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WILTON PARK CONFERENCE

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THE HIV AND HCV EPIDEMICS -

LESSONS FOR POLICY MAKERS & CONCLUSIONS ON ACTION

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CONTEXT

Participants from many parts of the world, with different expertise and engagements with the Human Immunodeficiency Virus (HIV) and the Hepatitis C Virus (HCV) gathered at the Wilton Park facility of the United Kingdom Foreign and Commonwealth Office (FCO) on 26-28 February 2018 to consider ways of slowing the epidemics amongst people who inject drugs (PWIDs).

[*] Based on the remarks of the author at the dinner and in the concluding session of the Wilton Park Conference on Slowing the HIV and HCV Epidemics amongst People Who Inject Drugs (WP 1578), Wilton Park, England, 26 February 2018.

[**] Co-chair of the Human Rights Institute of the International Bar Association (2018); Member of the UN SG's High Level Panel on Access to Essential Medicines (UNDP, 2016); Member of the UNAIDS/Lancet Commission on Defeating AIDS and Advancing Global Health, 2015; Commissioner of the UNDP Global Commission on HIV and the Law (2011-12); Patron of the Kirby Institute for Infection and Immunity in Society (2011 -); Patron of the Burnet Institute (2010 -); Justice of the High Court of Australia (1996-2009); Commissioner of the WHO Global Commission on AIDS (1989-94).

The available, data showed that PWID were at a much higher risk of acquiring HIV and/or HCV than the general population. Starting with an estimated 15.6 million PWID globally, it was generally believed that approximately 1 in 6 (17.8%) of them are living with HIV. More than half of that cohort are co-infected with HCV. Globally, PWID constitute 23% of new HCV infections and 31% of HCV-related deaths. The epicentres of the co-infections are Eastern Europe and Latin America.

In 2011 UNAIDS announced a target to cut new HIV infections amongst PWID by half before 2016. However, such infections actually increased by 33% by 2014. The UN Sustainable Development Goals (SDGs) agreed in 2015 committed the Organisation to strengthen the prevention and treatment of “substance abuse”, including narcotic “drug abuse”. In many countries of the world, PWID face not only serious health challenges but also the application of criminal laws and their procedures, with consequent extra burdens of incarceration, isolation, unemployment and homelessness. One obvious question presented to the conference was whether, in tackling HCV, lessons could be learned from the earlier experience of the international community in tackling HIV.

TEN LESSONS

LESSON ONE: EPIDEMICS AND HUMAN RIGHTS

Dating back to Biblical times, epidemics have usually been tackled by the application of harsh measures designed to isolate those actually or potentially infected from the general population, through quarantine and by the application of the criminal law. However, by the time HIV appeared in significant numbers in the 1990s, the global manifestations made it impossible to resort to that strategy. It was in that context that the United Nations discovered two exceptional leaders, Halfdan Mahler (Denmark), the Director-General of the World Health Organisation (WHO) and Jonathan Mann (USA), whom Mahler appointed as the first Director of the WHO Global Programme on AIDS (GPA). It was Mann who propounded the close link between a successful strategy on HIV and strict observance of the human rights of those infected or at the primary risk of infection.

I was appointed by Dr Mann in 1989 to be a member of the inaugural WHO Global Commission on AIDS. This followed Mann's visit to Australia where he explained his insights that had brought this initiative about.

According to Mann, a regional meeting of WHO personnel had been convened in Brazzaville. An epidemiologist from the United States, Mann had observed emaciated patients coming out of the jungle in Zaire (as Congo was then named) to seek treatment for an apparently new and puzzling condition. At the Brazzaville meeting, Mann confronted Dr Mahler with these experiences. It would have been easy for Mahler to have ignored the passionate American doctor. However, he did not. Immediately upon his return to Geneva, Mahler summoned Mann to WHO headquarters and placed him in charge of the new health crisis.

With few staff or resources and even fewer effective medications or strategies, Mann was forced back onto basic principles. These took him, later with the support of the Global Commission on AIDS, to appreciating a new relationship between the prospect of slowing the growing epidemic by respecting the human rights of those affected and those at risk. When the cause of the epidemic, a virus HIV, had been identified by one of the members of the Global Commission (Dr Luc Montagnier) all attention was focused on preventing the passage of bodily fluids containing the virus amongst persons at risk. Public health and other laws were in this case to be invoked to protect the vulnerable; not to punish them or merely to frighten them.

In the early days of the AIDS crisis, I had observed Mahler and Mann at close quarters. That experience taught me the significance of leadership in tackling a new epidemic. But it also taught the importance of embracing new ideas and novel strategies. Supported by the Global Commission on AIDS and drawing on the experience of several members including Professor June Osborn (USA) a professor of public health, an immediate and novel strategy was mapped out. It insisted on designing responses to the epidemic that were based strictly in empirical data. Moreover, the responses accepted the "AIDS paradox". Paradoxically, the best way to tackle this epidemic was by engaging with those who were infected or at risk. This was an approach quite different from the traditional epidemiological strategy. Its novelty presented difficulties for those who adhered to conventional thinking. Yet in time it was vindicated.

