

Statement of the Johannesburg Civil Society Consultation on ART for Prevention

On 29 April 2009, 30 representatives of civil society organisations from Kenya, Tanzania, Uganda, Botswana, Mauritius, South Africa and Namibia met at a consultative meeting co-hosted by ARASA, OSISA and OSI to discuss the ART for Prevention Model and the practical application of this model to HIV programming.

Having the considered the ART for Prevention Model the participants resolved to state as follows:

Whilst we acknowledge the model's potential to advance the universal access agenda, we nevertheless have fundamental concerns about the assumptions on which the model is based, it's shortcoming from a human rights perspective and it's inattention to vulnerable and marginalised groups.

We agree with commentators who have pointed out that the model is based on overly-optimistic and unproven assumptions about:

- Long term impact of treatment on infectiousness
- Sexual behaviour of Africans and the extent of transmission during the acute phase
- Availability of second line regimens
- Likelihood of universal uptake of testing on a voluntary basis
- Individual clinical benefit of immediate initiation of ART
- Likelihood of lifelong adherence to treatment amongst asymptomatic individuals
- Capacity of health systems to deliver testing and treatment beyond to those who need it.

In addition we are concerned that the model fails to adequately acknowledge:

- The extent of modes of transmission in Africa other than through heterosexual sex;
- Legal, social and economic barriers to uptake of testing and treatment, particularly among women and other vulnerable groups; and
- Ideological opposition to evidence based prevention measures such as barrier methods, sex education, needle exchange and substitution therapy that need to be scaled up for the model to work.

As individuals and organisations who work closely with or represent sex workers, prisoners, refugees, LGBTI, MSM, WSW, IDU, PWD, children and other vulnerable and marginalised populations, we are astonished that the model appears to ignore the socio-economic and cultural reality faced by these populations. The models exclusive focus on heterosexual sexual transmission ignores those populations for whom heterosexual sex is not their major HIV risk factor. Moreover even for populations such as sex workers and refugees for whom heterosexual sex is a major risk factor, the model ignores the way in

which these groups are chronically left out of national HIV prevention, treatment, care and support programmes.

As the model's authors acknowledge, any universal testing and treatment model raises fears of coercion and other violations of individual human rights.

Based on our experience we have every reason to fear that the implementation of this model in its current form will in practice violate rights, including those to autonomy and bodily integrity.

In addition, even if these concerns could be addressed the model does not address the range of human rights violations that fuel HIV vulnerability and impede access to treatment and testing in first place. As such we feel the model is fundamentally at odds with a human rights based response to HIV. Given the inextricable links between human rights and public health we feel that resources would be better expended on scaling up efforts to combat HIV related human rights abuses than on a model that fundamentally fails to take these into account.

If the model is to be implemented in its current form it falls on the authors to demonstrate that any limitations of rights that occur are justifiable in accordance with the provisions of international human rights law. Given the flawed and optimistic assumptions on which the model is based, the authors argument that the benefits of eradicating aids outweigh the potential violations of individual rights that this may occasion, is hard to accept.

As advocates for universal testing and treatment we acknowledge the potential that this model may hold to advance the universal access agenda. This is however by no means self evident.

We therefore recommend the following before any further action is taken towards the piloting or implementation of this model:

- High level discussion of why progress towards universal access is so slow and how we can better hold governments accountable to universal access commitments
- The implementation of an ambitious strategy for scaling up human rights interventions that address vulnerabilities and barriers to accessing testing and treatment
- Additional research into the validity of assumptions on which the model is based, both those acknowledged by the authors and those that are not
- An analysis of what model would look like if many of key assumptions did not materialise and how these projections would be balanced against the obvious human rights concerns raised
- An inclusive and transparent process of civil society consultation, particularly in countries where the model may be piloted or introduced.

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