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THE THIRD PHASE OF HIV/AIDS

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The Hon. Michael Kirby AC CMG

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The Hon. Michael Kirby AC CMG*

THE CENTRAL INCONVENIENT TRUTH

Two basic facts combine to provide the central inconvenient truth concerning the HIV/AIDS epidemic as it stands at this time:

- Despite worldwide attempts to alert vulnerable populations to the risk of HIV transmission and notwithstanding some lowering of those risks by the growing availability of anti-retroviral drugs (ARVs), the global rate of transmission of HIV remains, at this stage, about 2.7 million new infections each year[1]. Upon one view, this means that the epidemic has already passed its peak. However, the figure is still unacceptably high. It demonstrates the

* Member of the UNAIDS Global Reference Panel on HIV/AIDS and Human Rights 2003-; member WHO Global Commission on AIDS 1988-92; Justice of the High Court of Australia 1996-2009.

1 Richard Horton, "Putting Prevention at the Forefront of HIV/AIDS", *Lancet* (2008) 372: 421.

comparative failure of current prevention strategies, at least as these are presently implemented; and

- The world is currently facing a time of the most serious economic downturn in global markets since the Great Depression of 1929. The initiatives launched by the United States of America under former President George W. Bush, including PEPFAR, UNGASS and the creation of the Global Fund to Fight Aids Tuberculosis and Malaria (the 'Global Fund') were all actions taken during times of relative economic stability and prosperity. The global economic downturn has presented real prospects of a diminution of available funds to respond to HIV/AIDS and certainly a tightening of expenditure and a lowering of enthusiasm for financial subventions arising from the shrinkage of available resources.

The coincidence of these phenomena has meant that we are obliged to accept the likelihood that the world will not be able, or willing, to pour huge resources indefinitely into the special health problem of HIV/AIDS and specifically to fund the expensive ARVs which make such a profound difference to the lives of persons infected with HIV. This reality, in turn, affects the likely future impact of ARVs in reducing the viral load of patients, which is itself a contributor to diminished

transmission of the virus. In this sense, the ongoing incidence of very high levels of sero-conversions and diminishing funds for the special international response to this pandemic mean that it is essential to address, more urgently than in the past, the challenge of prevention of further transmission. The principal lesson of the current age is that the world will not continue forking out huge expenditures on this particular health condition at the rate in which those sums are likely to be needed by the ongoing levels of HIV infections.

This is an inconvenient truth because it seems unthinkable that, having secured the availability of ARVs to millions of patients infected with HIV in developing countries, the world would either (a) refuse ARVs to newly infected patients reported as from now; or (b) even worse, withdraw ARVs from those who have received their life enhancing benefits. Yet, in the present economic condition of the world, one or both of these consequences must be considered as a serious possibility.

Once this inconvenient truth is recognised, it demands that UNAIDS and everyone concerned with the global response to HIV/AIDS, must address urgently and honestly the tricky challenge of prevention and the

strategies likely to work to prevent more infections with HIV, so as to reduce the rate at which such infections are occurring.

POTENTIAL STRATEGIES

Several options are available for prevention strategies. Each of them is hotly contested, to some extent unproved and controversial:

- *Quarantine strategy:* The traditional response to an epidemic is isolation of the infected, and suspects, and then quarantine as a means of preventing the condition spreading to the uninfected. In the early years of HIV/AIDS, proposals were sometimes voiced that this strategy should be followed. Only Cuba rigorously adhered to this approach, although some countries introduced immigration controls and visa obligations demanding health checks for entry, some of which remain in place. The basic problem with this traditional strategy was the rapid early spread of the virus internationally; the initial difficulty of detecting infection; the costs and disadvantages of widespread screening to sustain such a policy; the rapid escalation of the cohort of people infected; and the disproportion of isolation and quarantine, given the large impact of that strategy on the economy and individual lives and the

limited modes of transmission requiring very close or intimate contact with the person infected with HIV. As a global strategy, quarantine is not now, if it ever was, an effective response to HIV and AIDS.