LESSON TWO: WORKING WITH THE AFFECTED

The first meeting of the Global Commission on AIDS convened in 1989 in the meeting room of the Executive Board of WHO. Lars Olaf Kallings (Sweden) was in the chair. In addition to Montagnier and Osborn, the Commission included already famous names in the fields of science and public health

including Robert Gallo of the United States. But that was not all. Mann had constructed the membership of the Commission with an eye to addressing the global reach of AIDS. But also to reach the communities upon whom the epidemic had already fallen hardest. These included gay men who were complaining vociferously about the neglect of politicians and of pharmaceutical corporations.

At the table were Daniel Defert, the founder of a civil society organisation in France, established to speak up for the group who became known, in UN parlance, as men who have sex with men (MSM). Defert was the domestic partner and collaborator of Michel Foucault, the great French philosopher. Foucault had died in Paris in 1984 of neurological complications caused by HIV and AIDS. Defert founded the AIDES charity in memory of Foucault. He was strong and insistent as a voice for people living with HIV and AIDS (PLWHA).

Also present was Richard Rector. He was an American from civil society, then working in Denmark and openly living with HIV. Openness was rare in these days. He was strong and brave. Although he attended a number of meetings of the Commission, he did not survive. He died during my service on the Commission. His presence was symbolic of Mann's

insistence that, in this epidemic, it was essential to speak *with* those principally affected. Not only *at* or *about* them: *with* them. And to hear and act on their voices and insights, in the hope of capturing their sense of urgency.

This was another innovation of Mann. It continued and it expanded with the epidemic. If Mann were with us today he would insist that PWID must also secure their voices at the table of the HCV and HIV epidemics. Those voices were heard at Wilton Park. But they must be heard beyond conferences. Their perceptions are vital. In so far as criminal offences impede access to their voices, such offences need urgently to be reconsidered and modified.

LESSON THREE: INTERNATIONAL ORGANISATIONS

The third lesson of HIV from those early days lay in the importance of securing an effective international response. As with HCV, the challenge from the start of HIV was global. It was not confined to a single country or region. It was truly global. It expanded no doubt because of the ease of international travel and the commonalities and interface of the vulnerable groups most affected.

With HIV, the international institutions began with GPA and expanded to the Global Commission on AIDS. However, this expansion was soon redoubled when effective pharmaceuticals appeared in the 1990s that promised significant and speedy improvement in mortality and in the medical conditions of PLWHA.

Thus the United Nations, under S-G Kofi Annan, promoted the establishment of the Global Fund against AIDS, Tuberculosis and Malaria (GF). In the United States, President George W. Bush established the President's Emergency Fund (PEFAR). These two bodies contributed enormously and innovatively to the availability of funds for the impoverished and disadvantaged PLWHAs, most of whom lived in least developed countries. Without these sources of funds, there was no possibility that the pharmaceutical treatment, including the antiretroviral therapies (ART), would have been available to the 20 million PLWHAs who are now living in better health because of the speedy global response to the provision of essential healthcare which had become available.

Other global bodies were then created to advance the identification of the impediments to treatment and the needs of those infected. These bodies included the UNDP Global

Commission on HIV and the Law;[1] the UNAIDS/Lancet Commission on Access to Healthcare;[2] and the UN Secretary-General's High Level Panel on Access to Essential Health Technology,[3] on all of which I served.

So far, there is nothing like the global institutional responses in the case of the HCV epidemic. Whereas HIV was, in the beginning, equally disrespectable and regarded with fear and loathing by many, HCV has involved a different global journey. This has included the early development of a pharmaceutical treatment which, if adhered to, can secure a 95% rate of curing the infection among patients living with HCV. To this time, no similar cure has been found for HIV.

An informal, international non-institutional arrangement arose by cooperation between the owner of the intellectual property in the curative agent *Sobosbuvir*, Gilead (which also supported the convening of the Wilton Park conference) and individual suppliers. Still the development of global institutions has been more difficult in the case of HCV because of the sub-national, national and international laws imposing sanctions on the possession and use of defined drugs relevant to the modes of transmission of HCV.

[1] UNDP, Global Commission on HIV and the Law, *Risks, Rights & Health* (July 2012, New York).
[2] Report published *The Lancet* (June 2015) "Comment, AIDS and Global Health, the Path to Sustainable Development and *The Lancet* Commissions: Defeating AIDS – Advancing Global Health (Piot and ors).
[3] Report of the United Nations Secretary-General's High Level Panel on Access to Medicines – *Promoting Innovation and Access to Health Technologies* (September 2016, New York).

Nevertheless, the particular challenges presented by HCV has been picked up in more recent reports from UN global commissions, and by the GF and national health schemes, as well as by the Global Commission on Drugs. This is an international body formed by civil society. It has played an important role in promoting policies aimed to facilitate the removal of criminal sanctions for individual possession and use of presently illegal drugs.

LESSON FOUR: ENGAGING WITH OPPONENTS

A fourth lesson from the HIV response is to be learnt from the way in which Mann, from the start, invited to the table, and encouraged the participation of, participants who were hostile to the removal of impugned criminal sanctions.

