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AUSTRALASIAN ASSOCIATION OF BIOETHICS AND HEALTH LAW

QUEENSLAND UNIVERSITY OF TECHNOLOGY

BRISBANE

KIRBY ORATION 2023

20 NOVEMBER 2023

LET NO ONE BE LEFT BEHIND?

The Hon. Michael Kirby AC CMG

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The Hon. Michael Kirby AC CMG[**]

2023 AABHL AT QUT

It is a great honour for me to deliver this Oration, named in my honour, for the Australasian Association of Bioethics and Health Law (AABHL). Over a long career, I have enjoyed many honours including lending my name to persons, companion animals, Institutes, buildings, mooting competitions, lecture halls, professorial chairs, barristerial chambers, office rooms, mooting competitions, and university prizes. However, to name a serious public lecture after me is a special honour. Over the years, I have given lectures named after honoured friends. The Kirby Oration of AABHL is particularly treasures as it is concerned with issues of healthcare, bioethics and human rights.

Since my early days in the Australian Law Reform Commission (1975-83), I have been involved in the exploration of many subjects that fit within the broad domain served by AABHL and its members.[1] I recollect earlier orations given by me on associated topics, including for the Australian Bioethics Association (as it then was). In Brisbane in 1995, I was encouraged by my then recent appointment as a member of the Ethical, Legal and Social Issues Working Group of the International Council of the Human Genome Organisation. My lecture was on "Bioethics, the Human Genome Project and Our Future".[2] That was delivered at a time shortly before my appointment to the High Court of Australia, where I met many relevant issues and challenges.

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[*] Text for an oration delivered at Queensland University of Technology on 20 November 2023 ("Kirby Oration").
[**] Former Justice of the High Court of Australia (1996-2009); Commissioner of the UNDP Global Commission on HIV and the Law (2011-12); Ambassador (Patron) of APCOM, Bangkok (2017-2023).
[1] This started with the ALRC Report No. 7, *Human Tissue Transplants* 1977.
[2] Australian Bioethics Association, 4th National Conference, Brisbane, 25 September 1995.

I am particularly proud that I was invited to take part in the launch of the Australian Centre for Health Law Research at QUT. This has become a most distinguished centre of research and reflection in vexed topics of health law. Scholars, many of them from QUT, have participated in successive editions of *Health Law in Australia.*[3] They include Professor Ben White; Fiona McDonald; and Lindy Wilmott. They were the editors of the First Edition of that seminal book, published in 2010. I have contributed Forewords to successive editions of that outstanding work. The latest, 4th edition, will be published shortly. It is an outstanding analysis of law and policy that represents a leading text on these topics available in Australia. I commend the coming 4th Edition for all who work in this field. It recounts many of the changes that have come about in recent years. Responding to the COVID-19 pandemic; systemic failings in how Australia cares for older people; and for people with disabilities in residential care facilities; the gradual introduction throughout the nation of legislation on voluntary assisted dying; and the growing significance of developments in artificial intelligence, a topic of great importance for the future of healthcare, diagnosis, treatment and public policy.

A common theme in my talk in 1995, as in my successive introductory words for the new editions of *Health Law in Australia,* has been the growing importance of international law and international institutions for the shaping of Australasian developments in this field of discourse. That process had already begun when I delivered my 1995 lecture. I hope to demonstrate the way in which the predicted impact of international law, policy and institutions have enlarged in the intervening period.

We are fortunate in Australia to have the Centre based at QUT and the participation in an outstanding text, of experts from other distinguished universities and other institutions. Events of recent times have shown the global impact of new and unexpected pandemics as well as the legal and bioethical features of successive occasions involving the Ebola pandemics, the SARS epidemic; the COVID-19 pandemic; and, most recently, the Monkey Pox epidemic of 2022. In an age of pandemics, it is not possible to confine legal and policy reflections to purely municipal developments. The very nature of epidemics, and especially the broader-based pandemics of recent years, requires a

[3] Thomson Reuters (Sydney) 1st Ed, 2010, 4th Ed, 2023.

global outlook and transborder responses. These, in turn, take reflection from the wider context of international human rights law and its local applications.