- *Blood screening, mother to child transmission strategies:* Once HIV, the causative agent of AIDS, was isolated and gave rise to efficient testing procedures, it became possible to screen blood products and to identify the prophylactic procedures available to eliminate some of the early vectors of HIV infection[2]. As well, in mother to child transmission, efficient and inexpensive therapies (e.g. involving the administration of drugs such as neviripine) became available to reduce risks of HIV infection of the neonate. Post exposure prophylaxis (PEP) was later available to diminish the chances of infection. However, all such strategies are of limited importance in terms of the overall epidemic, affecting as they do miniscule numbers of an ongoing crisis affecting many millions.

- *Criminalisation strategy*: In a number of countries, particularly in Africa, a rash of legislation has been enacted in recent years to

[2] Ronald Bayer and Claire Eddington, "HIV Testing, Human Rights & Global AIDS Policy – Exceptionalism and its Discontents" (2009) 34 *Journal of Health Politics, Policy & Law*, 301.

criminalise knowing transmission of HIV, principally in otherwise adult consensual sexual relations. A draft "model" AIDS law or code has been recommended, principally for Francophone African countries ("the N'Djamena code") containing such offences. In Anglophone Africa, similar laws have been enacted. In many developed countries, laws penalising "wilful" transmission of HIV have been enacted or established legal offences (assault occasioning grievous bodily harm) utilised to sanction identified behaviour. Commonly, such offences have been prosecuted against persons alleged to be guilty of multiple infections and often against foreigners. The utility of such laws to deter conduct contributing to such a major epidemic is highly doubtful and certainly not established. The cost of such prosecutions makes them a dubious strategy. The use of criminal sanctions tends to enhance stigma, reinforce discrimination and promote fear connected with HIV. Whilst a relatively minor place may be envisaged for criminal law in combating the HIV epidemic, such sanctions are unlikely to be a major part of any national or global HIV prevention strategy;

- *Universal testing and/or circumcision strategies*: Some epidemiologists have urged the promotion of widespread,

mandatory or "opt-out" testing for HIV as a way of re-medicalising the HIV epidemic[3]. The large and continuing rate of sero-conversions has resulted in mathematical epidemiological models designed to test the feasibility and effectiveness of mass screening as part of the treatment of HIV, in effect as a chronic medical condition[4]. The mathematical models have been questioned although reported successes in Botswana have been cited in support of this strategy. As against such programs, allowance has to be made for the difficulties of initiating widespread testing in societies with rudimentary systems of health care; the stigma and violence that can accompany the identification of individual HIV status; the common unavailability of ARVs, particularly in the long run; and ongoing concerns about the long-term effectiveness of ARVs and their possible harmful side effects. In the current economic circumstances, as a universal strategy for preventing the spread UNAIDS, mandatory or opt-out testing for HIV is highly contestable as an effective prevention strategy. Circumcision of adult males to reduce risks of HIV transmission appears an effective but likewise a limited strategy. It does not provide a life-

[3] See e.g. Roger England, "The writing is on the wall for UNAIDS" *BMJ* 2008; 336, 1072.

[4] R.M. Granich, C.F. Gilks, C. Dye, K.M. De Cock and B.G. Williams, "Universal Voluntary HIV Testing with Immediate Antiretroviral Therapy as a Strategy for Elimination of HIV Transmission: A Mathematical Model", *Lancet* (2009) 373: 48-57. See Bayer and Eddington 320.

long immunity to the patient; it requires high quality health care facilities to perform the operation correctly; and in some potential countries, it runs into cultural barriers and hostility. There is no equivalent effective operation for women. Circumcision, however useful, cannot therefore be a universal HIV prevention strategy; and