By the last meeting of the Global Commission on AIDS that I attended in June 1991 (the fourth), Jonathan Mann had resigned from GPA because of disputes he had with the new Director-General of WHO, Dr Hiroshi Nakajima. Indeed, his resignation had occurred in the very midst of the third meeting of the Global Commission. Mann was promptly replaced by Dr Mike Merson, another public health expert from the United

States. Lars Kallings also resigned, upon taking up an appointment as a consultant to WHO. Missing as well were regional directors of WHO who had previously attended meetings of the Global Commission in Geneva. Also absent was the brilliant cabinet of officials and experts that Mann had gathered around him (including Drs. Daniel Tarantola and Manuel Carballo). The scientists Luc Montagnier and Robert Gallo remained at the table. To their number had been added Howard Temin, who in 1975 had shared the Nobel Prize in Physiology and Medicine with David Baltimore, a friend of Mann.

Mann had taken pains to include contrarian voices. These included Dr al Adawi, the Health Minister of Kuwait. He expressed reservations concerning the outreach of GPA to gay groups and others vulnerable to HIV because of their sexual activities. Specifically, he mentioned his son, studying in the United States, who had reassured him that young people were not concerned about AIDS because it basically only attacked gays.

When many members of the Global Commission cautioned against this approach of exclusion and diminution, Dr al Adwai admitted to the “bad impression” he had felt when he saw gay

demonstrators at a ministerial meeting on health in London.[4] He protested that he would not discriminate against them. But the impression he conveyed had narrowed the importance of AIDS and HIV. Somewhat similar views to those of Dr al Adwadi were expressed, although in quieter tones, by Dr Peter Sumbung, a public health expert from Indonesia. The advantage of having such people at the table was that it allowed other participants to share their inclusive attitudes with them, essential to the successful strategy against HIV being urged by GPA. It also brought elements of reality and a corrective to those who spent their lives in surroundings sympathetic to (or even as members of) the vulnerable communities at special risk of infection by HIV.

Similar strategies to those urged by Mann were later followed by Dr Peter Piot, the founding Executive Director of UNAIDS and by his successor, Michel Sidibé. They each insisted on engagement with religious leaders of differing faiths. By exposing these persons to HIV experts, they hoped to open their minds and sometimes their hearts and understanding. But by exposing the experts to their way of thinking, the dimension of the challenge of HIV was brought home with even greater power. So it must be with the HCV epidemic.

[4] M.D. Kirby, "GPA: Under New Management – A Personal Report on the Fourth Meeting of the Global Commission on AIDS" (June 1991, unpublished), available online.

LESSON FIVE: ENGAGING DONOR COUNTRIES

A fifth lesson from the struggle against HIV concerned the importance of securing and maintaining financial subventions for the ART pharmaceuticals, once they came on the market for the treatment of HIV, and especially after generic copies were produced, radically reducing their costs.

The impact of generic competition to render ART generally affordable was demonstrated in the report of the Global Commission of HIV and the Law published in 2012. When the generics became available in large numbers by June 2000, the first line antiretroviral cost of ART on the open market was $USD10,439 per patient per year. Shortly thereafter Brazil's pharmaceutical laboratories were selling generic copies at a price of $USD2,767. In response to this plunge in the cost of the copied drugs, the lowest brand product price fell to $USD727 by September 2001. This pattern continued thereafter so that by June 2010, the branded product sold for $USD337 for a year's supply. However, Cipla Pharmaceuticals in India were by then producing the generic copy for $USD67.[5]

With these developments an incentive and expectation followed that donor countries could provide funds for the purchase of

[5] UNDP, above n.1, 77 ("Generic Competition: Making ARVs Affordable". Attributed to MSF, untangling the web of antiretroviral price reductions, 14th ed., 2011).

ART in sufficient quantity to serve the needs of millions of PLWHAs. Thus began the remarkable program of international co-operation by which wealthier countries committed to subventions, including to the Global Fund, so as to provide lifesaving medications to millions of infected individuals. This was an act of global solidarity and generosity that made a previously unthinkable provision of medication a reality. It would not have happened without a humane response from the global community. But it would not have been possible at all without scientific innovation and the stimulus and competition of generic pharmaceuticals made available to the needy in the lowest and middle income countries where HIV was widespread and PWHAs already comprised millions of the population.

Because of international and national economic developments, the past levels of commitment by advanced economies to the GF and bilateral support of HIV programs have recently declined. In 2017 President Trump proposed the reduction of the United States subvention; but fortunately this was not accepted by Congress.[6] Nevertheless, in circumstances of increasingly populist politics, the previous levels of foreign aid devoted to the HIV epidemic may now be endangered Australia, whilst maintaining support for the GF and

[6] See Johnson, "Trump wants Drastic Cuts to Global AIDS Fight", *Washington Blade*, February 16, 2018 (v.49 iss 7), 1

international health programs for its neighbours, has significantly curtailed overseas aid. Much of the US and UK media is relentlessly hostile to such aid.

