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POSITIVE VOICE: PEOPLE + HIV

AIDS HEALTHCARE FOUNDATION

WORKSHOP ON GREEK JUSTICE,
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COMMANDMENTS

The Hon. Michael Kirby AC, CMG

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THE HON MICHAEL KIRBY AC CMG*

A TALE OF FIVE CITIES

One of the most famous novelists in the English language was Charles Dickens. One of his greatest novels is a *Tale of Two Cities*. It tells the story of a huge international crisis that followed the French Revolution of 1789. It does so from the viewpoint of concurrent happenings in Paris and London.

As is well known, the book begins with the famous words:

“It was the best of times. It was the worst of times.”

So it is today with HIV. These are bad times, especially in developing and poorer countries; but also in middle income countries. Yet they are times when vulnerable people are being supported in an epidemic, as never before. When people living with HIV and AIDS are standing up for their rights, with the aid of civil society. And when important advances are being made in healthcare and treatment.

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I will recount a tale of five cities facing the HIV epidemic. It is not a global story. But it gives and glimpse of diverse global realities.

First *Johannesburg, South Africa*. The epicentre of the HIV epidemic. There, President Thabo Mbeki, trawling the internet at night, came upon a website of HIV denialist. He embraced their cause. He refused to believe that AIDS was caused by a virus. Specifically he denied the existence, or relevance, of the Human Immunodeficiency Virus (HIV). He would not permit his government to make anti-retroviral drugs available to South Africans. As a consequence, he refused to provide the drug Navaropine, then the best available means to reduce the risks of horizontal transmission of HIV from mothers to their newborn children. Although data in other countries demonstrated the high effectiveness of administration of this drug to neonates just before and after birth, to reduce HIV infection in about 70% of those treated, Mbeki rejected the pleas for its provision. Shamefully, his government did not step in to reverse this decision.

Fortunately at the end of apartheid, South Africa had secured a modern constitution. It contained, exceptionally, provisions protecting a right to healthcare. Proceedings were brought before the Constitutional Court of South Africa by the Treatment Action Group.¹ Because of the potential costs of treatment, it might have been understandable if the Court has passed the problem back to the government and parliament. It did not. It made orders providing that the government afford mothers access to the relatively inexpensive drugs that would substantially reduce the rates of child infection. Eventually, the government of South Africa complied. Later, President Mbeki was “recalled” from office by the governing party. Now, an unprecedented program of access to ARV is in place. This is a tale of political failure and of legal and judicial success, spurred on by civil society.

Kingston, Jamaica is the playground of the Anglophone tourist Caribbean. As in most, but not all, countries in the Caribbean, formerly ruled by Britain, homosexual acts are criminalised. This is so even where the participants are adults, fully

¹ *Minister of Health v Treatment Action Campaign* [2002] 5LRC 216 (SACC).

consenting and acting in private. In most other colonial regimes of nations other than Britain, such criminal laws had been repealed long ago.

Unfortunately, the rates of HIV infection of men who have sex with men (MSM) in Jamaica is very high. The HIV rate in the population generally is 2%, already significant. But amongst MSM it is 30%. Because of the criminal laws in place, insufficient has been done to engage the affected community and to inform it of the special risk to MSM of HIV transmission.

Jamaica has been an independent nation for decades. Its Constitution has admirable provision guaranteeing equality to all citizens. Fearful that this provision might be invoked to remove the criminal penalties upon MSM, the local legislature enacted a constitutional amendment, purporting to exclude any decision of the courts affecting the anti-sodomy law. Despite urgings by the United Nations, and belatedly by the Commonwealth Secretariat, Jamaica stands resolute against any law reform. It receives funding to support the provision of ARVs to its population. But it resists the most obvious reforms that would help to reduce such infections.

The resistance to such reforms stems mainly from religious beliefs. They resist enlightened policies on part of the law-makers. Recently, I was sent to Kingston by UNDP to speak with ministers and officials, so as to tackle the logjam in reform. The ministers acknowledged the problem; but they feared that any action by them would fail because of religious resistance in the populus. The officials insisted that visiting United Nations experts had to respect local religious and cultural norms. The same answers are given in Nigeria, Uganda and elsewhere in Africa when UN leaders urge repeal of the sodomy laws. In fact, in some African countries, new legislation has actually been proposed to impose the death penalty on gays. In the Caribbean and in Africa civil society, pressure for relevant reforms is very weak. In Jamaica there are virtually no openly gay citizens. Certainly in positions of influence and responsibility. Fear and stigma rule.