- *Human rights strategy*: A further option builds upon the experience of developed countries which tackled the HIV/AIDS epidemic early with strategies of mass education; widespread provision of condoms; community engagement; the enactment of laws for the protection of vulnerable and exposed groups; and the encouragement of HIV testing after informed counselling and patient consent. Although never objectively demonstrated with mathematical certainty as the cause for the decline of HIV infections in developed countries, the common experience of the foregoing strategies in such countries has been the rapid reduction in sero-conversions once they were introduced. Whether such strategies can be adopted in developing countries, with cultural, religious and other hostilities towards the legal, medical and social initiatives required, is a matter for debate. But, so far, the only countries that have achieved significant success in reducing HIV

infections are developed countries that have adopted laws and policies such as (1) decriminalisation of commercial sex work and the empowerment of commercial and other sex workers (CSWs); (2) decriminalisation of adult consensual sex between males (MSM); (3) needle exchange for injecting drug users (IDUs); and (4) enactment of anti-discrimination laws and other policies and measures, including mass education, to protect the community including vulnerable groups and persons living with HIV and AIDS (PLWHAs).

Of all the foregoing strategies, none has been proved to have universal application[5]. Little objective research has been conducted to differentiate the causative and effective policies from factors that are purely coincidental. Nevertheless, it can reasonably be concluded that the criminalisation strategy is ineffective; the mass testing and circumcision strategy is so far unproved and not universally available; mass education is difficult to introduce at the necessary level of particularity; and the human rights strategy is also controversial because it occasions strongly hostile approaches in many of the developing

[5] UNAIDS, Joint Action for Results: *UNAIDS Outcome Framework 2009-2011* (May 2009).

countries which constitute the present epicentre of the HIV/AIDS pandemic.

ADOPTING AN EMPIRICAL APPROACH

From the earliest days of the global response to HIV/AIDS, the activities of the World Health Organisation's Global Program on AIDS (GPA) and the work of the initial Global Commission on AIDS, leading epidemiologists, such as Professor June Osborn (USA) and Dr. Jonathan Mann (Director of GPA) insisted on an empirical approach to prevention strategies. Every strategy propounded for adoption in response to the sudden appearance of HIV had to be tested against a thorough and scientific examination of the objective data. All strategies and policies were to be judged not on purely intuitive grounds, hunch or guesswork but on the basis of analysis of sound empirical information. It is this approach that has, to this time, guided the successive policies of WHO, GPA, UNAIDS and other United Nations organs and agencies.

Of the initial participants in the Global Commission on AIDS, some, like Richard Rector (USA/Denmark), a person openly living with HIV, are dead. Others still work in the field and have been justly honoured for

their activities on the scientific challenges (including Luc Montignier) (France), Nobel Laureate, and Robert Gallo (USA). Others have moved out of the AIDS area. Dr. Jim Curran (originally of NIH, USA), who played such an important part in identifying the existence of agents causing the epidemic in the earliest days, and I are among the only original participants still on the scene. In that sense, we are a link to the beginning.

The initial insistence upon a strictly empirical approach was correct. It should continue to inform the conclusions about the epidemic and future strategies of UNAIDS and its participating agencies. Whilst it is not always possible to measure with exactitude the comparative effectiveness of differing preventative strategies, the adoption of a sound empirical approach, based on established evidence, is the only safe way to address the AIDS pandemic now and in the future. In this respect, the approach of the agencies of the United Nations has, from the start, been correct. It is a scientific approach and must prevail now and in the future[6].

[6] K. Buse & Ors., editorial, "HIV – Know Your Epidemic, Act on its Politics", *JRSocMed* 2008: 101: 572-573 at 572.

AWARENESS OF SUB-AGENDAS

Twenty years ago, at the University of Michigan Law School, I advanced arguments for a human rights approach to the laws and policies governing MSM, CSWs and IDUs in the context of responding effectively to the AIDS epidemic. At the end of my remarks, I was challenged by a young law student. Surely, he said, observance of a human rights approach to such laws was justification enough without the need to prove beneficial consequences. There was merit in the student's proposition. The world should support changes to national laws that are contrary to fundamental principles of human rights. However, the reality is that many such changes are slow in coming. Sometimes, they conflict with local religious, cultural and social norms.