Every effort needs to be devoted to rebuilding past levels of support and indeed to increase such support if the costs of HCV therapy (and the huge numbers potentially involved) are to be addressed successfully. This presents a challenge that requires international leadership. The retirements of Ban Ki-moon (ex UNSG) and Helen Clark (ex-Administrator UNDP) show how fragile is the assurance of support of energetic global champions for causes associated with global healthcare for adults, especially those in vulnerable groups that lack broad popular empathy.

LESSON SIX: ADDRESSING OVERREACH OF CRIMINAL LAW

There is a common theme in many of the impediments that delays support for vulnerable groups. This is certainly relevant both to the HIV and HCV epidemics. This is the relevant overreach of the criminal law in most nations and the lack of an intellectual framework to support a global effort to wind back this overreach.

Until recently, scholars and officials involved in universal human rights law and policy have largely refrained from attempting to conceptualise the principles that should govern the imposition of criminal (as distinct from civil or regulatory) sanctions upon stigmatised human conduct. It is the want of a uniform approach to identifying activities that are properly criminal in nature, and those that are not, that has led to the proliferation of many criminal sanctions. Often the imposition of such sanctions can only be explained by reference to understandings of religious norms or considerations of legal history and traditions or simple habit or majoritarian distaste. The advent of universal human rights law has led to some analysis of municipal criminal law, when measured against international human rights norms. However, the underlying question of the lessons of such norms for the outer boundaries of domestic criminal law has not been substantially tackled. At least, until now. This is surprising; but it is perhaps explained by the sharp controversies over the content of criminal law and the log-jams that have arisen in relation to charting the outer boundaries proper to that classification.

In February 2017, a number of United Nations agencies and civil society organisations convened a conference in Bellagio, Italy, to begin the task of expressing the fundamental principles that should govern the inclusion of forms of social control in

national criminal law. The event took place at the Rockefeller Center at Bellagio. The principal organisers were the Office of the United Nations High Commissioner for Human Rights (OHCHR), UNAIDS and UNDP. The difficulties of reconciling the approaches taken over many centuries by different legal systems (including those loosely collected as either civil law or common law countries) presented distinctive problems for analysis. The areas of the law of chief concern included those identified in the earlier UNDP Global Commission on HIV and the Law.[7] These were:

(1) Laws on illegal drugs;
(2) Laws on sex work and prostitution;
(3) Laws on proscribed adult consensual private sexual conduct, specifically sodomy, buggery, incest, bestiality;
(4) Laws affecting transgender persons;
(5) Laws affecting prisoners, migrants and refugee applicants;
(6) Laws on pornography and erotic media; and
(7) Laws on sexual education and instruction.

Save for particular domestic constitutional limitations, some legal traditions impose restrictions on the ambit of criminal law by reference to notions such as “proportionality” and suitability

[7] UNDP Global Commission above n.1.

to the operation of state control, with its oppressive potential. However, the recent widespread expansion of criminal laws devised to address counter terrorism and security issues, has included many that target particular beliefs or convictions and also self-regarding conduct.

A follow-up meeting to address the issues opened at the Bellagio meeting has been organised by the International Commission of Jurists, UNAIDS and OHCHR for 3-4 May 2018. The specific focus of this meeting is to examine provisions in criminal law that have provable negative consequences for public health outcomes. The guiding star for these investigations derives from the principles of universal human rights. In the case of HIV, several of the key populations, susceptible to criminalisation, are affected. In the case of the HCV epidemic, the principal category affected is that of people who inject drugs (PWID). Hitherto, criminal laws have been enacted unimpeded, affecting these populations (sometimes influenced by international treaty law).

If broad agreed principles, anchored in the international law of human rights, could be identified (especially if ultimately supported by resolutions or other action of the UN Human Rights Council) this could provide an important tool by which to tackle the global overuse of criminal law, with its adverse health

consequences. Otherwise, critics of reform will resort to the contention that the objections are purely personal, or self-interested and do not comply with local, social, cultural or religious norms. This is especially so where those norms can find validation and support in international treaty law in matters of drug control.[8]

LESSON SEVEN: ENGAGING WITH ADVOCATES

Ever since the beginning of the HIV epidemic, the UN has engaged with celebrities and other advocates to create high level awareness of HIV and of the need for self-protection and the protection of others. The noted film actress, Elizabeth Taylor, was an early and generous media voice. At the beginning of the HIV epidemic she and others lent not only their images and involvement but also their talent in conveying messages to overcome hostility and fear.

Subsequently, other stars (including from LGBT circles like Sir Elton John and Ricky Martin) not only lent their images but established charitable foundations to provide financial support for HIV causes. The Gates Foundation, founded by husband and wife partners Bill and Melinda Gates, took a major decision

[8] Richard Lines, *Drug Control and Human Rights in International Law*, Cambridge Uni Press, Cambridge, 2017. The book traces the development of international treaty law from the *International Opium Convention* 1912, through the *Covenant* of the League of Nations to the *Single Convention on Narcotic Drugs* 1961, 520 UNTS 151; the *Convention on Psychotropic Substances*, 1971 (1019 UNTS 14956) and the *UN Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988 (1582 UNTS 95).

to provide huge funds to HIV charities. The Clinton Foundation did likewise. In Australia, Ita Buttrose, a major media professional lent support to the Bobby Goldsmith Foundation. Business leaders, including Alan Joyce, CEO of Qantas Airlines, has been forthright in voicing his support for political, business and public health outcomes. These leaders have contributed to overcoming the stigma previously associated with minority sexual orientation and gender identity.

