This lack of clarity renders a state’s duties to prevent the spread of HIV/AIDS under the right imprecise as well. In addition, Burma is not a

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<sup>115</sup> NATIONAL COALITION GOVERNMENT OF THE UNION OF BURMA HUMAN RIGHTS DOCUMENTATION UNIT, BURMA HUMAN RIGHTS YEARBOOK 2002-03: RIGHTS TO EDUCATION AND HEALTH (2003) [hereinafter HUMAN RIGHTS YEARBOOK], <http://www.ibiblio.org/obl/docs/Yearbook2002-3/yearbooks/Home%20Page.htm>.

<sup>116</sup> GARY REID ET AL., REVISITING ‘THE HIDDEN EPIDEMIC’: A SITUATION ASSESSMENT OF DRUG USE IN ASIA IN THE CONTEXT OF HIV/AIDS 140 (The Centre for Harm Reduction, The Burnet Institute, Australia 2002), [http://www.ibiblio.org/obl/docs/revisiting\\_The\\_Hidden\\_Epidemic'.htm](http://www.ibiblio.org/obl/docs/revisiting_The_Hidden_Epidemic'.htm).

<sup>117</sup> HUMAN RIGHTS YEARBOOK, *supra* note 115.

<sup>118</sup> *Burma Junta Threatens an Opposition Member for Distributing HIV/AIDS Education Leaflets*, DEMOCRATIC VOICE OF BURMA, Jan. 17, 2005, <http://english.dvb.no/news.php?id=3905>.

<sup>119</sup> *Burmese Authority Arrested a Man for Keeping HIV/AIDS Prevention Leaflet*, DEMOCRATIC VOICE OF BURMA, Jan. 9, 2005, <http://english.dvb.no/news.php?id=3847>.

<sup>120</sup> See *supra*, Part III.B.

party to any treaty with a right-to-health obligation broad enough to encompass HIV/AIDS prevention measures, and the vagueness of the right to health precludes its classification as customary international law.<sup>121</sup> Finally, even if there was a binding right-to-health obligation on Burma broad enough to encompass HIV/AIDS prevention, international human rights law lacks the mechanisms to enforce such an obligation on an unwilling state such as Burma.

A. *The Ambiguity Inherent in the Right to Health Inhibits the Formation of a Universal Standard or Clear HIV/AIDS Prevention Duties*

The right to health is an inherently ambiguous concept that has largely “defied efforts to give it more than a broad, aspirational meaning.”<sup>122</sup> WHO first recognized the right to health as a fundamental right in its constitution, defining health broadly as a “state of complete physical, mental, and social wellbeing.”<sup>123</sup> Similarly, the International Covenant on Economic and Social Rights (“ICESCR”) defined the right as “the highest attainable standard of physical and mental health.”<sup>124</sup> The United Nation’s Economic and Social Council released a General Comment in 2000 in an attempt to further elucidate the right to health.<sup>125</sup> The Comment incorporates both medical care and preventative measures within the right-to-health mandate:

The committee interprets the right to health, as defined in article 12.1 [of the ICESCR], as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.<sup>126</sup>

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<sup>121</sup> Customary international law evolves from state practice followed from a sense of legal obligation instead of a process of treaty law involving formal negotiation and express consent. A rule of customary international law binds all states that did not object to the rule while it was in the process of formation. DUNOFF, *supra* note 29.

<sup>122</sup> FIDLER, *supra* note 4, at 181.

<sup>123</sup> Constitution of the World Health Organization, July 22, 1946, 62 Stat. 2679, pmb1., 14 U.N.T.S. 185, reprinted in World Health Organization Basic Documents 1 (40th ed. 1994).

<sup>124</sup> ICESCR, *supra* note 3, art. 12(1).

<sup>125</sup> U.N. Econ. & Soc. Council [ESOSOC], *General Comment No. 14: The right to the highest attainable standard of health*, 11/08/2000 E/C. 12/2000/4. (Aug. 11, 2000) [hereinafter *General Comment*].

<sup>126</sup> *Id.* at ¶ 11.

