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UNAIDS

PROGRAMME CO-ORDINATING BOARD

THEMATIC SEGMENT ON NON-DISCRIMINATION

WHO HEADQUARTERS, GENEVA

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HIV: ENDING THE EPIDEMIOLOGICAL AIRBRUSH

The Hon. Michael Kirby AC, CMG

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THE HON MICHAEL KIRBY AC CMG[**]

RETURN TO THE ROOM

The last time I sat in this room was in 1992, nearly a quarter of a century ago. I sat there, at the oval table, in a seat facing the Chair.

Near me sat Robert Gallo (USA), whose scientific work had then recently contributed to the development of the test to identify the presence of the Human Immunodeficiency Virus (HIV). On the same side of the table, but a little distant, sat Luc Montagnier (France). His Nobel Prize lay in the distance. He received it for his work as co-discoverer of the HIV virus.

In the Chair of the meeting in 1992 was Professor Mike Merson (Yale University, USA), who had replaced as director of the Global Programme on AIDS (GPA) the remarkable international civil servant, Jonathan Mann. It was Mann who first drew to the notice of the then director-general of the World Health Organisation (WHO) Halfdan Mahler (Denmark), the worrying features of "slim disease" manifesting itself in Central Africa. In the midst of a tropical thunder storm in Brazzaville, he told

[*] Text upon which was based the address of the author to the UNAIDS Co-ordinating Board Thematic Segment on Non-discrimination on 13 December 2004 in Geneva. Personal views.

[**] Member of the World Health Organisation Global Commission on AIDS (1988-1992); Commissioner of the UNDP Global Commission on HIV and the Law (2010-12); Member of the UNAIDS Reference Group on Human Rights (2002 -).

Mahler of this peculiar condition. Fortunately Mahler remembered and summoned Mann back to Geneva to be the first head of GPA. He held that post until relieved of it in dramatic circumstances, in the midst of the fourth meeting of the Global Commission on AIDS in Geneva in June 1991. In effect, he was sacked by Mahler's successor Hiroshi Nakajima (Japan) for publically criticising the DG's sense of urgency and priority. These were early days in the AIDS epidemic. They were fraught with danger, anger and fear[1].

At our table, Gallo would refer frequently to his new book *Virus Hunting: AIDS, Cancer and the Human Reterovirus.* The quieter Montagnier, sometimes breaking into English to make a telling point to the Global Commission, confined the majority of his recess conversations to his scientific colleagues. One of them, Howard Temin was a Nobel Laureate in Medicine. It was he who would predict that despite the mutations of the virus, there would be an effective vaccine developed with 5-10 years and a therapeutic cure within 20. Here we are 30 years after the first report of HIV, still with no vaccine and still no cure that will cause the infected to throw off completely the dangerous virus.

It was in this room that Mann and June Osborn (University of Michigan, USA) first propounded the AIDS paradox. Whereas with earlier epidemics, law would be invoked for quarantine and other controlling purposes, in this one, it was too late for that strategy, so a different human rights approach was urged. Protecting the rights of the infected, so as to reach out to them and to secure their co-operation in strategies of prevention, designed to slow the spread of HIV, was advocated. As we sat around this table, outside in the streets of Geneva, Djibouti, Kingston, Jamaica and Hobart, Tasmania, this human rights strategy would be difficult to sell. The intuitive response of persons in the street was punishment, not protection. Yet punishment would not bring the desired outcomes. On the contrary, it would exacerbate fear and drive people away from the new HIV test and from such early forms of therapy as were available and others that would come.

[1] M.D. Kirby, "GPA Under New Management: A Personal Report on the Fourth Meeting of the Global Commission on AIDS", June 1991, 2-4.

Under the inspired leadership of Jonathan Mann, followed in due course at UNAIDS by Peter Piot (Belgium) and Michel Sidibé (Mali), the human rights approach would continue to apply. From time to time it has been questioned. With the advent of antiretroviral drugs (ARV) it has been challenged. But the countries that have done best in their response to HIV have followed the WHO and UNAIDS strategy. Those that have not have done so have performed poorly and their people have suffered. Particularly suffered if they were members of the most vulnerable groups: men who have sex with men (MSM), sex workers (CSW), drug users (IJU), transgender persons (TGP), prisoners, migrants and women and children in some societies.