In the case of some public advocates, who have been open about their HIV+ status, this has helped to spread essential healthcare messages. However, the emergence of such leaders in Western countries may be contrasted with the situation in the Caribbean, Africa and most parts of Asia (India is an exception). In the African continent, Justice Edwin Cameron of the Constitutional Court of South Africa, is still the only prominent gay man who is also living openly with HIV.

There is a dearth of equivalent figures supporting the struggle for HCV acceptance, support and treatment. Finding celebrities and well-known advocates for HCV is difficult. At the Wilton Park conference it was pointed out that the putting a face to an epidemic is more difficult in the case of PWID because of the threat of potential criminal liability. That potential was also present earlier in the case of HIV. However, it was widely

removed by the repeal of laws against gay sex in many countries. To some extent it explained the insistence, by some countries that retained the relevant criminal laws, that these laws are not enforced, at least not vigorously. But this is not so in relation to universal laws on drug possession and use.

Whilst the difficulty of securing celebrity supporters is in the case of HCV must be acknowledged, it is vital that personalities should be found to allow citizens to put a face and a name to the disease of Hepatitis C. It is much harder to hate infected persons who are known or recognised for their humanity than those who are just a part of a mega statistic and entirely anonymous. The challenge of getting HCV onto the public consciousness is a large one. It needs to be tackled if progress is to be made for the millions living with HCV. The earlier experience with HIV should point the way.

LESSON EIGHT: RECOGNISING SIGNIFICANT GAME-CHANGER

At the first meeting of the Global Commission on AIDS in 1989, the members asked Luc Montagnier and Robert Gallo for their predictions about the time that would be required for the development of a cure and a vaccine for HIV. Montagnier said that the differential progression of HIV in different patients and

in babies born to infected mothers offered an insight into discovering a cure. Why did some neonates throw off the virus whereas most became themselves infected? He suggested that understanding this phenomenon would speed the discovery of a cure.

Robert Gallo put dates on his answer. He said that developing and commodifying a cure would take up to 20 years. A vaccine might take longer. Yet here we are 30 years later, and there is no cure and no safe vaccine for HIV. HIV mutates so as to elude human scientific ingenuity. Fortunately, by the combination of therapies, a point was reached in the mid-1990s to provide extremely effective treatment, so long as the treatmemt is regularly updated to incorporate more recent lines of therapy. Whilst an HIV vaccine has not yet been developed which is safe and effective, the advent of PREP treatment has afforded powerful new protection to vulnerable groups from becoming infected with HIV. PREP treatment is now increasingly available. Some countries, such as Australia, have added it to the pubic Pharmaceutical Benefits Scheme so that it can be purchased at low, affordable prices. To a large extent PREP, in Western countries, is replacing the earlier insistence on condoms and similar barriers to prevent entry of the virus into a new host.

In the case of HCV, repeated medical investigations have shown the effectiveness of the now available therapy not only to palliate the effect of the HCV virus but to cure the patient who has been exposed to that virus. Repeated trials have shown that persons who undertake the antiviral treatment for HIV will, in approximately 95% of cases, if the therapy is faithfully administered over a 12 week plus period, emerge free of the virus.

This is a remarkable scientific development. The original inventors sold their intellectual property to Gilead Sciences Inc. for a reported price of $USD14 billion. This sum was recouped quickly. The initial market price for the branded therapy differed greatly from country to country. In high income countries such as the USA, the original market price was of the order of $USD84,000. In a middle income country, such as Egypt, where there is a large HCV epidemic, the therapy was made available by Gilead for a reported original price of $USD900 per course of treatment. Other countries, such as Australia, with effective national health systems, have been able to negotiate a cost per dosage that varies according to the number of patients treated. The span of differential costs began as extremely wide, as it was originally in the case of ART for treatment of HIV. However, with the cooperation or toleration of generic

competitors, it did not take long for the prices of HCV therapy to come down, including in higher income countries.

In many cases of poorer developing countries, this has happened with the acquiescence of the patent holder, Gilead. In other countries (such as Malaysia) it has occurred by the insistence of the country concerned of its legal, moral or political obligations to provide therapy at costs affordable by ordinary citizens. Reportedly, the proposed cost of the 12 week therapy in Malaysia dropped initially from an original price of $USD40,000 to $USD12,000. On the notification of Malaysia of its intention to initiate a compulsory licence for the therapy, the cost came down still further to $USD300. Reportedly, it has now become available without challenge by the patent owner.