Despite these broad definitions of the right to health, a government does not have a duty to ensure the perfect health of its populace. As one commentator states, “[t]he overall human rights framework allows individuals life, liberty, and the pursuit of obesity.”<sup>127</sup>

Likewise, a state is not obligated to devote as many resources as are needed to fully realize the right to health regardless of the state’s available economic resources.<sup>128</sup> Rather, as the Economic and Social Council Comment on the right to health states, “[t]he notion of ‘the highest attainable standard of health’ in article 12.1 [of the ICECSR] takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources.”<sup>129</sup> Thus, poorer countries are not required to spend as much per capita on health as wealthier countries, and the rate of infectious diseases in countries such as Burma need not necessarily be comparable to those in countries such as the United States.<sup>130</sup>

Instead, a state’s compliance with the right to health depends on the universally recognized principle of “progressive realization,”<sup>131</sup> whereby a state progressively works “as expeditiously and effectively as possible”<sup>132</sup> toward fulfilling right-to-health goals “within the parameters of available economic resources and epidemiological conditions.”<sup>133</sup> While the principle of progressive realization recognizes the economic disparities that may effect the ability of states to promote health within their borders, a state is nonetheless required to “show constant progress in moving towards full realization of rights.”<sup>134</sup> Hence, while the inability of a state to comply with health obligations may be permissible under progressive realization, a total unwillingness of a state party to comply with its right-to-health obligations is not.<sup>135</sup>

The concept of progressive realization affects the general duties of states in terms of the right to health. Generally speaking, a government’s responsibility in regard to the right to health is understood to include obligations to respect, protect, and fulfill the right.<sup>136</sup> A government must

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<sup>127</sup> FIDLER, *supra* note 4, at 183.

<sup>128</sup> *See id.* at 183-84.

<sup>129</sup> *General Comment*, *supra* note 125, at ¶ 9.

<sup>130</sup> *See* FIDLER, *supra* note 4, at 184.

<sup>131</sup> *Id.*; Gruskin & Tarantola, *supra* note 23, at 316.

<sup>132</sup> WHO, *25 Questions and Answers on Health and Human Rights*, Health and Human Rights Publication Series, Issue No. 1, at 16 (July 2002).

<sup>133</sup> FIDLER, *supra* note 4, at 184.

<sup>134</sup> WHO, *supra* note 132, at 16.

<sup>135</sup> *Id.*

<sup>136</sup> Gruskin & Tarantola, *supra* note 23, at 315.

respect the right by not violating it directly (e.g., withholding care from prisoners), protect the right by preventing its violation by non-state actors (e.g., making it illegal to deny health insurance to a sub-population), and fulfill the right by implementing affirmative measures towards its achievement.<sup>137</sup> When these duties are examined through the lens of progressive realization, however, it becomes difficult to determine at what point a government crosses the line between permissible inaction due to lack of resources, and impermissible inaction in violation of the right to health.<sup>138</sup> Because the principle of progressive realization guarantees that a right-to-health treaty provision will mean different things depending on the economic situation of the state to which it applies, the principle both “creates problems for elaborating the content of the right to health” itself, and likewise, makes it more difficult to determine whether a particular state is violating its health obligations.<sup>139</sup> As one commentator stated, “[t]his sort of generalized approach leaves one with little hard content; if the right to health covers everything, then it means nothing.”<sup>140</sup> In response to this ambiguity, commentators have attempted to clarify a government’s right-to-health obligations under progressive realization by analyzing relevant treaties for both minimum and maximum content,<sup>141</sup> as well as positive and negative duties in regard to the right to health.<sup>142</sup>

The minimum-content approach attempts to construct a narrower definition of the right-to-health in addition to the broad, aspirational definitions above, by giving more concrete content to right-to-health obligations and defining the duties of all states under progressive realization.<sup>143</sup> For example, WHO’s right-to-health initiative is premised on the assumption that there exists a universal minimum right to primary health care, regardless of a particular state’s economic resources.<sup>144</sup> A health care program must include, at a minimum, “education concerning prevailing health problems and the methods of preventing and controlling them”<sup>145</sup> and “prevention and control of locally endemic diseases.”<sup>146</sup>

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<sup>137</sup> *Id.* at 315-16.

<sup>138</sup> *Cf.* Jamar, *supra* note 17, at 52 (discussing the uncertainty of what a state must do to fulfill its duty under the right to health and noting that the “vast differences among situations . . . make articulation of a right premised on particular steps virtually impossible”).