In the compartmentalised organs of the United Nations, human rights issues are typically the special responsibility of the Human Rights Council, the treaty bodies established by international law, and the Offices of the High Commissioner for Human Rights (OHCHR) and of the High Commissioner for Refugees (OHCR). Typically, they are not the responsibility, as such, of the World Health Organisation (WHO), UNAIDS, UNDP or other bodies concerned with human health, nutrition and environment. Typically, different personnel are involved in these

tasks. There is a similar and parallel delineation of responsibilities in the political and bureaucratic organisation of most nation states.

It is important for homosexual and other participants in the dialogue about AIDS, often attracted to it because of the early impact of the epidemic on themselves and their friends, to be conscious of the need for complete honesty and rigour in propounding strategies of decriminalisation because of a personal commitment to such goals. Such motivations might discredit the strategies and set back the cause of reform, if it were concluded that their adoption was the outcome of personal agendas, as distinct from policies demonstrably proved as likely to reduce the spread and prevalence of HIV. This would not necessarily mean an end to the efforts to secure legal reform. They would simply be divorced, as such, from the responses chosen to contain the HIV/AIDS epidemic.

Making due allowance for personal inclinations, reformist pre-dispositions and lack of incontestable proof of effectiveness to a scientific standard, the fact remains that the nation states that have been

most successful in turning around the early rapid rise of HIV infections, have been those that have adopted human rights respecting strategies:

(a) Consultation with, and involvement of, affected community groups;

(b) Removal of criminal laws against, and the provision of anti-discrimination protection of, MSM;

(c) Needle exchange and other protections for IDUs;

(d) Education to empower CSWs; provision of free condoms to them and to their customers; decriminalisation of the pre-existing criminal offences; and termination of official harassment;

(e) Protection of prisoners from infection by measures of education; availability of condoms; and provision of needle-cleaning agents within prisons;

(f) Removal of legal restrictions on the ready availability of condoms; distribution of condoms and lubricants at relevant venues; and placement of condom vending machines in public facilities;

(g) Assurance of the security and safety of the blood supply;

(h) Public facilities for the deposit of sharps;

(i) Mass campaigns of public education, including in junior colleges and high schools; and

(j) Enactment of anti-discrimination laws addressed to discrimination against women, MSM, CSWs, IDUs and people living with HIV and AIDS (PLWHA).

Persuading nation states to adopt the foregoing and complementary strategies has not proved easy for the United Nations generally or for WHO, UNDP and UNAIDS in particular.

Throughout the developing world, and often in countries on the front line of the HIV/AIDS epidemic, laws inherited from colonial times impose serious punishments on MSM, CSWs and IDUs. Sometimes, as in the case of IDUs, national laws are actually reinforced by other United Nations programs (as in UNODC) and by international conventions. Often, however, the laws are simply inherited from colonial criminal codes. This is especially the case in countries of the Commonwealth of

Nations where 41 of the 53 member states maintain criminal laws against MSM[7].

The need to reform such laws, partly for human rights reasons and partly to strengthen strategies against HIV/AIDS, has recently been emphasised at a number of international fora. It stands to reason that persons who are criminalised and stigmatised, who have low self-esteem and also are subject to violence and discrimination, will often be placed outside the effective reach of health measures designed to reduce the risks of further HIV infection. The most effective ways to reduce HIV spread are likely to include measures that involve an outreach to individuals and groups especially vulnerable to infection. Whilst it would be highly desirable to improve, so far as possible, the accurate measurement of the impact of the foregoing legal and social strategies, it would be wrong to postpone adopting them until specific data demonstrated their utility beyond doubt. Decision-making in health strategies does not necessarily wait for compelling data. In the face of the unacceptably high global rates of HIV infection, there is a place for intuition and common sense. These suggest that behaviour modification

[7] Human Rights Watch, *This Alien Legacy. The Origins of "Sodomy" Laws and British Colonialism*, Washington DC (2008); The South and South-East Asia Resource Centre on Sexuality*, Human Rights and Criminalisation of Consensual Same-Sex Acts in the Commonwealth*, Bangalore, May 2008 (Sumit Baudh, ed.),

in vulnerable people is more likely to be achieved by strategies that reach out to, and involve, them and which convey prevention information in persuasive and unthreatening terms.

