Lack of basic human rights as a key contributing factor to the ongoing global struggle against HIV and AIDS.

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Abstract

All human beings have inherent rights, regardless of their nationality, place of residence, sex or any other status (Office of the High Commissioner for Human Rights (OHCHR) 2015a). This article gives a brief history of the AIDS epidemic, as well as the current situation, to explore why people in specific areas and key populations are affected and discuss how human rights and HIV/AIDS are inextricably linked and how lack of respect for human rights continues to contribute to its spread and impact (OHCHR 2015b).

Article

AIDS (Acquired Immunodeficiency Syndrome) is reported as having been first discovered in 1981 and has since killed over 39 million people worldwide (World Health Organisation (WHO) 2014a). The first discovery of AIDS was reported in America when otherwise fit and healthy homosexual men began dying from opportunistic infections, which their immune systems should have been able to 'fight off' (Freidman-Kein et al. 1981). The origin of AIDS was unknown and early theories suggested that it was caused by lifestyle choices, such as homosexuality, and as a result, was commonly referred to as the '*gay plague'* (Greene 2007).

The media contributed to rising panic, stigma and controversy in 1982, when heterosexual people began contracting AIDS, labelling it as a disease associated with four categories of people (*the four H club*): homosexuals; heroin addicts; haemophiliacs; and Haitians (Avert 2014a). In 1983 and 1984, reports were on the rise, reaching 1000 cases in America (De Cock, Jaffe and Curran 2012) and Human Immunodeficiency Virus (HIV) was discovered to be the cause of AIDS, offering possible solutions to ending the epidemic (Montagnier 2010). Thirty years later, in 2013, it was estimated that 35 million people were living with HIV/AIDS and it currently affects every country in the world (WHO 2014a).

It is now known that anyone can contract HIV, and that it is transmitted by an infected person through five types of bodily fluid: semen; cervicovaginal secretions; rectal secretions; blood; and breast milk (National Aids Manual 2015). HIV, a virus specific to humans, is a mutation of Simian Immunodeficiency Viruses (SIV), believed to be the result of humans hunting and eating infected primates in Africa (Sharp and Hahn 2011). More recent studies now conclude that HIV/AIDS existed pre 1981, with its origins being

traced back as far as 1959, in the Democratic Republic of Congo (Worobey et al. 2008).

Treatment for HIV/AIDS remained ineffective until 1995-1996 when new combinations of drugs became available, known as antiretroviral therapy (ART) (Palmisano and Vella 2011). The introduction of ART has contributed to the change of HIV from a fatal disease to a chronic illness and is considered to be one of modern medicine's greatest achievements (Volberding et al. 2008). While ART does not eliminate the HIV virus from the infected person's body, if continually taken, it can control and prevent it from damaging the immune system (Palmisano and Vella 2011) and allow the patient to lead a healthy life (WHO 2014a). According to the World Bank (2015), only 13.6 million people were receiving ART in 2014, less than 40% of the global HIV population. It is also estimated that less than 50% of people infected with HIV know that they are HIV positive (World Bank 2015). These figures demonstrate that there is still a lot of work to be done before the goal of ending HIV/AIDS is accomplished.

The WHO (2013), states that the highest possible standard of health is regarded as a given right for every human being on this planet. While HIV affects every country, in 2007, 95% of all new HIV infections were in low- and middle-income countries (LMIC). Two thirds of all new infections occurred in Sub-Saharan Africa, which is reported as one of the worst affected areas (WHO 2008), accounting for 24.7 million of the total 35 million people living with HIV, or one in every twenty people. The second worst affected area reported is Asia and the Pacific, where 4.8 million people have contracted the disease and its prevalence is closer to one in every three hundred and forty people (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2014a). This suggests that a person's place of birth will greatly affect their chances of contracting HIV, as well as the right to a high standard of health.