<sup>139</sup> FIDLER, *supra* note 4, at 184.

<sup>140</sup> Jamar, *supra* note 17, at 53.

<sup>141</sup> FIDLER, *supra* note 4, at 185.

<sup>142</sup> Jamar, *supra* note 17, at 58.

<sup>143</sup> *See* FIDLER, *supra* note 4, at 186.

<sup>144</sup> *See* Jamar, *supra* note 17, at 46-47.

<sup>145</sup> *Id.* at 47.

<sup>146</sup> *Id.*

Establishing negative and positive duties of states under this narrower right-to-health obligation is another way commentators have attempted to solidify state responsibility.<sup>147</sup> As one commentator states:

The narrower, core conception of the right includes negative and positive aspects. Examples of the negative aspect include the duty of states to refrain from barring access to health-related information and the duty of states not to take health-harming actions. The affirmative aspect of the narrow, core right to health imposes a duty on a state to intervene or to act, to the extent of its available resources, to prevent, reduce, or address serious threats to the health of individuals or the population. An example may be a failure of a state to address the AIDS epidemic through at least education and minimal public health actions.<sup>148</sup>

Under the negative-positive duty rubric, a state has both a negative duty not to prevent access to health information or take actions harmful to health, and a positive duty to take at least some affirmative steps to educate the public regarding health.<sup>149</sup> The focus on a state's negative duties theoretically overcomes the vagueness inherent in progressive realization, at least in regard to those things that a state must refrain from doing. If it costs nothing for a state simply not to impede the flow of information, then there is no problem of lack of resources upon which the progressive realization principle is premised. Thus, such negative duties can theoretically be made binding on parties to right-to-health treaty provisions regardless of their economic resources. For example, it could be argued that a state has a negative duty not to censor information regarding how to prevent the spread of AIDS. Because it does not cost a state anything to simply refrain from acting, economic disparities between countries would not render the duty to refrain from censoring more difficult in a poorer country. Thus, the duty not to censor could theoretically be made binding on those states that are parties to treaties with right-to-health provisions regardless of economic disparities and regardless of the principle of progressive realization.

Despite the apparent clarity of the negative conception of a state's right-to-health duties, some ambiguity exists even under this narrower characterization. For example, some nations prefer to forego or limit

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<sup>147</sup> *See id.* at 4.

<sup>148</sup> *Id.*

<sup>149</sup> *See id.* at 5.

condom promotion campaigns in favor of campaigns promoting abstinence.<sup>150</sup> Such abstinence-only programs, like those found in the United States,<sup>151</sup> are likely the best-funded HIV prevention programs in the world.<sup>152</sup> Whether such nations are violating the right to health of their people by inhibiting the flow of information about condom use is unclear, but the fact that many states choose abstinence promotion over the endorsement of condom use highlights the absence of a universally accepted duty of states to protect the right to health, even in the negative sense.

As for the affirmative duties under this narrower conception, the vagueness inherent in progressive realization still inhibits the formation of a universal standard.<sup>153</sup> For example, while there is a basic affirmative duty for a state to take steps to prevent locally endemic diseases, “the allocative problem exists just as strongly for [this] basic, almost minimal activit[y].”<sup>154</sup> The duty of any particular state is still dependent on the extent of its available resources and a violation of the right to health under the affirmative prong still depends on a case-by-case analysis.<sup>155</sup> Despite the difficulties with progressive realization and accompanying minimum-content analysis of the right to health, these methods are most commonly used to analyze and give substance to a state’s obligation under the right to health.<sup>156</sup>

When the obligation of states to combat the spread of HIV/AIDS is conceptualized under the rubric of international human rights law generally and the right to health specifically, the scope of the obligation suffers from the same ambiguities. A broadly defined right to health, such as WHO’s definition as “a state of complete physical, mental, and social well being,” can’t realistically be achieved in any context and is simply unenforceable.<sup>157</sup> Similarly, the principle of progressive realization renders the right to health indeterminate, and whether a particular state’s AIDS program violates the state’s right-to-health obligations is largely dependent on the state’s

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<sup>150</sup> Joanne Csete, *Abstinence and Ignorance: Dismissing Science in the Fight against AIDS*, 31 HUM. RTS. MAG. 7 (2004).

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> See Jamar, *supra* note 17, at 57.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* at 61.