THE BASIC PROBLEM

The fundamental problem facing a shift to a new global strategy on now prevention needs to be stated. It is that most nation states are not sympathetic to recommendations that the foregoing prevention strategies. They do not respond favourably to proposals for decriminalisation of existing criminal laws. Instead, they tend to favour enacting new criminal laws, imposing sanctions on those who transmit HIV. Proof of these propositions may be found in the relatively small numbers of developing countries that have embraced the strategy of decriminalisation and the large number of them enacting new criminal laws to penalise transmission of HIV by consensual adult sexual conduct.

In part, this contradictory position derives from:

- The inertia of old criminal laws and the desire to be seen as doing something;

- The attractions of enacting a comprehensive law to deal with HIV which typically includes new criminal offences;

- The religious, moral and political resistance to decriminalisation of MSM, CSWs and IDUs;

- The frustration present in society because of the ongoing toll of the infected and the demand for the punishment of those responsible; and

- The inclination to hang on to stigmatisation of “deviants” (AIDS has been described as a “deviant’s disease”) and the unwillingness to accept the paradox that containment of HIV spread lies through strategies that involve protection rather than punishment of such “deviants”.

An indication of the truth of these propositions is that only one country of the Commonwealth of Nations in Africa voted in favour of the Franco-Brazilian proposal to the General Assembly in December 2008, calling for repeal of the criminal laws against MSM (Mauritius). Only three

African countries in all did so. Even South Africa, which enjoys constitutional protections against discrimination on the ground of sexual orientation and whose legislature has repealed criminal laws and enacted other laws protective of sexual minorities, did not vote in favour of the proposal. Yet, in the past five years, many countries throughout Africa have adopted provisions penalising HIV transmission. In short, the current strategies of many nations in the front line are exactly opposite to those suggested to be successful in reducing HIV transmission on the experience of developed countries.

The United Nations Organisation, as a membership body of nation states, highly dependent on regional groupings and voting patterns, reflects the foregoing disparity between best practice and the current initiatives in HIV prevention.

This disparity would always be of concern in a pandemic that continues to expand at the present significant rate. However, it is of a special concern in the current global financial crisis where limitless funds for ARVs for the rapidly expanding numbers of HIV patients appear to be unavailable or, at the least, highly uncertain.

The basic problem thus facing the United Nations, WHO and UNAIDS is how to change the present unfavourable responses into ones more likely to reduce the rate and number of HIV infections. Specifically, it is how to achieve a turnaround in circumstances where it is not possible for the United Nations or any other body simply to impose a new approach. What is needed appears to be a combination of persuasion, encouragement and acceptable coercion[8]. The stimulus for such strategies must derive from the commitment of the global community, and of the United Nations itself, to protection of the fundamental rights to life and basic health care of all persons. As well, the self-interest of the international community must be mobilised in circumstances where the countries that are most in need of ARVs are usually those least able to afford to pay for the essential medicines. It is this reality, but in an unpromising political and economic environment, that adds considerable urgency to the need to radical change in the present paradigm[9].

PLANETS IN RARE CONJUNCTION

[8] UNAIDS, *Preparing for the Future*, (report of the UNAIDS Leadership Transition working Group), Geneva, 2009. p.2.

[9] Chinua Ukukwe "The Future of UNAIDS" in *worldpress.org*, 8 December 2008. The first strategy is to tackle "weakest link in the fight" viz "lack of capacity to prevent HIV transmission at individual levels and the lack of capacity to mobilise care and support at family and community levels".