It is clear that the demographic and epidemiological patterns of HIV/AIDS have changed significantly from the beginning of the epidemic and it has become one of the world's greatest health challenges, affecting every country, in particular countries in Sub-Saharan Africa (De Cock, Jaffe and Curran 2012). On a global level new HIV infections have decreased by 33% since 2001 and AIDS related deaths by 29% since 2005, however not all of the world's regions have experienced this decline (UNAIDS 2013a). It would appear that the epidemiology of the disease is still changing; in 2012 Sub-Saharan Africa was noted to have 40% (1 million) less new infections than in 2001, and 22% less AIDS related deaths. This reduction in new infections and AIDS related deaths is also seen to varying degrees in the Caribbean, Latin America and South East Asia (UNAIDS 2013a). Increases in prevalence have been noted in the Middle East and North Africa, where over 50% more infections have occurred and AIDS related deaths have more than doubled (UNAIDS 2013a). Other examples of areas with an increase in new infections and AIDS related deaths are East Asia, Central Asia and Eastern Europe, however to a lesser degree (UNAIDS 2013a).

Despite a reduction in HIV infections in Sub-Saharan Africa, it is still the area reported to have the highest prevalence of HIV/AIDS, in particular Southern Africa, which is considered to be the world's HIV/AIDS epicentre. Nine Southern African countries account for roughly one third of the world's HIV infections, even though they only equate to 2% of the world's population (De Cock, Jaffe and Curran 2012). South Africa in particular has been reported to contain 18% of the world's HIV population, with 16% of the 2.1 million new HIV infections in 2013 occurring there (UNAIDS 2014a).

Vulnerable groups such as women and children are considered to be at higher risk of developing HIV: in 2012 women accounted for 16.1 million and children for 3.3 million of the 35 million people living with HIV worldwide (UNAIDS 2013b). As well as woman and children, there are certain groups of people, known as key populations, where HIV infections continue to increase (Avert 2014b). The WHO (2014b) has identified five key populations that it states programmes should focus their efforts on, due to the proportionately high amount of HIV infections. These are men who have sex with men (MSM); people in prisons and other enclosed settings; people who inject drugs; sex workers; and transgender people. USAID (2014) state that despite the need for appropriate healthcare for these groups, they currently receive inadequate and unsuccessful treatment interventions from healthcare professionals due to a variety of social barriers which stand in their way, including stigma and discrimination.

The implications such inequalities have for health care provision is that certain areas and certain key populations remain untreated. These key populations need to be targeted and more resources are required to be made available to effectively treat infected people and prevent infection from spreading. Unfortunately, many of the worst affected areas have the least access to healthcare services, meaning that the people who are at the highest risk are unable to be treated or even diagnosed (Palmisano and Vella 2011). If the HIV/AIDS epidemic is going to end and cease to be a public health threat, then the lack of available healthcare will also need to end. Using the knowledge obtained from demographic and epidemiological studies to strategically target specific populations, it is possible that there could be a future with no new HIV infections (UNAIDS 2014b).

At the turn of the century, world leaders agreed 8 goals, known as The Millennium Development Goals (United Nations 2014), to be accomplished by 2015, designed to tackle extreme poverty in all areas of the world and promote human rights. Goal six related to HIV/AIDS and had two separate targets to accomplish: to have halted new infections by 2015 and to have universal treatment for all that need it by 2010. This ambitious goal has not yet been accomplished, however, progress has been made, with a notable reduction of 44% in new HIV infections between 2001 and 2012 (United Nations 2014). Despite this reduction in new infections, there were still 2.3 million new cases in 2012 and 1.6 million AIDS related deaths. Progress was seen as ART was made available to 9.5 million people in LMIC, and antiretroviral prophylaxis was received by 900,000 pregnant women in 2012. However, with 56% of people eligible for ART still not receiving it and 600

children dying of AIDS related causes every day in 2012, the AIDS epidemic is far from over (United Nations 2014).

The WHO (2012) describes Treatment as Prevention (TasP) as a key strategy in ending the AIDS epidemic. It refers to prophylactically treating an infected person with ART so that the level of HIV in their system is too low to infect other people. Starting ART early into the onset of HIV infection can reduce the risks of transmission during heterosexual sex by 96% (Cohen et al. 2011), as well as mother to child transmission by up to 90% (The Centers for Disease Control and Prevention 2006) and potentially reduce the risk of transmission for MSM (Muessig et al. 2012).

Despite numerous global health strategies since the beginning of the epidemic, HIV/AIDS still remains one of the world's biggest health challenges. The diverse range of countries it affects and the social, cultural and economic differences between these countries offers some explanation to the on-going spread of infection (WHO 2014b). HIV is mainly prevalent in LMIC, where the governments' primary goal is economic growth and development projects (United Nations Development Programme (UNDP) 2013). These projects attract large quantities of male migrant workers, resulting in high infection rates due to the increase in people using sex workers and crowded accommodation. Increase in incidence of HIV is also reported at border crossings and ports due to the increased level of migration and use of sex workers (UNDP 2013). Sex workers are reported as being twelve times more likely to be infected than the general population and the migrant workers that become infected from sex workers frequently have family at home who become infected when they return (UNAIDS 2014b).