In *New Delhi, India*, early efforts to secure laws appropriate to the challenges of HIV were partly successful. However, India too had received, in the *Indian Penal Code*, section 377, a provision of British law criminalising homosexual acts. Suggestions that the democratic legislature should repeal or modify that provision fell on deaf ears. India, it was said, was 'socially conservative'. Although the law dated from colonial times, getting rid of it ran into religious and social objections.

Eventually, a civil society organisation, NAZ Foundation, brought proceedings in the courts. It challenged the validity of section 377 on the basis that it was incompatible with constitutional promises of equality and privacy. In a most important decision in 2009, the High Court of Delhi unanimously upheld the challenge. It ruled that section 377 could only be used in the case of underage and therefore unconsensual sexual activity. Anything more was constitutionally invalid.² An appeal against this decision has been taken to the Supreme Court of India and awaits a ruling. However, so far the Indian case demonstrates again the failure of the political process and the success of proceedings brought by civil society in the courts.

In *Sydney, Australia*, the AIDS epidemic took an early and heavy toll. Because of my own sexuality, I lost 12 gay friends to AIDS. For me, it has never been a theoretical problem. I have seen it close up and dangerous.

When HIV came along, we were fortunate, in Australia, in our politicians. The Federal Minister for Health (Dr Neal Blewett) served in the Labor Government of Prime Minister Bob Hawke. The Opposition spokesman on health was Professor Peter Baume, a senator for the conservative parties. Minister Blewett took care to appeal to his opposite number in Parliament to adopt policies that put people before partisan politics. Fortunately, this proposal was accepted. Ever since that time, under both Labor and conservative governments in Australia, there has been substantial unanimity in HIV policy, both at home and in our foreign aid programs. The strategy that was adopted included:

² *Naz Foundation v Delhi* [2009] 4 *Law Reports of the Commonwealth* 83 (Delhi HC, per A.P. Shah CJ and S. Muralidhar J).

- (1) The removal of the remaining criminal laws still in place against gays;
- (2) The de-criminalisation of commercial sex work;
- (3) The adoption of a nationwide clean syringe exchange program; and
- (4) The provision of HIV medicines on national health.

The result of these strategies has been the levels of HIV infection in Australia have remained remarkably stable, although there is some evidence of an increase in recent times. This was a case where the politicians of the nation acted with courage and wisdom. The population was the beneficiary.

Proof of that wisdom may be seen in the rates of infections amongst injecting drug users (IJU). In New Zealand, where needle exchange was adopted even earlier than in Australia, HIV amongst people using drugs stands at about 1%. In Australia, 2%. In Canada, (where the facility has only been available in British Columbia) the national level is 18%. In Thailand it runs at 43%. In Russia 36%.³ Countries that take precautions that place protecting life above other strategies received a significant and beneficial dividend. That dividend is paid both in costs saved and lives protected.

Finally, there is the case of *Athens, Greece*. Here, as this workshop has shown:

- * Although there are no criminal laws against adult gay sex, there are substantial social and religious impediments to effective policies that reach out to MSM. I applaud the facilities developed by Positive Voice in a populous suburb of Athens. It is friendly, available, anonymous and empowering. It should be supported and its example copied in other cities if Greece. But the criminal law is not the only impediment in knowledge and access to prevention;

³ UNDP, *Global Commission on HIV and the Law, Risks, Rights and Health* (July 2012), 29 at 33.

- * In Greece there is no needle exchange system in place. Some statistical information suggests the risks of the epidemic in Greece moving to mirror the epidemic in neighbouring countries of Eastern Europe and the former Soviet Union. In those countries the major vector for HIV is injecting drug use. There is no more efficient way to pass HIV than by direct injection into the blood stream. The use and reuse of infected needles is highly risky in this respect. The IJUs reflect the sexuality of the majority population. It is therefore vital to nip in the bud the growth of this risky mode of transmission. Attempts to stamp out all drug use have not succeeded. Harm reduction is a much more effective and sensible option;
- * Likewise, in Greece, sex workers are often disempowered. They are disrespected, at least in public discourse, largely because of religious and social stigma towards them. The well known event in April/May 2012, in which sex workers in Athens were arrested, photographed and had their personal data (including HIV positive findings) widely publicised, on the supposed ground of protecting public health, is a shocking and counterproductive course of conduct. It is likely to drive sex workers underground and to place them outside the reach of healthcare messages and protective strategies; and
- * The decision of the Supreme Court of Greece upholding an employer's right to dismiss workers found HIV positive is out of line with UNAIDS recommendations. It is disproportionate to any risk presented by working with HIV positive persons. It discourages individuals from being open about their HIV status and undergoing an HIV test to discover their sero-status. It thus discourages early access to ARVs, administration of which significantly reduces the risks for further transmission of HIV by those infected. The same should be said of proposal to introduce criminal laws that would punish transmission of HIV in circumstances of adult consensual activity. This too is contrary to UNAIDS advice.⁴

⁴ UNAIDS, *Criminalisation of HIV Transmission* (Geneva), August 2008.

