Commentary

Human Rights as a Cornerstone of AIDS Prevention, Treatment and Public Health Measures

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The International AIDS Conference (IAC) and the Singapore AIDS Conference (SAC) are biannual meetings held on even years. Both these meetings are occasions for discussion and sharing of updated information on epidemiology, biomedical advances, behavioural and social science, and to provide a platform for broadcasting results of research and interventions. It is interesting to note the differences in the scope of the 2 meetings – the SAC deals largely with the local epidemic, highlighting educational, prevention, treatment and support programmes. The IAC is a completely different animal, the recent 2010 conference in Vienna was attended by over twenty thousand delegates, there were hundreds of oral and poster sessions, the plenary sessions were headlined by a string of Nobel laureates, top researchers, celebrities, philanthropists, and heads of state. A significant part of the programme is usually dedicated to sessions on social, legal, cultural, economic and political dimensions of the pandemic. Of special significance and importance is the active participation of community groups and networks of affected communities, international NGOs, global and regional funding agencies, pharmaceutical manufacturers and persons living with HIV/AIDS.

The International AIDS Conference always attracts intense global media interest. Significant findings and novel concepts in biomedical and epidemiological sciences, urgent issues facing global and regional programmes, as well as important policy announcements are often made at the IAC. Among the main political and economic issues in focus at the 2010 IAC were calls for all governments to honour their commitment to universal access to prevention, treatment, care and support as enshrined in the 2006 UN Political Declaration on HIV/AIDS,[1] the Vienna declaration[2] which is a statement seeking to improve community health and safety by calling for the incorporation of scientific evidence into policies on illicit drug use, and appeals to developed nations to honour promises and to replenish the Global Fund for AIDS, Tuberculosis and Malaria.

There is now clear evidence that anti-retroviral treatment (ART) is extremely effective in stopping the progression of HIV disease. ART can also prevent horizontal as well as vertical transmission of HIV. Effective treatment of HIV-infected individuals results in suppression of viraemia that leads to reduced infectivity and HIV transmission at the population level.[3] The mantra of "test and treat" is gaining credence among experts. This concept of voluntary universal testing programmes with early initiation of anti-retroviral medications for individuals who test positive is now being advanced as a novel prevention strategy. However increasing HIV testing and induction of infected individuals into treatment and care programmes must be accompanied by safeguards against HIV-related discrimination. ART are also being proposed to as tools to prevent HIV transmission when used as pre- and post-exposure prophylaxis. A milestone research report announced in Vienna was that of the vaginal microbicide containing tenofovir that was found to be over 50% effective in preventing HIV transmission.[4] Such female controlled prevention tools will be a valuable addition to the list of useful prevention strategies. Several clinical trials to study the effectiveness of oral pre-exposure prophylaxis are ongoing and results are due to be announced within the next few months.

The theme of the 2010 Vienna IAC was "Rights Here, Right Now", a statement that underlines the centrality of human rights in all aspects of HIV prevention, treatment and care. It is widely accepted that anti-homosexual laws are barriers to AIDS prevention and care. Studies have shown increasing incidence of HIV infection among MSM (men who have sex with men) in many countries around the world.[5] Globally MSM are several fold higher risk of contracting HIV infection than heterosexuals and are marginalised and discriminated against; a number of countries still criminalise homosexual sex. A recent UNDP report reinforces the argument that homophobic legal and social environments hamper prevention, education and behavioural change programmes.[6] Mathematical modelling has also demonstrated that MSM specific intervention programmes will also have a positive impact on the HIV epidemic in the general population.

Punitive laws and police action against sex workers are similarly barriers to programmes reaching out these

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persons. Communities with significant injecting drug use and that have implemented harm reduction programmes have been successful in limiting HIV transmission. It is estimated that from 2010 to 2015, HIV prevalence could have been reduced by 41% in Odessa (Ukraine), 43% in Karachi (Pakistan), and 30% in Nairobi (Kenya) through a 60% reduction of the unmet need of programmes for opioid substitution, needle exchange, and antiretroviral therapy.[7] Successful prevention of HIV transmission in the highest risk communities is critical to the overall success of HIV prevention in the community at large.

Human rights are also denied through entry bans imposed on HIV-infected persons. From a public health perspective it has been shown that such regulations do not have any useful effect on epidemiology, in fact by exacerbating HIV-related stigma and discrimination such laws may actually lead to increased transmission.[8] Furthermore host countries do not impose exit travel bans on its HIV-infected citizens. Recognising and accepting these regulations to be misguided, more and more countries e.g. USA and China, have recently repealed their laws that restricted entry to HIV-infected persons. In many countries law reform that addresses and removes outdated legal and administrative obstacles to HIV prevention have been successfully introduced.

Globally over 5 million individuals in developing countries are now on anti-retroviral treatment. This has been made possible through the concerted efforts of global organisations, generosity of funders and activism of affected communities. Unfortunately the recent economic uncertainty has resulted in several governments cutting back on AIDS relief, and many in developing countries now face the prospect of treatment interruption due to this. In Singapore the poorest patients now have access to Medifund for help. On the ground the majority of HIV/AIDS patients gain access to affordable treatment from overseas supplies of generic medications through a variety of channels. However universal access also requires that HIV-infected persons overcome the agony of stigmatisation, shame and fear that many of them still experience. Half of new HIV infections notified in 2009 were in the late stage of the infection.[9] The majority of persons testing positive at anonymous testing sites do not seek medical attention. AIDS workers still have to counsel, treat and care for patients who present with complications of severe immune-suppression, patients who were too afraid to seek treatment until it was too late. For these patients universal access is not a reality here.

Unfortunately despite the rapid advances in ART and prevention science, a HIV vaccine and a cure for HIV are still distant promises. Until then we must continue to improve and implement combination approaches of prevention – behavioural, biomedical and structural - and review our policies and regulations that impact human rights of persons living with HIV/AIDS. In two years time we will again review our programmes vis-à-vis global standards. I hope there will be good news to report then.

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