Treatment as prevention must not violate human rights from Nigeria-aids.org

The expansion of HIV testing programmes and the advocacy of universal testing and treatment of those who test positive as a means of prevention must not violate the human rights of target populations, AIDS advocates attending the 5th International AIDS Conference on HIV Pathogenesis, Treatment and Prevention stated on Monday in Cape Town, South Africa.

Representatives from the organisations Human Rights Watch and the AIDS and Rights Alliance of Southern Africa (ARASA) told HIV testing proponents to ensure that testing is not coercive, that it is linked to treatment provision and treatment education, that the peer counsellors who perform testing understand confidentiality and informed consent, and that those who test positive are not subjected to ostracism within their communities.

The background to a series of seminars and discussions on the way forward for treatment as prevention has been a political disagreement among the HIV advocacy and public health communities dating from last year.

In 2008, two mathematical models appeared in HIV journals showing that universal treatment of people who test positive for HIV would reduce the epidemic in the worst-affected countries by 90 to 95% by the year 2050.

The first, by Julio Montaner’s team (Lima) at the British Columbia Centre for Excellence in HIV/AIDS, found that two-thirds of infections in the province would be averted if all patients started treatment when their CD4 cell count was around 350 cells/mm3.

The second modelling exercise (Granich) was conducted by the World Health Organization (WHO) and published in The Lancet last November. This model found that achieving the somewhat utopian goal of universal HIV testing and treatment for everyone diagnosed HIV-positive would reduce HIV incidence from 2% a year to 0.1% a year within ten years and would reduce prevalence by 95% by 2050.

At the IAS Conference several meetings pitted advocates of ‘the right to know’ against advocates for a broader definition of civic health and safety.

Dr. Julio Montaner introduced a “town hall meeting” on the issue by saying that the idea of treatment as prevention was initially advanced because the Government of British Columbia was threatening to cap what it would pay for antiretrovirals. Montaner said he had brought up the dimension of the public health good of ARV’s ability to reduce infectiousness and was told to research it. “We did it as an additional justification for not rationing antiretrovirals,” he said.

In a plenary, WHO’s Ruben Granich emphasised that the initial huge cost of a universal testing and treatment programme would be overtaken by the cost of doing nothing and seeing a continued increase in global HIV prevalence by 2030.

At the town hall meeting he said that he wished that WHO had stressed the truly voluntary aspect of any proposed testing, with informed consent and no coercion or criminalisation of those who test positive.

Teguest Guerma, Associate Director of WHO’s HIV/AIDS Department, told the town hall meeting that she would like to tackle “the perception that the WHO only supports public health rather than human rights”.

She added: “We think that, along other human rights, it is a human right to know your status and to be able to access treatment.” She emphasised that using antiretrovirals for prevention was not yet a WHO policy and the next step would be a meeting in November to explore what evidence was needed.

However, Joseph Amon, director of the Health and Human Rights Division at Human Rights Watch, told the meeting that ‘the right to know’ could not be equated with ‘the right to live’ in situations where testing programmes were at best inefficient. Knowing might not result in any positive outcome.

In situations where confidentiality was violated, it could also only too easily turn change from being ‘the right to know’ into ‘the right of others to know’ their neighbours’ HIV status, a demand which, coming as it did periodically from employers, healthcare workers, immigration officials, schools and others, had had to be consistently resisted from the start of the epidemic.
He added that people's right to know they had HIV was meaningless without an equal right to the health information they needed to make sense of knowing. He criticised Granich's model for building in unwarranted assumptions such as positing that HIV-positive Africans would have on average eight new sexual partners a year, sustained over ten years. 'The problem with saying that testing is evidence-based prevention is actually a shortage of evidence, for instance that expanding testing actually does lead to expanded access to antiretrovirals.'