The existence, so quickly and unexpectedly, of a curative agent in the case of HCV has proved a game changer for that disease. If there were no cure, demands for heavy costs for experimental drugs will often be quietly borne. However, when a cure is established by a therapy of speedy duration in a disease which is commonly slow, insidious and life threatening, demands for widespread affordable medicines will inevitably become more insistent. Refusal will be viewed as intolerable in a civilised legal order that respects the human rights of those faced with high risks of unnecessary death.

Whilst it is pointed out that, in practice, access to affordable HCV therapy is commonly available in many countries, and whilst proper appreciation must be expressed for the cooperation of the patent holder, there are basic problems in the presently emerging situation. These problems include the dependence for the access to lifesaving drugs and fulfilment of human rights entitlements dependent upon market forces and philanthropy on the part of a major pharmaceutical corporation. If access to essential healthcare, promising life to millions of human beings, is a basic human right, it cannot, consistently with international law, be limited by such chance variables.

Nor is the division of the world into “highly developed”, “middle income” and “least developed” countries an acceptable one. No such division is expressed in any of the international human rights treaties or other human rights law. The suggested division superimposes upon rights that belong to *individuals*, operative categories that are not only missing from international human rights law but actually cut across the operation of such law. These categories also potentially impede the attainment of the SDGs adopted in September 2015 by the UN General Assembly. If it is to be a goal of the international community that all persons will have access to essential health technologies by 2030, such an entitlement cannot be

undermined or qualified by insistence on categories that refer to the economic conditions of residence in, or the nationality of, individuals as distinct from the basic human rights of such individuals.

This issue was discussed in the UN SG's High Level on Access to Essential Medicines.[9] Basically, it is, self-evident. The subdivision of the world into three classes of countries is reminiscent of the Pope's Line, by which a mediaeval Roman pontiff divided the globe between the areas of influence respectively of Spain and Portugal. That line left a colonial legacy for centuries, right into the present age. However, such a division cannot be reimposed in the contemporary world merely by economic power. It should not be superimposed upon the enjoyment of universal and fundamental human rights of individuals. Certainly, that should not happen without the clearest possible authority expressed in human rights treaty law. Such exceptional authority does not exist, either in relation to the HIV epidemic or the HCV epidemic.

LESSON NINE: ESSENTIAL ENGAGEMENT WITH POLICE

A common difficulty faced by policy makers responding to the HIV and HCV epidemics has been the hostility, in the past, of

[9] High Level Panel report, above n.3.

police and other public control officials. That hostility has produced a culture of secrecy and of hiding relevant conduct. More particularly, it has tended to put persons affected out of contact from healthcare, health checks, access to medicines and early engagement with available treatment.

These considerations explain the great emphasis in many countries upon the removal, or modification, of domestic criminal laws affecting individuals living with HIV, and more recently with HCV.

In the case of HIV, at least in most Western countries, the problem has tended to initiate the steps that have led to reform of the criminal laws applicable to person in sexual minorities (LGBT) and; sex workers. It has also, to some degree, instituted changes protective of PWUD and PWID. Thus, in respect of drug use, the protective approach has sometimes encouraged sterile needle exchange; the establishment of safe injecting facilities; the occasional provision of bleach in prisons for sterilising illicit needles; and the removal of criminal sanctions in the case of the possession and use of small quantities of some drugs (notably cannabis). None of the foregoing law reforms was easy to secure. Many were fiercely contested by police authorities, dedicated to the ‘war against drugs’.

However, the ultimate acceptance of syringe exchange has led, in the countries that pioneered it (New Zealand, Australia and the United Kingdom), to a radical decrease infections amongst PWID as against infections in such persons in other countries. The mean level of HIV infections in PWID in New Zealand is 1%; in Australia 2%; in the UK 2% and in Canada (where the facility of syringe exchange is not universally available) 17%, and in USA 30%. In the Russian Federation, where all of the above initiatives are strongly resisted by the federal government, the level of HIV infection amongst PWID is higher than 50%.

Police and other officials live in the societies in which they operate. Under present laws, they have close and frequent contact with PWID. Some of them become aware of the objective value, in saving lives and health, of syringe exchange and other harm prevention measures.

There is still much opposition in many police circles worldwide to law reform on sex work, homosexuality and drug use. However, enormous strides have been made in the past three decades and progress is continuing.

Police and other like officials (in the US and other nations, fire and emergency services must also be added) have substantial interaction with PWID. They see close up the humanity and suffering of the persons involved and of their families; but also the degradation and life threatening dangers of overdose, of HIV and HCV infection and premature death. This reality is vividly illustrated in a special issue of *Time* magazine on the opioid crisis in the United States, whose publication coincided with the Wilton Park Conference.[10] Yet approximately the same time tabloid media in Australia welcomed the appointment of a "hardened detective" to take charge of "a new drug war" in Sydney's western suburbs and in nearby disadvantaged rural areas.[11] However, this initiative was also followed by sustained applause for uniformed Australian federal and state police (as well as defence and fire services personnel) marching in the Sydney Gay and Lesbian Mardi Gras, a few days later.[12]

There is much evidence that achieving real progress in law reform affecting PWID depends significantly on cooperation with well-informed police personnel.[13] Not all police will be