<sup>156</sup> See Jamar, *supra* note 17.

<sup>157</sup> GOSTIN, *supra* note 25, at 82.

particular economic situation, and must be determined by an analysis of that situation rather than simply by reference to a universal standard.<sup>158</sup>

Defining the right to health more narrowly for the purpose of identifying enforceable criteria may help to determine when a state violates its right-to-health obligations with regard to AIDS.<sup>159</sup> Similarly, distinguishing between a state's duty to take affirmative steps (such as spreading condom awareness) and the duty to refrain from certain activity (such as censoring AIDS awareness campaigns by non-state actors) can, theoretically, establish some universal duties on the part of states, at least to refrain from certain conduct. As discussed above, however, even under the narrower conceptions, a state's duty to take minimal affirmative steps is rendered unclear by the principle of progressive realization, while the state's negative duties are also somewhat ambiguous.

In sum, even if the right to health is binding on states such as Burma, it is unclear what HIV/AIDS prevention measures a state must implement or allow in order to comply with its duties in guaranteeing the right to health. The ambiguity inherent in the right-to-health concept inhibits the articulation of clear HIV/AIDS prevention duties on the part of states under the right to health.

*B. Specific Treaty Provisions to Which Burma Is a Party Fail to Establish a Binding Right to Health Obligation Broad Enough to Encompass HIV/AIDS Prevention Measures*

There is no right-to-health obligation binding on Burma that clearly establishes an obligation to implement HIV/AIDS prevention measures. Burma is not a party to the ICESCR, the main international document that binds states parties to recognize the right to health.<sup>160</sup> The only major international human rights treaties to which Burma is a party are CEDAW<sup>161</sup> and CRC.<sup>162</sup>

While Burma is bound by the provisions of CEDAW, it is unlikely that the health care provision will be interpreted to impose an affirmative duty to implement the provisions of the UNAIDS plan. CEDAW calls on

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<sup>158</sup> See generally Jamar, *supra* note 17, at 25 (noting that "what must be done to comply with the duty in the United States would be different from that in India or Brazil because of the differences in economic and other available resources").

<sup>159</sup> *Id.* at 58 (noting generally that "the attempt at narrowing the concept. . . seeks to define a certain minimum standard of conduct which can be unequivocally demanded and measured").

<sup>160</sup> ICESCR, *supra* note 3; see also ICESCR Ratifications and Reservations, <http://www.ohchr.org/english/countries/ratification/3.htm>.

<sup>161</sup> CEDAW, *supra* note 3; Office of the High Commissioner for Human Rights, *supra* note 51, at 7.

<sup>162</sup> CRC, *supra* note 3; Office of the High Commissioner for Human Rights, *supra* note 51, at 7.

states' parties "[to] take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."<sup>163</sup> The language of the CEDAW health care provision is framed in terms of equality in the provision of health care services already offered, however, rather than as a duty to provide a particular type of health care service (aside from family planning) in the first place.<sup>164</sup> Additionally, the emphasis of the treaty's language is on health care rather than health itself, which would imply that Burma could satisfy its duty simply by providing health care services for those who seek them. A duty to prevent the spread of disease by distributing condoms, raising awareness about how to prevent the transmission of the AIDS virus, or otherwise, does not clearly fall within this narrow right to health care.

Similarly, it is unlikely that the CRC's right-to-health provision will impose an affirmative duty on Burma to implement the provisions of the UNAIDS plan. The CRC declares that "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."<sup>165</sup> In addition, the CRC calls on state parties, among other things, to ensure the provision of necessary health care to children<sup>166</sup> and the development of preventative health care.<sup>167</sup> While the provision refers to both the broad right to health (rather than the more narrow right-to-health-care provision of CEDAW) and to the need for preventative health care, the CRC applies only to the rights of children, a population of individuals who are much less likely to contract the disease through sexual or intravenous drug use activity.<sup>168</sup> Thus, the CRC does not encompass a state duty to supply AIDS prevention measures to the adult population.

### C. *The Right to Health Does Not Rise to the Level of Customary International Law*

Even if Burma is not a party to a treaty with a general right-to-health provision like that contained in ICESCR, such a general right would still be binding on Burma if it was found to be customary international law.

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<sup>163</sup> CEDAW, *supra* note 3, at art. 12(1).