Local infrastructure, poor health services and lack of education also present obstacles to delivering HIV treatment in many LMIC. Governments often lack the resources to treat HIV effectively and the public lack knowledge about prevention of infection. Treatment is often avoided due to the stigma that still surrounds HIV/AIDS, meaning many will remain untreated (Hoffman and Rockstroh 2012).

A sizeable barrier to delivering effective HIV treatment, is that homosexuality is still regarded as being illegal in 78 countries (UNAIDS 2014b), leaving MSM, one of the five key populations, vulnerable and unprotected. Criminalisation of homosexuality prevents treatment from reaching the people who need it and increases the risk of infection to the wider public (Beyrer and Baral 2011). Currently 60% of countries have policies, regulations or laws that are preventing MSM from receiving HIV treatment or even diagnosis (UNAIDS 2013b).

According to the WHO (2014b), a key healthcare intervention for the prevention of HIV infection is universal condom and lubricant use and availability. They state that increasing the availability of free male and female condoms and lubricant is an essential component of the HIV response, particularly targeting key populations. Use of male condoms reduces the risk of HIV infection by up to 94%, and while there is less evidence surrounding use of female condoms, evidence suggests they also reduce the risk of

infection. The use of lubricants prevents the condoms from breaking and becoming ineffective (WHO 2014b).

In the Gap Report (UNAIDS 2014b, page 15) it was reported that "In Sub-Saharan Africa, only eight male condoms were available per year for each sexually active individual. Among young people, condom access was even less." As Sub-Saharan Africa accounts for 70% of the world's HIV infections, then condom availability is required to be much greater. In contrast to Sub-Saharan Africa, in the UK condoms are readily available, free of charge and confidentially (NHS Choices 2013). It is estimated that in the UK there were 107,800 people living with HIV in 2013 (Yin et al. 2014). The UK has sufficient infrastructure to provide treatment to those who need it and in 2013 there were 81,510 people receiving care for HIV infection. Of all newly diagnosed adults in 2013, 98% were reported as receiving care within 3 months, regardless of sexual orientation, gender, age, ethnic group and location (Yin et al. 2014).

Even if condom use was made readily available in areas such as Sub-Saharan Africa, there may be other obstacles that prevent them from being used. In some countries, possession of a condom can be seen as evidence of criminal activity and grounds for harassment from police (WHO 2014b). In Malawi, where women suffer from increased gender inequality, they often do not have the right to refuse sex or insist on condom usage (Conroy 2006). Many women and girls are forced into the sex trade to make money, increasing their risk of contracting HIV. In Sub-Saharan Africa, women become infected 5-7 years earlier than men due to gender inequalities and lack of choice to say no as an adolescent (UNAIDS 2014a). If condom use is going to be effective in countries such as Malawi, then behavioural change strategies need to be targeted more towards males and towards the empowerment of women. The lack of women's rights in Sub-Saharan Africa is one of the reasons that the area suffers from such a proportionately high amount of infections, yet it is not an area that has received appropriate attention. In order to reduce infections and end the epidemic, protecting the rights of women and girls in Sub-Saharan Africa, as well as the world over, is key and should be considered in all national AIDS programmes (Conroy 2006).

Universal condom and lubricant use and distribution is an important intervention in response to the high rates of HIV infection globally and aims to contribute to promoting health as a human right by universally distributing affordable or free condoms and lubricant to those who need it. However, the reality is that basic human rights are being ignored in so many countries that this intervention is not working as effectively as it could.

If the AIDS epidemic is ever going to end, then basic human rights must be respected for everyone on this planet. HIV and AIDS affect a diverse range of cultures, countries and people, therefore in order for treatment and prevention to be effective it needs to be specific to the needs of each individual or group. HIV still has a lot of stigma attached to it, which combined with human rights issues, has a large effect on people not seeking diagnosis of the disease. Lack of basic human rights and adequate infrastructure is hindering treatment and prevention of HIV in many areas of

the globe, and this situation is likely to continue until these issues are adequately addressed.

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