[10] *Time* magazine, w/e 5 March 2018.
[11] Emma Partridge, "Wild West's High Noon – Bush gets a new sheriff to smash ice scourge", *Daily Telegraph* (Sydney), 12 February 2018, 1.
[12] Sydney's 40th Mardi Gras was held on 3 March 2018. It was preceded by official apologies in the New South Wales Parliament and by New South Wales Police: Joseph C. Chetcuti, *Sydney's First Mardi Gras – What Brought It On and How It Changed Us* (Melbourne, 2018) at 216-219.
[13] See M. Hellard et al, "Eradication of Hepatitis C Infection: the Importance of Targeting People Who Inject Drugs", *Hepatogy*, February 2014, 366; J.S. Doyle et al, "Global Policy and Access to New Hepatitis C

sympathetic and cooperative. However, when they are or become so, they may evolve to be informed, experienced and powerful advocates for change. Importantly, they are commonly on the front line of the failures and inadequacies of current punitive approaches to the possession and use of illegal drugs.

Police cooperation should be a high priority in the roll out of therapy for PLWHAs. Even more so it is essential to effective engagement with PWID with HCV. The symptoms of HCV are often less noticeable to the affected individual than the symptoms of HIV. Great difficulties have been experienced in attracting patients at risk of HCV to undertake tests for the presence of HCV and securing and maintaining early access to the lifesaving therapy. Substituting a strategy of public health for the exclusive reliance on criminal sanctions is therefore much more likely to succeed with police support once an affordable therapeutic cure becomes available. This is why the Executive Director of UNAIDS (Michel Sidibé) has strongly urged engagement with police, just as earlier he insisted on engagement with religious and "faith" communities to

Therapies for People Who Inject Drugs" (2015) 26 *Int J Drug Policy* 1067; N. Crofts and D. Patterson, "Police Must Join the Fast Track to End AIDS by 2030" (2016) 19(suppl.3) *Int J AIDS Soc* 21153.

encourage them to reconsider their opposition to law reform relevant to HIV and HCV.[14]

LESSON TEN: COURAGE FOR RATIONALITY

The final lesson to be derived for HCV from the HIV experience is the importance of the individual embrace of the lesson Jonathan Mann taught concerning the inextricable connection between global public health and human rights.

The purpose of many of the earlier criminal laws, targeting possession and use of drugs relevant to the HIV and HCV epidemics was essentially to promote fear and stigma. If such emotions could be imprinted on the community's psyche, it was hoped that sex outside monogamous marital relationships would be stamped out and that all illegal drug use would be avoided. The criminalisation of specified sexual and illegal drug using conduct was designed to instil not only fear but self-loathing and a shamed silence on the part of those who questioned or did not observe the law. In that silence serious epidemics were incubated, including the epidemics of the epidemics of HIV and HCV.

[14] (2018) *J Int AIDS Soc*, (Special issue on police, law enforcement and HIV) Foreword (2018). See also D. Wolfe and ors, "Human Rights and Access to Hepatitis C Treatment for People Who Inject Drugs" (2015) *Int J Drug Policy*, 1572.

I know these truths because, in Australia in the 1960s and 70s, although a gay man, I kept my sexual identity a secret in order to avoid the shame to myself and my family of exposure at that time. Eventually, when in 1969 I met my partner, Johan van Vloten, I came to see that the shame and stigma were irrational and unnatural. However, I still kept basically silent. I observed a substantially drug free life. When HIV came along, my partner and I participated in different ways in responding to the epidemic. We lost many friends to HIV and AIDS. Their suffering enlivened our voices and our action. So it was with many. So it must now be with HCV.

Education and the correction of false stereotypes about human subjects caught up in ineffective reliance on criminal sanctions is just as essential in the case of HCV as it was earlier with HIV. Indeed more so because of the undoubted fact that some illegal drugs are objectively dangerous to human health. Regulation of their availability is necessary, even where reliance on criminal punishment for personal use and possession is abolished or modified.

In the United States, as a result of the epidemic of opioid addiction and overdose deaths, the realisation of the dimension of the problem has begun to produce new approaches. President Trump has acknowledged the national concern for

the protection of the wellbeing of the citizens who have become involved in the latest epidemic. He has promised funding. Law enforcement by criminal sanctions is not effective, as the enormous expansion of the prison population of the United States and the continuance of drug use demonstrates. Something new and better needs to be tried. To be extent that it is required, the impediment to action, presented by the International Conventions on narcotic drugs will need to be reformed. Knowledge of the recommendations of the Global Commission on Drugs needs to be spread beyond those who are already converted. New allies must be found. The strategies earlier adopted towards HIV suggest some for the strategies that are needed to tackle HCV.

Change in the law and change in expert opinion will not alone be enough to tackle effectively the residual cases of HIV. Even today, with 20 million persons in receipt of affordable ART treatment against HIV, there remain at least 15 million persons who are infected with HIV but who have, as yet, no effective access to ART. The access to HCV therapy, although life-saving, is still low. In the path of expansion in access stand the obstacles of law enforcement, stigma, shame, hostility and fear. These obstacles are now much more serious in most places than the obstacle of the cost of therapy.