<sup>164</sup> *Id.*

<sup>165</sup> CRC, *supra* note 3, at art. 24(1).

<sup>166</sup> *Id.* at art. 24(2)(b).

<sup>167</sup> *Id.* at art. 24(2)(f).

<sup>168</sup> See STEVE BERRY, AVERT CHILDREN, HIV & AIDS (June 2005), <http://www.avert.org/children.htm>.



Customary international law is defined by the Restatement (Third) of Foreign Relations as that which “results from a general and consistent practice of states followed by them from a sense of legal obligation.”<sup>169</sup> Thus, in order to qualify as customary international law, a practice must satisfy both the state practice and *opinio juris* (state’s sense of legal obligation) prongs of the customary international law definition.<sup>170</sup> Once a practice qualifies as customary international law, it is binding on all states that have not objected persistently to the practice, regardless of whether they have specifically ratified a treaty containing an agreement to comply with it.<sup>171</sup>

Commentators differ on whether the right to health, or international documents containing the right, have ascended to the level of customary international law. Some observers have stated, for example, that “to the extent the right to health is enunciated in the UDHR, it is likely customary international law,”<sup>172</sup> and “there is considerable support for the proposition that the rights embodied in the ICESCR should be considered part of customary law.”<sup>173</sup> Factors that support a finding that the right to health constitutes customary international law include the fact that the right is found, in one form or another, in numerous multilateral treaties and non-binding international documents,<sup>174</sup> and the fact that many nations have established an explicit right to health in their constitutions, otherwise subscribed in some way to the right itself, or acceded to international documents that contain the right within their provisions.<sup>175</sup> Indeed, Burma

<sup>169</sup> RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102 (1987).

<sup>170</sup> See Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?* 34 IND. L. REV. 1457, 1464 (2001).

<sup>171</sup> See DUNOFF, *supra* note 29, at 32.

<sup>172</sup> Lesley Stone et al., *When the Right to Health and the Right to Religion Conflict: A Human Rights Analysis*, 12 MICH. ST. J. INT’L L. 247, 268 n.87 (2004).

<sup>173</sup> Patrick L. Wojahn, *A Conflict of Rights: Intellectual Property under TRIPS, the Right to Health, and AIDS Drugs*, 6 UCLA J. INT’L L. & FOREIGN AFF. 463, 494 (2001-2002); see also Connie de la Vega, *Protecting Economic, Social and Cultural Rights*, 15 WHITTIER L. REV. 471, 478-80 (1994) (arguing that economic, social, and cultural rights should be applied in U.S. courts as customary international law); Kinney, *supra* note 170, at 1464 (“the ICESCR is arguably customary international law due to its widespread acceptance internationally . . . [and] may be binding on all countries regardless of ratification”); Stone, *supra* note 172, at 268 (“[s]tates that have signed and ratified the ICESCR . . . may also be bound by its enumerated rights through the operation of customary international law”).

<sup>174</sup> See, e.g., ICERD, *supra* note 3; American Declaration of the Rights and Duties of Man, art. 11, O.A.S. Res. XXX, adopted by the Ninth International Conference of American States (1948), Bogotá Colombia, reprinted in ORGANIZATION OF AMERICAN STATES, BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992), <http://www1.umn.edu/humanrts/oasinstr/zoas2dec.htm> (providing that “[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources”).

<sup>175</sup> Kinney, *supra* note 170, at 1465.

itself has integrated many of the provisions of the UDHR into its domestic law and its constitution.<sup>176</sup> In 1999, Burmese Foreign Minister U Win Aung categorically stated in an address to the United Nations General Assembly that “we fully prescribe [sic] to the human rights norms enshrined in the Universal Declaration of Human Rights.”<sup>177</sup> While this pronouncement alone does not make the UDHR binding on Burma, such statements may serve as indications that its provisions have risen to the level of customary international law.<sup>178</sup>

On the other hand, many U.S. scholars have rejected the contention that economic, social, and cultural rights, such as the right to health, are customary international law.<sup>179</sup> One article noted that “although some parts of the [UDHR] have been so widely recognized that they have become customary international law, and therefore binding on all nations that have not opposed them, there is no indication that the right to health has been recognized in this manner.”<sup>180</sup> Likewise, other commentators stated, “[w]hile the standard advanced by General Comment 14 [to the ICESCR] may eventually become customary international law, the universal acceptance of a broad right to health may nonetheless not occur for an extended period of time.”<sup>181</sup>