Despite many reasons for pessimism about the prospects of altering the foregoing global dynamic, a number of features afford a message of optimism that a change in the direction of the world community may be happening, with prospects of new and more effective attention to prevention. Amongst the considerations mentioned have been:

1. *The UN Secretary-General:* The Secretary-General of the United Nations, Ban Ki-moon has, since his election, repeatedly emphasised the need for member states to take strong measures to deliver a "broader human rights agenda" as this will both reflect the basic mission of the United Nations and, at the same time, contribute to prevention of HIV transmission. More than his predecessors, including Kofi Annan and Boutros Boutros Ghali (the latter of whom established UNAIDS), Secretary-General Ban has ventured into the need for changes in the laws of members states on the "areas of sex work, travel restrictions, homophobia and criminalisation of HIV transmission, ensuring access to justice and use of the law by promoting property and inheritance rights, protecting access to and retention of employment and protecting marginalised groups and reinforcing the work of the UN". He has repeatedly emphasised the need to halt sexual violence against women and girls; to empower young people to protect themselves

from HIV; and to enhance protection for people affected by HIV, and to protect vulnerable groups, including drug users. In Turin, Italy, the Secretary-General said: "People forget. We are here to act. We are here to deliver results. We are agents of change. Our job is to change the UN – and, through it, the world"[10]. In April 2009, he distributed to the General Assembly, a progress report on the implementation of the Declaration of Commitment on HIVAIDS and the Political Declaration on HIV/AIDS[11]. Exceptionally, on the cover of that report to the General Assembly (A/63/812), the Secretary-General quoted from a speech that he had earlier made at the International AIDS Conference in Mexico City, when he said[12]:

> "In most countries, discrimination remains legal against women, men who have sex with men, sex workers, drug users and ethnic minorities. This must change. I call on all countries to live up to their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and members of vulnerable groups ... In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result,

[10] UNAIDS, Joint Action for Results: UNAIDS Outcome Framework 2009-2011 (May 2009).

[11] United Nations General Assembly, 60-3rd session, *Progress made in the implementation of the Declaration of commitment on HIV/AIDS and the Political Declaration on HIV/AID* (report of the Secretary-General), 7 April 2009, Doc.A/63/812

[12] Speech by Secretary General at the International AIDS conference in Mexico City, 3 August 2008, quoted UNAIDS, UN Guidance Note on HIV and Sex Work (2009, Geneva).

there are fewer infections, less demand for anti-retroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us".

2. *The Administrator UNDP*: The new Administrator of the United Nations Development Program (UNDP), Ms. Helen Clark, former Prime Minister of New Zealand, likewise has a strong track record, both in adopting sensible national policies to combat the spread of HIV/AIDS and to protect the rights of PLWHAs. She has also suggested, in her own country, the repeal of counter-productive laws that render the effort against HIV/AIDS more difficult and less effective. There is every reason to believe that, as Administrator of UNDP, she will continue these policies, now on a wider stage.

3. *High Commissioner for Human Rights*: The new High Commissioner for Human Rights, Ms. Navi Pillay, in December 2008 supported the proposal calling for a universal statement by the United Nations to abolish the criminal offences against MSM. She said: "Ironically many of these laws, like apartheid laws that criminalised sexual relations between consenting adults of different races, are relics of the colonial era and are increasingly recognised as anachronistic and as inconsistent both with international law and with traditional values of dignity, inclusion and respect for

all"[13]. High Commissioner Pillay, like her predecessors, High Commissioners Mary Robinson and Louise Arbour, has repeatedly called for action to reform outmoded, and often unenforced criminal laws which nonetheless reinforce stigma, violence and discrimination and also impede the successful strategies to contain the spread of HIV[14].

4. *New United States administration*: On coming into office as President of the United States, President Barak Obama signalled an important change of policy. He committed his administration to protection of vulnerable groups, including MSM. On 19 March 2009, he announced that the United States would sing on to the statement before the General Assembly of the United Nations calling for an end to the criminal laws against homosexuals. He has undertaken to tackle other legal and policy impediments on this and related subjects.

5. *Executive Director, UNAIDS*: Finally and most importantly, the appointment of Dr. Michel Sidibé as Executive Director of UNAIDS, in succession to Dr. Peter Piot, ushers in a new era. Since his

[13] N. Pillay, cited "Homosexual Punishments Unacceptable: United Nations", Sydney Star Observer, 30 December 2008, 3.