Those who do not learn the lesson of history are condemned to repeat their mistakes. It must be hoped that the lessons that the international community has learned from its engagement with HIV will come to the rescue of the lives of millions of human beings infected with HCV and presently too unaware or too afraid to seek testing of their condition and too frightened or too poor to seek therapy that can save their lives.

It is to learn the lessons of history that the Wilton Park conference was convened. Those who participated will return to their ordinary lives with a heightened sense of urgency and a realisation of individual obligations to inform a distracted world about the ten lessons suggested for HCV by the earlier encounter with HIV.

ACTION

As the debates about the issues of the Wilton Park Conference came to an end, many of the foregoing lessons appeared to have been taken to heart. Upon the large number of legal and policy questions there appeared to be a broad consensus amongst the participants. On other matters there was less clarity and more room for disagreement, especially concerning some of the practical ways forward in this sensitive and difficult area.

CONSENSUS AREAS OF REFORM

Amongst the issues on which high levels of consensus appeared to exist were:

* The adoption of immediately available initiatives such as procedures to simplify the diagnosis of HCV and to ensure that those in prisons, who had been exposed to HCV (and also HIV) should be given the best available healthcare, as a primary responsibility of the state;

* The need in future dialogues on the topic to consider the inclusion of experience additional to that gathered at Wilton Park on this occasion. Amongst the categories mentioned were participation of persons with expertise in HCV in South America, the Caribbean and the Pacific; participation of politicians with experience in gaining law reform; the active participation of police and of other officials, of judges; the involvement of parents, partners and families of those infected with HCV; engagement with media; and participation of religious leaders;

* The urgent necessity to increase the numbers of persons receiving treatment for HCV includes the urgency of

retaining and following up engagement, immediately contact has first been made;

* The urgent necessity of medical and social education for people working in relevant areas of healthcare, some of whom reflect attitudes of stigma and hostility to PWID common to the general community;

* The need to expand and promote the financial and epidemiological cases for change in the current legal matrix affecting PWID as well as to spread awareness about the relevance of the SDGs proclaimed by the United Nations in 2015;

* The urgent need to study success stories involving radical and less radical legal reforms that have been achieved in drug law and policy in recent decades Portugal, Czechia, Norway, Switzerland, Georgia etc and the needle exchange, safe injecting facilities and methadone programs adopted in Australia and New Zealand;

* There is also a need to study the precise causes of the difficulties of securing reform: the often hostile role of the state, of politics and elements in the media; the need to engage with political, professional and other sources of power in society to offer rational persuasion; and the need

to recognise the differences between drugs, some of which are relatively benign and others undoubtedly dangerous and clearly requiring close regulation.

DECRIMINALISATION & BOLDNESS

More problematic during the Wilton Park conference were the discussions about the exact areas and potentialities of reform specific to HCV, including in respect of decriminalisation:

* Some experts urged concentration on local changes that would be easier to secure if much more limited in impact on the HCV epidemic;

* Others insisted on the need for international leadership and speedy global change, given the transcontinental dimension of the HCV challenge and the potential presented to practical lifesaving by new treatment now widely available to be rolled out to millions. The lesson of HIV suggested to some the urgency of global approaches. But whether these would be feasible in the context of the HCV epidemic and in relation to presently illegal drugs law reform was contested by others as overly optimistic;

* Voices were raised to propose that significant global change would not be secured until the present UN

Conventions on drugs were amended, modified or abandoned. On the other hand, the difficulty of getting the slow-moving UN machinery to embrace such changes in the face of frequent, widespread hostility from many sources, was widely acknowledged;

* Even those who recognised the impediments to reform of the UN treaty law on narcotic drugs insisted that such treaties still reserve much scope for national reforms that should be pressed on urgently by nations using the latitude reserved to them in the Conventions; and

* Additionally, if scientific knowledge and rational consideration suggest the need to reform the international Conventions on drugs, expert meetings should, so it was urged, say as much. Experts should not hold back or engage in self-censorship. Bold necessary reforms would require bold proposals for decriminalisation. If boldness had been missing from the early United Nations initiatives on HIV/AIDS, millions of PWLHAs who are now living on ART treatment would already have died. The same is clearly true for HCV. Boldness should be the watchword for action by the international community. But where is the leadership for such humanitarian boldness?

The participants departed Wilton Park with expressions of appreciation to the host institution and to the organisers. Despite differences, it is clear that many lessons for HCV may be learned from the way that humanity responded to the HIV epidemic. The two epidemics are not identical. However, there are common features and lessons. Indeed, the development of an affordable and effective cure for HCV makes the urgency of a humanitarian global response to the HCV epidemic even more urgent. It demands that the remaining impediments be overcome and that time should not be lost. Each participant left Wilton Park with the troubling challenge expressed by Gandhi to accompany them on their journey home: What can I personally do to be the change I wish to see in the world?[15]

[15] M.D. Kirby, *What Would Gandhi Do?* "Penguin Books, London, 2013.