The major factor weighing against finding a right to health in customary international law is the ambiguity of the right-to-health concept, which prevents a consistent state practice, followed out of a sense of legal obligation, from developing. Because the right to health is generally framed in broad, aspirational terms, it is very difficult to define the scope of a state’s obligations.<sup>182</sup> Furthermore, the principle of progressive realization guarantees that the right to health differs depending on the context in which it applies, making it difficult or impossible to form a customary international

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<sup>176</sup> Khin Maung Win, *Human Rights Norms in Burmese Society*, LEGAL ISSUES ON BURMA J. NO. 17, at 24, 35 (2004).

<sup>177</sup> Quoted in Myint Zan, *Judicial Independence in Burma: Constitutional History, Actual Practice and Future Prospects*, 4 S. CROSS. U. L. REV. 17, 58 n.118 (2000).

<sup>178</sup> Article 38(1)(b) of the Statute of the International Court of Justice (June 26, 1949), is the traditional starting point in determining what international law is, and provides that international custom can serve as evidence of customary international law, or “general practice accepted as law.”

<sup>179</sup> Wojahn, *supra* note 173, at 495.

<sup>180</sup> Sanford J. Fox & Diony Young, *International Protection of Children’s Right to Health: The Medical Screening of Newborns*, 11 B.C. THIRD WORLD L.J. 1, 18-19 (1991).

<sup>181</sup> Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 109 (2004); *see also* Stephen J. Powell, *The Place of Human Rights Law in World Trade Organization Rules*, 16 FLA. J. INT’L L. 219, 229 (2004) (noting the silence of customary international law on the right to health).

<sup>182</sup> Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 YALE J. HEALTH POL’Y L. & ETHICS 137, 156 (2005).

law standard.<sup>183</sup> Even a core minimum-content approach<sup>184</sup> to the right to health requires states only to take steps, outside of the core minimum content of the right, toward the progressive realization of rights depending on the states' particular economic circumstances.<sup>185</sup> If the right to health means different things in different contexts, it will be very difficult to show both a consistent state practice and an *opinio juris* of states regarding the right.

It could be argued that the negative duties of states to refrain from taking measures harmful to health or interfering with health information have gained the requisite consistent state practice and *opinio juris* to achieve the level of customary international law.<sup>186</sup> Under this theory, while Burma may not have an affirmative obligation to implement AIDS awareness campaigns, distribute condoms, or educate sex workers regarding their use, it would have a negative duty under customary international law not to interfere with helpful health measures such as the possession of condoms or syringes and AIDS awareness campaigns regarding prevention methods.

It is unclear, in light of the continued popularity of abstinence-only campaigns in countries such as the United States and others,<sup>187</sup> whether the negative duties of states under the right to health obligate them to allow information regarding the best methods of preventing HIV/AIDS transmission (such as condom use). Burma may well argue that negative duties allow for education regarding certain kinds of prevention measures over others. For instance, while there are reports that Burmese police officers arrest those who possess condoms, the Burmese government allows abstinence campaigns urging individuals to forego extra-marital sexual activity altogether.<sup>188</sup> Likewise, while Burma bans the possession of syringes, it allows the existence of anti-drug campaigns.<sup>189</sup> Many states adhere to an abstinence-based platform in their fight against HIV/AIDS, thereby choosing a method other than that recommended by the international community. This fact weighs heavily against finding that the implementation of those health programs and measures deemed most effective by the international community has achieved the consistent state practice and *opinio juris* necessary for customary international law status.

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<sup>183</sup> Cf. Jamar, *supra* note 17, at 52.

<sup>184</sup> See *supra*, Part IV.A.

<sup>185</sup> See Meier, *supra* note 182, at 158.

<sup>186</sup> See Jamar, *supra* note 17, at 58-59 (noting that a state may be found in violation of the right to health if it obstructs access to medical care or health-related information).

<sup>187</sup> Csete, *supra* note 150.

<sup>188</sup> See discussion *supra*, Part III.B.