UDHR @ 75 YEARS

In the coming year, staring on 10 December 2023, it will be impossible to escape consideration of the 75th anniversary of the *Universal Declaration of Human Rights* (UDHR). Knowing about this important development, helps to explain why global perspectives and principles have emerged to defend fundamental human rights in the context of healthcare as elsewhere.

According to the World Health Organisation and the United Nations Office of the High Commissioner for Human Rights: [4]

> *"A human rights-based approach to health specifically aims at realising the right to health and other health related human rights. Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights. Elimination of all forms of discrimination is at the core."*

This is only one (but an important example) of the impacts of the UDHR on the field of health law, bioethics and human rights.

The modern global human rights developments arose, in part, as a consequence of the terrible losses and suffering before, during and after the Second World War. As a consequence of those events, the international community resolved, in 1945, to establish a new global institution (the United Nations Organisation) and to include in its objectives the attainment of universal human rights. It was immediately perceived that, without respect for universal human rights, it was likely that the international community would continue to revert to war and violence. This was even more obviously

[4] World Health Organisation and UN Office of the High Commissioner for Human Rights, *A Human Rights-based Approach to Health*. https://www.ohchr.org/sites/default/files/hrba_healthfora.pdf. Cf R. Sifras and P. Gerber, (2023) 48(3) *AltLJ* at 161.

unacceptable in the era that followed the detonation of the nuclear weapons over Hiroshima and Nagasaki in August 1945.

Initially, it was intended that the *Charter* of the United Nations would include an International Bill of Rights. However, as in the development of the United States Constitution, the drafters ran out of time to complete the preparation of that compilation. They therefore postponed the task to a later time. They established a committee to initiate the drafting and to seek consensus between the relevant international experts. To chair that committee, the General Assembly appointed Mrs Eleanor Roosevelt, widow of the late President of the United States of America, F.D. Roosevelt. Here challenge was to secure the consensus. It was an inspired choice.

The draft for the UDHR was completed in 1948, three years after the end of the War and the adoption of the UN *Charter*. At about this time, one of the first new agencies of the United Nations, the World Health Organisation (WHO), was created in Geneva on the site of the former League of Nations. It was evident to the members of the Roosevelt committee that health rights were amongst those that should be treated as important for all human beings.

Eventually, Article 25 of the UDHR declared:

> *25.1 Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond control*.

There were disagreements within the Roosevelt committee as to the inclusion of such "economic, social and cultural rights" in the UDHR. Western countries tended to think in terms only of "civil and political rights", as expressing the ambit of universal human rights. However, to secure consensus in the nascent UN institutions, the broader ambit was adopted. A right to health, in the language expressed in Article 25 of the UDHR, became part of the instrument. It has been elaborated since in many later documents,

most importantly in Article 12 of the *International Covenant on Economic Social and Cultural Rights* which says:

> "12.1 The States Parties to the present covenant recognised the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 12.2 The steps to be taken by the States Parties to the present covenant to achieve the realisation of this right shall include those necessary for:
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness."

I am a link between this 2023 conference of AABHL in Brisbane and the adoption of the UDHR 75 years ago. I had encounters in my early life with each of three great primary contributors to the task of drafting the UDHR:

* Eleanor Roosevelt in 1943 drove past my primary school in Sydney Australia on her way to open a new hospital built nearby with American aid for soldiers injured in the War in the Pacific. I remember that visit. I claim, that as her motorcade passed by, my eye locked with those of this great lady and humanitarian;

* Dr H. V. Evatt was the Australian third President of the General Assembly of the United Nations, meeting in December 1948 in Paris when the UDHR was adopted. Evatt had attended the same public school in Sydney as I had done. I encountered him there several times. He was a great champion of human rights; and

* Mr John Humphrey, a Canadian academic, took part the drafting of the UDHR for the Roosevelt committee. Later we would both serve together on the executive committee of the International Commission of Jurists in Geneva.