[14] N. Pillay, "Human Rights in the United Nations: Norms, Institutions and leadership" (2009) EHRLR Issue 1, 1 at 7.

appointment, Michael Sidibé has repeatedly referred to issues such as the laws on CSWs, IDUs and MSM. His willingness to place such strategies at the forefront of his endeavours towards prevention has greatly heartened those who have felt that, whereas UNAIDS and WHO have been recently more successful in promoting universal access to health care, the issue of prevention has not had equal or adequate attention. Clearly, it is necessary to match verbal support for vulnerable communities and issues with appropriate funding within UNAIDS to ensure the development of a new impetus in prevention strategies. These points have been made by Mark Heywood (South African AIDS Law Project and current chair of the UNAIDS Reference Panel on HIV/AIDS and Human Rights). The unique feature of the constitution of UNAIDS, as a body including nominees of non-governmental organisations and as a joint agency of the United Nations that has always closely involved such organisations in its work, lays emphasis upon the recognition of outreach for real effectiveness in discharging its mission[15]. That outreach has enjoyed considerable success in promoting the policy of universal access to treatment. If it has been less successful in prevention strategies this has, in part, been because of the criminalisation and

[15] P. Das and U. Samaraskera, "What Next for UNAIDS?", *Lancet* (2008) 372: 2099 at 2100.

stigmatisation of many of the individuals concerned and also of the organisations representing vulnerable people at risk. It is this feature of the next phase of the work of UNAIDS that gives it a direct interest in the reform of laws and policies that impede the effectiveness of the global HIV prevention strategy.

In Cambodia, between 1993-6, I served as Special Representative of the Secretary-General for Human Rights. I was the first office-holder to be appointed to that office. I therefore had a measure of discretion in charting the initial focus of concern of the Office of Human Rights in that country. I placed high on my agenda the human rights features of the HIV/AIDS epidemic. During the Khmer Rouge genocide (1975-89), Kampuchea had been isolated from most of the rest of the world. It had, to that extent, been partly isolated from the spread of HIV. Following the advent of the United Nations Transitional Authority for Cambodia (UNTAC), the incidence of HIV in Cambodia increased rapidly. The new government and National Assembly, understandably enough, embraced measures inconsistent with the AIDS paradox. CSWs were penalised and education campaigns, including public posters and distribution of condoms, were discouraged. As part of my mission, I endeavoured to have these policies changed and, in this respect, achieved some

success. The rapid increase in HIV in Cambodia was halted. It was turned around through great efforts on the part of Cambodian government and people, WHO and international donors.

However, each decade must re-learn the lessons of HIV prevention. This is true in Australia, where, after more than fifteen years of the plateauing of HIV infections, recent evidence suggests an increase in the rate of infection amongst MSM in some States. Similarly, in Cambodia, recent reports indicate a return to old, rejected strategies. The enactment of a new law against trafficking of sex workers has reportedly resulted in the closure of brothels, harassment of CSWs, use of the possession of condoms to support prosecution of people as CSWs and other counter-productive policies. There is a constant need to re-teach and re-learn the lessons of HIV prevention. Most importantly, these lessons demand the empowerment of individuals and groups, vulnerable to HIV infection.

STRATEGIES THAT WORK?

In the absence of a cure for HIV that rids the body of the virus and of a safe vaccine that prevents the uninfected from becoming infected, the

only available strategies for prevention of infection involve attempts at behaviour modification. The history of humanity teaches the difficulty of securing this objective, most especially in highly pleasurable activities significant for self-identification. The law teaches the only partly effective capacity of penal enactments and policies to secure these ends.

In the absence of more scientific studies, we cannot be absolutely sure about what mixture of legal initiatives, education and social tactics will succeed best in procuring the necessary behaviour modification to reduce HIV transmission amongst vulnerable individuals. We know the vectors of transmission and the groups that are most vulnerable to infection. We therefore know the physical and social targets of our attention, if we are to have success in reducing the presently unacceptable annual rates of sero-conversion. The world cannot afford those rates, either in terms of their affect upon the lives of individuals, the suffering they cause for families, communities and nations, or the impact of the consequential economic losses. Something radical, therefore, needs to be done.