FIVE COMMANDMENTS

A reflection on the different strategies adopted in the five mentioned cities shows the marked differences that exist in the response to HIV. It also suggests, that in this epidemic, at least, and at this stage of its progression (and without a vaccine or therapeutic cure), law can sometimes play a beneficial and supportive role. Sensible laws can help reduce transmission, in particular, they can do so by engaging those vulnerable groups at risk in awareness, education and self protection.

In these circumstances, it is appropriate now to proclaim the five commandments of Athens. This is five fewer than the Almighty. I hope that the smaller number will lead to greater compliance than has proved to be the case in obedience to the ten commandments given to Moses.

1. Do not put your faith in criminal law

Criminal law is not an effective tool in seeking to reduce the spread of HIV. It is expensive to administer. Any effectiveness depends upon perceptions of the risks of being apprehended rather than of suffering draconian punishments. Because most modes of transmitting HIV invariably occur in private often with consent, the effectiveness of the criminal law is very low.

2. Engage with and sensitise all branches of government about what works:

It is important to educate legislators so that they understand the paradoxes of responding to HIV and the ineffectiveness of punitive strategies. Education of legislators, officials and judges can be undertaken and can prove beneficial. The media should be engaged. And so should civil society. In South Africa, India and Australia, successful strategies were stimulated by civil society. Sometimes (as in South Africa and India) seminars had been conducted that informed members of the judiciary of the characteristics of HIV, its modes of transmission and the responses that work and those that fail;

3. *Engage participation with vulnerable groups*

At the very beginning of the HIV epidemic, the World Health Organisation and later UNAIDS and UNDP, have always insisted upon close engagement with individuals and groups representing communities at risk to HIV infection. This means engagement with MSM, IJUs, CSW, transgender persons and the broad sero-positive community. It is regrettable that, although much time was spent here in Athens to speak *about* CSWs arrested in Athens, no steps were taken to invite any of them to take part in the workshop. There should be less speaking *at* or *about* the vulnerable. There should be more speaking *with* the vulnerable. And listening to their stories;

4. *Base laws and policies on empirical science*

From the beginning of the global response to HIV, the UN has insisted on observing a scientific foundation for strategies to respond to HIV. Prosecuting and punishing persons who are found to have transmitted HIV in adult consensual sexual or drug using activities may sometimes be politically popular.⁵ However it is counterproductive and it has little, if any, effect to reduce transmission. Similarly, MSM, sex workers, drug users and other minorities may be unpopular. This sometimes presents an obstacle to legislators. But the only strategy with a chance of success is one that engages with such groups and individuals, seeks their views and involves them in self protection and protection of others; and

5. *Make yourself aware of preventive information:*

It is essential that legislators, officials and leading judges should be aware (and should make themselves aware) of the latest information on HIV transmission and the strategies that actually work. A good starting point will be to secure UNAIDS guidance notes, a copy of the *UNDP Global Commission Report on Risks, Rights and Health*; and legal decisions in other countries that may have relevance at home. There is now a rapidly expanding dossier of material judicial decisions on HIV transmission. These

⁵ UNAIDS, High-Level Policy Consultation on Criminalisation of HIV Non-Disclosure, Exposure and Transmission (meeting report, Oslo, Norway, 14-15 February 2012).

should be available to advocates, Bar associations, law faculties and the judiciary.

HIV/AIDS is not over. There is still no vaccine or cure. The global financial crisis imposes a substantial burden on even middle income countries. Promised subventions to the Global Fund have not always been delivered. Still about 2.7 million people are infected worldwide by HIV. In addition to infection by the virus, there is another infection abroad: the infection of ineffective and counterproductive laws. Law, for once, can be an ally to medical science and epidemiology. However, it requires informed decision-makers in the legal profession, the judiciary and in government.

This workshop in Athens has been an endeavour to raise awareness. I know that it has the strong support of UNAIDS and its Executive Director, Michel Sidibé. Like many, he was concerned by the events in April/May 2012 affecting sex workers in Greece. But although this has been the principal focus of discussion and attention, the problems in Greece lie deeper. Amidst the many other challenging issues facing the Greek community at this time, the challenges of HIV should not be ignored. Unless tackled effectively and resolutely, the problems do not go away. They remain in our midst to spread misery and loss. Greece needs to awaken to HIV. It is never too late.