Between meetings, we would discuss the drafting and adoption of the UDHR. His had been the pen that wrote the initial drafts of provisions in the UDHR. Even great projects like the UDHR must begin with a first draft. It was John Humphrey who wrote the immortal words of the opening provisions of Article 1 of the UDHR:

> *All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood*.

Each of these three champions of universal human rights is still alive in my recollections which I now share. We are all the inheritors of their work and legacy. However imperfect (being the product of human endeavour) the UDHR is a great step forward, towards universal basic human rights and their achievement. Later in my career, I was to see the progeny of the UDHR emerging. Relevantly to these remarks, in the field of health law and related subjects, a major testing ground arrived with the advent of the HIV/AIDS pandemic, effectively from the early 1980s.

THE AIDS PANDEMIC

Decades in my life passed between the adoption of the UDHR and the advent of HIV/AIDS. However, in the early 1980s, the first reports began to emerge of a new and dangerous pandemic, apparently originating in Africa. By chance, in Congo, a talented epidemiologist, Dr Jonathan Mann, was alerted to a new and frightening condition coming out of the jungle. This was described by locals as the “slim disease”, because of the emaciation of the victims. On the occasion of a visit to Brazzaville in neighbouring French Congo, Dr Mann alerted the Director-General of WHO, Dr Halfdan Mahler, to this new, apparently contagious condition. Mahler, upon his return to Geneva, summoned Dr Mann to help set up the WHO response. He created the Global Program on AIDS (GPA). He also established a WHO Global Commission on AIDS (as the disease had by then been renamed). He appointed me to be a member of that commission. It included brilliant scientists and ethicists. One of them was Dr Luc Montagnier, a French expert who had first isolated the virus causing AIDS (HIV). He was later to receive the Nobel Prize for his discovery.

To that time, the formal response of nation states, and of the international community, to such a condition was to isolate those who were infected. Quarantine was the standard legal initiative. However, so fast was the spread of HIV that it became clear that isolation would not work in this case. The puzzle was to find an effective response in circumstances where there was no known medication to treat the condition; and no vaccine to prevent infection. It was in these circumstances that Dr Mann and the Global Commission, turned to a paradoxical solution. This was to reach out to defined groups who appeared to be amongst the main targets of HIV. These were men who have sex with men (MSM); injecting drug users (IJU); commercial sex workers (CSW); and prisoners and detainees. GPA and WHO recommended that health officials should reach out to these groups; to reduce legal stigma against them; and, by explaining the nature and risks of infection, to help to reduce the rapid escalation of the infected. This strategy had many opponents at the time. They urged that detention rather than engagement was the correct policy. However, many epidemiologists and politicians embraced the paradox.

Fortunately, in Australia two political leaders emerged at this time. One, in the Hawke Government, was Minister Neal Blewett (Minister for Health). His counter part in the Opposition was Professor Peter Baume. They embraced the AIDS paradox. They urged law reform to remove the legal penalties that stigmatised and isolated the main groups who were becoming infected. This was a very unusual exercise in bipartisan politics. It involved considerable courage on the part of Drs Blewett and Baume. However, it worked. The rate of infections in Australia and New Zealand fell rapidly although they continued to grow in many other countries. Specially effective were the campaigns to promote the use of condoms for all sexual activity; provision of freely acceptable sterile equipment for drug injection; and steps to reduce the criminalisation of sex workers. By the mid-1990s, although no medical cure or vaccine was developed, the paradox had brought relief for the burgeoning numbers of infected. It also stimulated the development of a combination of therapies which was found to be effective in reducing the levels of HIV and the capacity of those under treatment to infect others with the HIV virus.