<sup>189</sup> *Id.*

D. *Even If Burma Were Bound to Implement HIV/AIDS Prevention Measures, International Human Rights Law Lacks Adequate Mechanisms to Enforce Such an Obligation*

Finally, even if a duty under the right to health were binding on Burma, and the current AIDS policies, or lack thereof, constituted a violation of that duty, there are no adequate mechanisms under international human rights law to enforce such an obligation. The lack of enforcement mechanisms for human rights law is a general problem of international law.<sup>190</sup> State sovereignty is one of the guiding principles of international law, generally requiring the consent of sovereign entities for them to be bound by and comply with international law.<sup>191</sup> Thus, the international community is reluctant to interfere with a state's internal affairs, even when there is a clear international duty binding on the state and a clear violation of that duty by the state.<sup>192</sup> Additionally, enforcement of international law is fundamentally hindered by the general principle of non-intervention enshrined in Article 2(4) of the U.N. Charter.<sup>193</sup> That section prohibits member states from "threat or use of force against the territorial integrity or political independence of any state,"<sup>194</sup> and thus outlaws all uses of force against states, even those states violating clear and binding international duties, except when authorized by the U.N. Security Council or when taken in self defense.<sup>195</sup>

As discussed previously, the duties of a state in regard to health are unclear and "getting a handle on the content of the right to health is a necessary first step to effective implementation."<sup>196</sup> Until core or negative health duties of states are defined so that they apply universally to all states, regardless of progressive realization, it is unlikely that the right will have clear enough parameters to compel the international community to enforce it, even against states with policies as harmful as Burma's. Similarly, it is not clear that Burma is bound to a right to health general enough to encompass the duty to prevent the spread of AIDS at all. Until Burma either accedes to the ICESCR, or the right to health gains customary international

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<sup>190</sup> Aart Hendricks & Brigit Toebes, *Towards a Universal Definition of the Right to Health?* 17 *MED. & L.* 319, 322 (1998).

<sup>191</sup> See Sarkin & Pietschmann, *supra* note 10, at 378.

<sup>192</sup> *Id.*

<sup>193</sup> U.N. Charter art. 2, para.4.

<sup>194</sup> *Id.*

<sup>195</sup> See DUNOFF, *supra* note 29, at 829.

<sup>196</sup> Kinney, *supra* note 170, at 1467.

law status, it is unlikely that the international community will enforce a state's duty to protect the right in the absence of a clearly binding obligation.

Even if the international community were willing to enforce a duty on Burma to protect the right to health in the context of furthering the AIDS prevention cause, mechanisms to do so do not exist. Social human rights are hindered by weak enforcement mechanisms in general.<sup>197</sup> Even under the ICESCR, there is "no international supervisory body that is entitled to receive and examine complaints submitted by individuals who claim to be . . . victim[s] of a violation of the right to the highest attainable level of health."<sup>198</sup> Thus, the principles of state sovereignty and non-intervention, the lack of enforcement mechanisms, and the lack of clarity inherent in the right to health all render Burma's duty to implement HIV/AIDS prevention measures unenforceable.

#### V. BURMA IS UNLIKELY TO BE SWAYED BY THE ETHICAL CALL OF A HEALTH-AND-HUMAN-RIGHTS APPROACH

Due to the lack of enforcement mechanisms in human rights law,<sup>199</sup> compliance with human rights norms in general and the right to health in particular depend in large part on state consent.<sup>200</sup> Implementation of international human rights law domestically depends on national legislation, policies, and programs that incorporate and execute human rights norms.<sup>201</sup> The implementation of such national legislation, policies, and programs in turn depends on the political willingness of the implementing state.<sup>202</sup> Such is also the case in regard to the implementation of AIDS prevention measures.<sup>203</sup> In the words of Kofi Anan, the Secretary-General of the United Nations, "[a]bove all, the challenge of AIDS is a test of leadership."<sup>204</sup> Therefore, the domestic implementation of international human rights law depends in large part on a state's willingness to recognize and realize its ethical duty to respect fundamental human rights.

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<sup>197</sup> Hendricks & Toebes, *supra* note 190.

<sup>198</sup> *Id.*

<sup>199</sup> *See supra*, Part IV.D.

<sup>200</sup> *Id.*

<sup>201</sup> *See* DAVID WEISSBRODT, JOAN FITZPATRICK & FRANK NEWMAN, INTERNATIONAL HUMAN RIGHTS: LAW, POLICY, AND PROCESS 26 (Anderson Publishing 2001).