We know what measures do not work to achieve behaviour modification and the measures that may work but inefficiently and at disproportionate cost. The imposition of new criminal sanctions and the initiation of expensive prosecutions represent such a strategy. It is now too late (if ever it was proportional) to embark on widespread measures of quarantine. That leaves education; promotion of awareness; promotion of condom availability and use; facilitating informed, consensual testing for HIV in sexually active and otherwise exposed populations; and strategies of law reform to encourage effective communication with individuals and groups most vulnerable to exposure and also to reduce the number of sexual partners and risky behaviour within such groups.

All of this is scarcely a perfect formula for effective prevention of HIV transmission. However, it has generally been successful in developed countries. If the world is serious about prevention, these strategies represent the measures that should be promoted in developing countries presently at the greatest risk.

THE THIRD PHASE OF AIDS

The first phase of HIV/AIDS was between 1985 and 1996. That was the period of initial indecision within WHO; the advent of Jonathan Mann; the Global Programme on AIDS; and the alert that Dr. Mann presented to the global community about the existence of HIV and the need to respond to it in a way that married epidemic control with respect for fundamental human rights. As an agency of the United Nations, WHO was bound to observe principles of human rights as expressed in United Nations' treaties and universal customary law. But it was Jonathan Mann who taught that respecting human rights was also an important factor in designing an effective global response to HIV/AIDS.

The second phase of HIV saw the establishment of UNAIDS in 1996 and the appointment of Dr. Peter Piot, a distinguished scientist who had played a part in identifying the ebola virus. A reticent epidemiologist, Dr. Piot became a kind of "rock star"[16], following in this respect in the footsteps of Jonathan Mann tragically killed in an airline disaster ten years ago. Dr. Piot continued the close association of global health and human rights. It was on his watch that a major successes were achieved to promote awareness of the human right to access to basic health care, necessary and available to combat the devastating

[16] Das and Samaraskera (above) at 2100.

consequences of HIV infection. The increase of global access to affordable ARVs, the initiation of the UNGASS and the creation of the Global Fund were achievements that Dr. Piot helped to promote.

The third phase of HIV/AIDS began in 2009 with the appointment of Dr. Michel Sidibé to succeed Peter Piot. Arriving in the unpromising circumstances of the global financial crisis, and with continuing high numbers of infections, Dr. Sidibé's challenge is to embrace an effective strategy for the prevention of fresh infections. In a sense, this is the greatest challenge of all, so far, because it requires the international community to confront the serious impediments that represent a blockage to the only strategies, of which we are currently aware, that have proved effective to prevent HIV transmission on a national and international scale.

The challenge is enormous and the obstacles are discouraging. But this is the point the world has now reached with the HIV/AIDS epidemic. From numerous perspectives, critics of UNAIDS call for change. But the one perspective that is clear is that the world will not tolerate, or agree to treat with ARVs, an expanding cohort of people infected with HIV/AIDS,

certainly at the current annual increase of 2.7 million. Something has to happen. The Secretary-General of the United Nations clearly recognises the urgency of new initiatives of prevention. So does Michel Sidibé. It behoves others to acknowledge the difficulties of devising effective strategies of prevention and to assist all relevant agencies of the United Nations, and UNAIDS itself, to ensure that the essential strategies are adopted. But are the nations of the world yet ready to embrace the AIDS paradox?

We in Australia cannot control the outcome of these dilemmas. Because they will be played out, in large part, in Asia and Africa they are very important to us and to our people. They are important to our indigenous people for they face special dangers as the HIV pandemic continues to grow. It is here that the cutting edge work in science, treatment and prevention of the Menzies School of Health Research and other Australian scientific centres is so important. We may not in Australia be able to determine the future of the pandemic. But by good science and good public health policy, we can serve our own nation well and give a good example to others.

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