Following these developments, further strategies were adopted by WHO. They included the creation of UNAIDS, a joint program of United Nations agencies to combine the

response to HIV within the UN. As treatment became more effective, demands were made in the international community for the provision of free or cheap therapies in least developed countries, otherwise unable to afford treatment of those most in need. It also led to the establishment of initiatives in developed countries (including the United States of America, Europe and Australasia) to help fund the worldwide cost of the antiretroviral drugs.

By the end of the 1990s, international cooperation had begun to make a mark on infection with HIV. Although by this stage (DSM-III R 1987), the previous position of WHO that homosexuality was a medical (mental) illness had been abandoned as erroneous, the outreach to LGBT groups for reasons of HIV containment led WHO and UN AIDS to affirmatively promote the removal of criminal laws against LGBT individuals. This was not popular in the countries in greatest need. But it had to be done in order to reduce the scale of HIV infections. It was in this indirect way that the UN WHO first became involved in the strategies to remove criminal laws against gay people. At the time, such laws existed in a majority of member states of the United Nations. Successive executive directors of UNAIDS took up the leadership in the endeavours to get rid of criminal laws against MSM. And also, to change criminal laws against injecting drug users and sex workers. Even prisoners and detainees were found to have basic rights to be protected against infection and to receive the best available medical treatment, open to distribution in the community.

International bodies beyond UNAIDS and WHO also became involved in the efforts to protect and treat people in the ‘vulnerable groups’. The result has been a significant drop in the number of countries which imposed criminal sanctions, particularly against gay men. The United Nations repeatedly drew attention to the moral unjustifiability of such laws. But for those who remained hostile, the initiatives were justified by reference to their effectiveness in bringing down the spread of the AIDS pandemic.

By reason of a number of relevant appointments in the Commonwealth of Nations, UNAIDS, United Nations Development Programme; and elsewhere, I found myself promoting both the moral case for reform of such criminal laws; but also the epidemiological case in circumstances (which still obtain) that no cure or vaccine was available to respond to AIDS in a purely medical way.

When COVID-19 (2019) and Monkey Pox (2022) emerged, just as the AIDS pandemic appeared to be gradually subsiding, lessons were learned from the way in which the international community had responded to the earlier pandemic. Specially vulnerable groups were engaged in the global response. Politicians explained often through daily briefings on public media, the importance of the principle derived from the response to HIV/AIDS: "Nothing about us without us". This is indeed a bioethical principle that those who are affected by serious medical conditions must be engaged in discussions of the public health and medical responses. When later pandemics came along, public health experts and health professionals reverted to the lessons that had been learned when responding to AIDS.

GLOBAL RESPONSE TO PANDEMICS

Intellectual property burdens: In 2011-12, I was invited to participate in a new global commission concerned with AIDS. This time it was created by United Nations Development Programme (UNDP) which works closely with WHO, UNAIDS and other UN bodies. In 2012, the UNDP Global Commission on HIV and the Law delivered its report, *Risks, Rights and Health*.[5] This report returned to many of the themes that had earlier been explored. It reverted to a consideration of the specially vulnerable groups and the ways to support them so as to afford to reduce infections.

Amongst the recommendations of this second global commission was one directed to the Secretary-General of the United Nations (at the time, Ban Ki-Moon (UNSG)). This urged that the UN should establish:

> "A neutral high-level body to review and assess proposals and recommend a new intellectual property regime for pharmaceutical products. Such a regime should be consistent with international human rights law and public health requirements, whilst safeguarding the justifiable rights of inventors."[6]

[5] UNDP Global Commission on HIV and the Law, Report, *Risks, Rights and Health* (July 2012), UNDP, New York.
[6] Ibid, p68 (Rec 6.1).

> In response to this recommendation the UNSG created a High-Level Panel on Access to Essential Healthcare. The concern was to ensure that intellectual property law (patents) was not adding unfairly to the cost of antiretroviral therapy and impeding the moves to protect people (especially vulnerable people) from infection or debilitating illness because of the cost.