<sup>202</sup> Gostin, *supra* note 1, at 20-21.

<sup>203</sup> *Id.*

<sup>204</sup> Kofi A. Annan, U.N. Sec'y-Gen., Address to the African Development Forum in Addis Ababa, (Dec. 7, 2000), available at [http://www.uneca.org/adf2000/daily\\_updates/speeches\\_and\\_press\\_releases/120700address\\_kofi\\_annan.htm](http://www.uneca.org/adf2000/daily_updates/speeches_and_press_releases/120700address_kofi_annan.htm).

The Burmese government, however, has proven itself highly resistant to being swayed by the ethical call of the human rights community. The Burmese government is largely unresponsive to the needs of its populace. The current military junta came to power through a military coup in 1962, after which it promptly assigned the new government leader, General Ne Win, full legislative, judicial, and executive powers of the state.<sup>205</sup> In its forty years of military rule, Burma's current regime has "abandoned all constitutional structures, has continually silenced any opposition and, above all, has continued to apply ruthless and inhumane means to achieve its ends—supposedly in the interests of the maintenance of the 'Union.'"<sup>206</sup>

As might be expected, the Burmese military junta has an abysmal human rights record. The long list of abuses perpetrated by the government includes: extra-judicial killings by security forces; torture of prisoners and detainees; arbitrary arrests; forced labor, including the widespread use of forced child labor; forced conscription of civilians into militia units; severe restrictions on the freedom of speech, press, assembly, association, and movement; and, discrimination against and harassment of Muslims and women.<sup>207</sup>

Likewise, education and health care are low priorities for the government, regardless of the needs or desires of the populace.<sup>208</sup> Total government spending on health has declined by more than seventy percent since 1990,<sup>209</sup> and the government's total expenditures on health and education are less than one percent of the national GDP.<sup>210</sup> The regime spends over two hundred percent more on the military than it does on health and education combined.<sup>211</sup> By comparison, the United States government spends almost fourteen percent of its GDP on healthcare, and Canada just over nine percent.<sup>212</sup>

Burma's lack of accountability to its populace and its continued unwillingness to comply with international human rights norms indicates that Burma's government is simply unresponsive to the ethical call of international human rights law. In order for international human rights law and the right to health to have an effect on Burma's policies, there must be

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<sup>205</sup> Gostin, *supra* note 1, at 20-21.

<sup>206</sup> *Id.* at 104.

<sup>207</sup> U.S. DEP'T OF STATE, Burma, in COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES - 2004, available at <http://www.state.gov/g/drl/rls/hrrpt/2003/27765.htm> (February 28, 2005).

<sup>208</sup> HUMAN RIGHTS WATCH, HUMAN RIGHTS WATCH WORLD REPORT 2003: ASIA: BURMA (2004), <http://hrw.org/wr2k3/asia2.html>.

<sup>209</sup> HUMAN RIGHTS YEARBOOK, *supra* note 115.

<sup>210</sup> *Id.*

<sup>211</sup> Sarkin & Pietschmann, *supra* note 10, at 388.

<sup>212</sup> Broadmoor, *supra* note 16.

mechanisms to compel Burma's compliance. An appeal to ethics is simply not enough.

## VI. CONCLUSION

Burma serves as an example of where the health and human rights approach to HIV/AIDS has failed, thereby compelling the conclusion that the right to health is not a model that is universally applicable or useful. This is not to suggest that other, more pragmatic approaches to the problem will necessarily be successful in the Burmese context. The impact of AIDS on Burma's already weak and isolated economy will not necessarily be enough to spur Burma's regime to take action. Likewise, while national security is a matter of concern for the Burmese government, the impact of AIDS is not likely to be a primary concern in light of much more pressing security issues.

Acknowledging the weaknesses of the health-and-human-rights approach to HIV/AIDS prevention in the Burmese and other contexts, however, can allow for a more holistic and realistic approach to AIDS prevention in the developing world. The approaches taken must incorporate both pragmatic and human rights components, depending on the context in which they are implemented. In difficult contexts such as that in Burma, an approach that subsumes health and human rights as the best method of encouraging compliance with AIDS prevention measures is destined to fail.