GLOBAL COMMISSION ON HIV AND LAW

Since those early days, I have retained a link to UNAIDS, including lately through its reference group on HIV and human rights. I return to this room in my capacity of a member of that group. It was in that capacity that I had the privilege, in December 2011, of offering a summing up for the thematic segment of the 20th UNAIDS Programme Co-ordinating Board (PCB) on HIV and Enabling Legal Environments. That segment was timely, coming as it did in the midst of deliberations of the UNDP Global Commission on HIV and the Law, on which I served as a Commissioner between 2010-12.

The report of that Commission was delivered to the Administrator of UNDP, the Executive-Director of UNAIDS and the Secretary-General of the United Nations in July 2012. At the opening of this meeting of the PCB, Michel Sidibé gave a most powerful commitment to following up the recommendations of the new Global Commission. It was constituted by distinguished and knowledgeable members, chaired by former president Fernando Henrique Cardoso (Brazil) with Shareen el Feki (Egypt) as vice-chair and including as a member former president Festus Gontebanye Mogae (Botswana). Much of the Commission report was addressed to issues of discrimination, in the society and the law. Accordingly, this thematic segment of the PCB should inform itself of the enquiry and recommendations of the Commission. There is no need to reinvent the wheel where useful and informed analysis and recommendations have already been provided. The PCB should

therefore invoke them, endorse them, support their implementation and call the countries of the world to account where they fail to implement the recommendations in that report.

I fully realise that the topics examined by the UNDP Global Commission are sensitive, such as law and policies on vulnerable women and children; on people who use drugs (IJU), on sex workers (CSW), on men who have sex with men (MSM), on transgender persons (TGP); prisoners and migrants. The recommendations of the Commission for a new approach to the global regime of intellectual property protection is also highly sensitive, in light of the large economic pressure to conform to, and not to question, the current law and practice.

However, there is a great urgency in addressing the Commission's recommendations. Although our objective, in the United Nations family, is to get to zero in new infections, in discrimination and in adverse legal procedures, there are forces at work that impede the attainment of those objectives.

More than 2.6 million new infections with HIV are recorded each year. The demands for, and likely costs of, ARVs continue to increase. Commitments given by member countries of the United Nations to support the Global Fund have sometimes been cut back because of the pressures of the Global Financial Crisis and its aftermath. The need to move HIV patients to second and third line therapies, currently unavailable in the form of generic drugs, highlights the urgency of developing a new global intellectual property regime more respectful of the fundamental rights of all persons to have access to the best available healthcare.

This confluence of epidemiological, legal and economic pressures should heighten our sense of urgency. Otherwise, the world faces the shocking prospect not only of a shortfall in the provision of ARVs to newly infected or previously untreated patients in need, but even of the withdrawal of ARVs from persons whose hopes have been raised by the great efforts of the United Nations, UNAIDS and the Global Fund over the past 5 years. Sadly, I have not seen in recent UN discourse the necessary sense of urgency and alarm. My long acquaintance with this epidemic encourages me to voice these concerns. Bluntly.

THREE CENTRAL MESSAGES

So what are the three central messages from the UNDP Global Commission report that this PCB should here and now resolve to accept and act upon?

1. *Embrace the paradox*:

   The first is to relearn the lessons taught a quarter century ago and repeated in the latest Global Commission report. Particularly, in the absence of a safe vaccine and therapeutic cure, we must continue to embrace the HIV paradox. Discrimination is an impediment to an effective response. Discrimination delays or defeats people at risk securing an HIV test, which is the first step on a path to behaviour change and, where necessary, early treatment. Early treatment is recognised not only for its therapeutic objectives, but also because it reduces infectability. ARV Treatment is thus essential to prevention. So this is why the successful strategies of engagement with IJU, CSW, MSM, TGP, prisoners, migrants and disempowered women and children is so important. Criminalising infection and penalising the vulnerable groups must stop. Just as the successive Global Commissions have strongly recommended;

2. *Know what works and act*:

   I realised that, in many countries there are religious, cultural and other impediments to engagement with these vulnerable groups. Taking steps in the name of human rights is not attractive in many lands. I discovered this when, between 1993-6, I served as the UN Secretary-General's Special Representative for Human Rights in Cambodia. Yet, where arguments of human rights failed, progress could sometimes be made when the economic consequences of failure to act were brought home. Every strategy must be deployed. For 25 years we have known the responses that work to reduce infections and those that fail. We know, for example, that harm reduction is much more effective, from an HIV prevention standpoint with IJUs than is criminalisation. This is demonstrated most vividly in the comparative rates of HIV infection in places where differing strategies have been adopted. Thus, the availability of sterile needle exchanges

in New Zealand (1%), Australia (2%) and Switzerland (2%) has significantly brought down the spread of HIV among IJU. Compare these figures with Russia (37%) and Thailand (42%) to realise the impact of law and policy[2]. The same consequences can be found in differing cities with differing policies. Thus in Edinburgh which effectively prohibited syringe exchange, the rate of infection amongst IJUs was over 50%. Whereas in Glasgow, where purchase and possession of syringes were allowed, IJU prevalence of HIV was between 1% and 2%.

The same date is available in respect of HIV amongst MSM. In Jamaica, where the general level of HIV in the population is already high (2%) it is shockingly so amongst MSM (30%). MSM in Jamaica face severe stigma, violence and humiliation as well as criminal laws. Often the source of the problem is religious and social stigma. But law can reinforce or palliate these impediments to treatment and other prevention strategies.

3. *Don't airbrush the problem:*

The worst form of discrimination is denial, rejections, exclusion, dismissal of the problem and of persons and groups at greatest risk. Sadly, this remains a major difficulty, even within the United Nations. In June 2011 I attended, as an observer, the Special Session of the General Assembly convened in New York to renew the commitments of the international community to addressing HIV and to providing funds essential for effective responses[3]. For me, the most shocking evidence of discrimination noticed at the Special Session was the insistence of a number of countries that the Organisation could not even mention the special vulnerability of MSM, TGP and CSW. The suggested reason was that it was contrary to religious belief and cultural norms. It could not be permitted. This attitude contradicted the resolve accepted in this room at the beginning of the epidemic 25 years ago. Strategies, policies and laws would be based on sound imperial data. That data does not permit a truthful denial of the special impact of HIV on MSM, TGP and CSW. No amount of religion or culture can be allowed to

[2] UNDP, *Global Commission on HIV and the Law, Risks, Rights and Health* (2012) 33.
[3] Described in Dennis Altman and Ors, "Men Who Have Sex with Men: Stigma and Discrimination", Viewpoint, *The Lancet*, July 2012, 91.

airbrush these groups out of existence. The world cannot tolerate a kind of epidemiological photoshop. It would attempt to expel the reality of these and other groups from the consciousness of humanity. In the end, the vulnerable groups were mentioned in the resolution. But a price was extracted. Opponents, led by some Arab and African States and the Holy Sea, claimed that to name a group was to legitimise it. Virtually every other group relevant to the epidemic was mentioned; but not those empirically proved to be facing the greatest risks. Mentioning them prevailed in the end but at a price of reserving to national government the right, in effect, to ignore them if culture or local attitudes so demanded. A time may come when these attitudes are perceived as equivalent to sweeping water from the floor whilst the tap is left running. Taxpayers in already cash strapped developed countries are bound to question the justification of aiding those who will not aid themselves.

HIV/AIDS AT 50?

Much progress has been made since the original WHO Global Commission that gathered in this room a quarter century ago. In science and in funding essential for universal access to essential health care. In taking hard but necessary steps to removing legal barriers, to promoting education and reducing stigma. Where will we be in a further quarter century: with AIDS at 50?

Will we then have the vaccine and cure predicated so confidently two decades ago? Will the international community have taken steps to assure the attainment, for all human beings, of access to essential healthcare? Will our species have risen above itself to confront stigma and discrimination effectively? Or will the findings and recommendations of the UNDP Global Commission of 2012 remain still to be achieved? Will we still be denying reality and just go on reaching for the airbrush? The lesson of the last two decades is that getting to zero will be more difficult and painful than some people think. Whether we reach zero, depends on us and what we all resolve to do today.