The SG appointed me to serve on this High-Level Panel. Its report, and a later report by a further commission (the UNAIDS-Lancet Commission on *Defeating AIDS – Advancing Global Health*)[7] made many recommendations. Sadly, an opportunity on the part of the organised international community to reconsider and re-express the law on intellectual property as affecting life-saving health drugs was missed.[8]

Whilst acknowledging very great gains, a latter report of the UNSG in mid-2023 noted that these gains "have stalled and the overall pace of progress in ending the AIDS pandemic is slowing, owing to faltering political will, funding constraints and fragile public health systems and a failure to confront the injustices and inequalities that fuel the pandemic."[9]

What can be said is that much was achieved by a remarkable combination of science; political compromise; and engagement with civil society. However, the burdens of intellectual property law and the cost of therapies; and the unwillingness of many states most at risk to take initiatives suggested by UN bodies and national governments with experience, had slowed down the prospects of foreseeing a world without AIDS by 2030, the year identified in the UN *Sustainable Development Goals*.[10]

More UN reports demonstrated that AIDS could be ended by 2030 and outlined the path to get there. International demands to improve entitlements to universal health coverage have often led to criticism of the promulgation and application of unilateral economic,

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[7] *High Level Panel on Access to Medicines*, UPDP, September 2016. Reported

[8] *The Lancet* (June 2015) p 5.

[9] See UN Declaration of Commitment on HIV/AIDS, adopted by the General Assembly in its resolution S-26/2 and the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030: adopted by the General Assembly in its resolution 75/284 of 8 June 2021. Report of the UN Secretary General, 8 May 2023 (A/77/877).

[10] Statement by UNAIDS (Ms Winnie Byanyaima, Executive Director of UNAIDS). Statement "Progress and Peril in Global Laws on Same-Sex Criminalisation" (8 November 2023).

financial and trade measures that impede the full achievement of economic and social development, particularly in developing countries. When the United States Government joined with the United Kingdom and the European Union in blocking acknowledgement "unilateral coercive measures (sanctions) can have negative impacts on the achievement of universal health coverage". Yet in 2019, the then Australian government voted against the adoption of the UN Human Rights Council[11] resolution calling for restrictions on such measures that the Australian spokesman said: "we believe that sanctions can be an appropriate, effective and legitimate measure that is fully compliant with international law and the United Nations *Charter*". Australia's explanation avoided any reference to the unilateral character of the sanctions being considered or the negative impact of such sanctions on the individual human rights of people in need of healthcare. In voting on the resolution, which was passed 40:3, Australia joined with the European Union, the United Kingdom and Japan against adoption of the resolution. This showed once again that unjust intellectual property laws, impeding human rights advancements in the healthcare sector, are often hard to achieve because of perceived economic advantages of enforcing the economic benefits of intellectual property law to the advantage of wealthy advanced countries.[12]

United approach to pandemics: Moving beyond attention to particular pandemics to a more conceptual approach to global responses to such serious health threats has been slow in coming. However, on 20 September 2023, the United Nations General Assembly convened a High-Level Meeting dedicated to Pandemic Prevention, Preparedness and Response. The timing was important because WHO was then concurrently negotiating major revisions to the International Health Regulations (2005). It was striving to prepare a new Pandemic Treaty.[13] The desirability of such a treaty is clear. It was demonstrated in the loss of valuable early warning possibilities when the first instances of COVID-19 were detected in Wuhan, China. Those medicos in China who expressed concern over the possibility of a new pandemic were criticised. Some were and threatened with criminal sanctions. Valuable months were lost in initiating a global reaction to COVID-19. This only came months later, early in 2020.

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[11] Statement "Progress and Peril in Global Laws on Same-Sex Criminalisation" (8 November 2023).
[12] HRC 40/3.
[13] L.O. Gostin, S. Welter, A. Finch and S.F. Halabi, "The UN Declaration on Pandemics: What Should Happen Next?" Reported in *Health Affairs Forefront*, Global Health Policy, 23 October 2023.

