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Time for action towards universal access to prevention, treatment, care and support: Beyond theory towards practice and protection

*Statement by group of independent experts advising UNAIDS on HIV and human rights**

Published in *The Lancet* on November 26, 2008, a theoretical model by Granich and colleagues concludes that a “massive scale up of universal voluntary HIV testing with immediate initiation of [anti-retroviral therapy] could nearly stop HIV transmission and drive HIV into an elimination phase”. As human rights advocates, we welcome a model that proposes the attainment of universal access to HIV treatment and HIV testing, and confirms the critical link between HIV prevention and HIV treatment. These are essential components of the right to health, as well as the goal of universal access to HIV prevention, treatment, care and support, and must be pursued with much greater efforts in the face of the HIV epidemic.

However, apart from passing cautions and a call for “further research,” the *Lancet* model does not really address the issues of acceptability and safe applicability of universal testing and treatment in the face of widespread stigma and discrimination. Nor does it address the risk that governments will fund and implement coercive biomedical and other approaches instead of empowering individuals through information, education and access to a range of HIV-related services.

To be both effective and just, programmes to scale-up HIV testing and treatment must be based on evidence and must protect the human rights of both the non-infected and the infected. We are concerned that the application of theoretical models to fictitious populations might divert attention from already-proven approaches to addressing HIV that take into account the widespread stigma, discrimination, and human rights violations that impede access to HIV services.

In the real world, the uptake of HIV prevention and treatment programmes is undermined by gender inequality and violence against women, mandatory testing and lack of confidentiality, stigma and discrimination against people living with HIV, and the criminalization and/or denial of the existence by some governments of key populations at risk of HIV infection, such as men who have sex with men, people who use drugs, and sex workers.

The *Lancet* model does not include, or cost, concrete programmes to reduce these barriers and support people’s ability to come forward for services on a long-term basis. Without attention to such programmes on par with that given to HIV testing and treatment, the model would not achieve the posited uptake necessary to achieve its goals. If efforts to determine the model’s potential are deemed worthy of further study, it is imperative that tangible human rights protections be given equal weight to the authors’ assumption that universal access to HIV testing and treatment could on its own reduce HIV-related stigma. In countries where HIV treatment has been available for many years and scaled up, stigma and discrimination may have been reduced somewhat, but remain widespread.

* This paper was produced by independent experts who also serve on the UNAIDS Reference Group on HIV and Human Rights, an independent group that advises UNAIDS on all matters relating to HIV and human rights. The views in this paper, as those of the UNAIDS Reference Group on HIV and Human Rights, do not necessarily reflect the views of the UNAIDS Secretariat or any of the UNAIDS Co-Sponsors.

While acknowledging that universal HIV testing with immediate treatment must be used in combination with other prevention interventions, the model neglects to define these or to call for their immediate scale-up. This creates the unfortunate and potentially dangerous impression that mass HIV testing and treatment represent a “magic bullet” against HIV, and that people should no longer have an array of choices by which to protect themselves from infection or by which to avoid the onward transmission of HIV, if already infected.

This impression is especially dangerous absent a clear description of how the voluntariness of HIV testing and treatment would be promoted and protected in the model. This omission combined with the enticing claim that massive annual, voluntary HIV testing and immediate treatment could greatly reduce mortality and have a substantial effect on HIV incidence, threatens to serve as justification for imposing mandatory HIV testing. Of particular risk is that vulnerable groups including sex workers, men who have sex with men, people who use drugs, and prisoners will be coercively tested on a massive scale in order to reach the 90% -plus rates of testing and treatment required by the model to reach its intended result.

Even as they note that “a trial of our theoretical strategy is technically feasible,” the authors of the *Lancet* model call for “further mathematical modelling, research and broad consultation.” If any further steps are to be taken, we believe they should be carried out transparently and responsibly, so as to advance knowledge without creating misperceptions and possibly confused attempts to “implement” such a model. This means full consultation with and participation by people living with HIV who are fully aware of the daily realities of stigma, violence and discrimination and who have been calling for programmes to address them since the beginning of the epidemic. We call on the modellers to include such programmes in their next round.

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