Michaela Clayton, Director of ARASA, expanded on this theme by giving as an example "Know Your Status", the universal HIV testing programme initiated in Lesotho. ARASA had conducted an evaluation programme. They found, amongst other things, that:

- Lay counsellors were putting people under pressure to test by, for instance, coming into their homes
- Lay counsellors had little understanding of confidentiality and would disclose subjects test results to family members
- Counsellors had little training in obtaining informed consent
- There was little effort by counsellors to advise on strategies to remain HIV-negative
- There was no monitoring of referrals to care and treatment

Professor Susan Kippax of the National Centre in HIV Social Research at the University of New South Wales in Australia emphasised the issue of deductive disclosure. She cited one Médecins Sans Frontières (MSF) project where locals told the researcher that they always knew who was positive because they get half an hour with the counsellor after the test, while the negative ones only get five minutes. The researcher found that people thus deduced to have HIV were still being isolated and ostracised from communities.

Joseph Amon added that people needed a variety of venues in which to test so that violations of confidentiality were less problematic.

Paula Akugizibwe of ARASA said that the legal framework often boxed in the potential dream of universal access, adding that in most countries, there is a lack of constitutional recognition of the right to health. This resulted in a situation of universal access for the mainstream and zero access for the margins, as epitomised by situations such as the position of injecting drug users or men who have sex with men.

Science is evolving faster that the legal human rights framework needed for successful interventions. The over-medicalisation of HIV is one of the greatest failures in the management of the epidemic", she said.

Joseph Amon added that until scientists could understand the social stress of a woman who, for example, he had met in Zimbabwe, who was afraid to test because of fear of being thrown out by the husband she loved, and who had probably infected her, they would consistently fail to understand community and individual resistance to the idea of testing for all.

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**Report Card: HIV Prevention for Girls and Young Women**

from [http://www.unfpa.org](http://www.unfpa.org)

This Report Card is one in a series produced by the International Planned Parenthood Federation (IPPF), under the umbrella of the Global Coalition on Women and AIDS, and with the support of the United Nations Population Fund (UNFPA) and Young Positives.

This Report Card is an advocacy tool. It aims to increase and improve the programmatic, policy and funding actions taken on HIV prevention for girls and young women in Nigeria. Its key audiences are national, regional and international policy and decision-makers, and service providers. It builds on global policy commitments, particularly those outlined in the Political Declaration on HIV/AIDS from the 2 June 2006 High-Level Meeting, to follow up on the United Nations General Assembly Special Session on AIDS (UNGASS).

This Report Card summarizes the current situation of HIV prevention strategies and services for girls and young women ages 15-24 years in Nigeria.

To access the article online, go to [http://www.unfpa.org/hiv/docs/report-cards/nigeria.pdf](http://www.unfpa.org/hiv/docs/report-cards/nigeria.pdf) or contact reach@northwestern.edu for a .pdf copy.

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REACH is a collaborative program of Northwestern University and the University of Ibadan with the support of the Bill & Melinda Gates Foundation. REACH aims to improve HIV/AIDS prevention strategies in Nigeria through social science and community-based research.
Harare — The Zimbabwe Farmers' Union has launched a gender and HIV and Aids policy to address farmers' health concerns as part of the union's efforts to boost agricultural production.

"It is a fact that without a clear policy on gender, HIV and Aids we are finished. Agriculture's most important input is labour. If the farmer is bedridden then there is no food.

"The same with gender; the woman provides labour and does the management because the husband is away, in short she is the real farmer. In most cases, her major contribution has gone unrecognised with her being denied access to credit facilities," he said.

Speaking at the same occasion the union's vice president, Mr Abdul Nyathi, emphasised that the ZFU was committed to the full implementation of these policies to achieve maximum production.

"The launch has been done but if we do not answer the question of implementation of these policies, then the policies are nothing. "We are committed to achieving the initial goal of this process but let us work as a team so that we enjoy the fruits.

"Here we are not looking at the reduction of HIV and Aids but at its total eradication," he said. Speaking at the launch of the Gender and HIV and Aids Policy in Harare on Monday, ZFU president Mr Silas Hungwe said the union needed such a policy because, if ignored, such issues could destroy the agricultural sector.

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