The global response to the idea of a political declaration has exhibited many weaknesses:

1. The adoption of seriously diluted language in addressing the urgency of the opportunity;

2. The failure to provide effective accountability for each of the UN declarations;

3. The lack of funding provisions to ensure that the proposed declaration would be followed up effectively; and

4. The omission to recommend enforceable international obligations to address the challenge when a new pandemic comes along.[14]

Whilst the political declaration was approved by the UNGA in New York on 20 September 2023, its provisions arguably represent a missed opportunity to put in place a more effective global mechanism for confronting future pandemics in a united way.

Regional conference on populations: On 15-17 November 2023 in Bangkok, Thailand, the 7th Asian and Pacific Population Conference was convened by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). Such conferences have been held at 10 yearly intervals in the past. This was the 7th such meeting. Participants in the meeting including representative of governments in the Asia Pacific Region; technical experts; and participants from civil society. I was invited by three United Nations agencies: UNAIDS, ESCAP and Asia-Pacific Regional Office of UNFPA ('UN Women').

The participating countries at this conference were mostly represented by senior ministers and officials in the region. The focus was on stating the action in the region to confront inequalities, social exclusion and impediments to the attainment of rights. A

[14] Ibid.

major focus was upon the “gender consideration”. The format included a number of panels. I was a participant in the round table panel on “Inequalities and Social Exclusion and Rights”. Each panel member was allowed a short interval to express new initiatives that they considered urgent. In doing so, I drew on my earlier international activities on HIV/AIDS. But also on my engagement with global response, in that context, to discrimination and exclusion affecting LGBTIQ+ populations. One of the worst instances of homophobia and hostility towards the minority, present in all countries, exhibiting non-majoritarian sexual orientation and gender identity (SOGI).

Throughout the ESCAP conference, but especially in the session in which I was engaged, there was a noticeable unwillingness of representatives to address the situation in their respective countries in relation to the SOGI minority. Asia and the Pacific has no regional human rights court or commission to stimulate or sanction egregious departures from universal standards affecting the SOGI minority. In most of the ESCAP member states in the region, there has been no concerted movement towards the decriminalisation of adult, consensual, private same-sex conduct. It still remains a criminal offence, carrying serious penalties and huge stigma. The result, during the session in which I was engaged, was that whilst many commendable advances were mentioned (particularly in relation to gender (women) and disabilities) almost no reference was made to advancements in the position of SOGI minorities.

The inescapable conclusion based on this silence was there had not been many such advances. The etiquette of the meeting was to avoid “pointing the finger” at member countries or national delegations. Criticisms, if any, had to be stated quietly and obliquely. However, I concluded that my participation had been supported because of my willingness to speak openly and honestly about my own minority sexual orientation (homosexual). If this was my expected task, I certainly fulfilled it. Almost every national report made to the ESCAP conference contained reference to a phrase common in UN human rights documentation:

> “No one should be left behind”.

This affirmation was repeatedly included in virtually all of the national reports until it became almost rote learning. The repeated use of the phrase appeared as an embrace of meaningless incantation of unthinking generalities.

In the three-minute reply that was allowed to me in which to respond to the national statements, I mentioned the repeated invocation "to leave no one behind". However, I indicated that, certainly in my earlier life, I had felt "left behind" and positively unwelcome on many occasions. The only way these feelings could be overcome, or navigated, was becoming a "great pretender". I drew the inference that SOGI status was alright, so long as those affected pretended not to be. However, such pretence encouraged the policy stance that there was no problem about SOGI and that it could be ignored throughout the ESCAP region. I tried, within the etiquette, to change the ESCAP participants to listen to minority voices and to address the legal and policy response that needed to be heard. The Supreme Court of Jamaica unanimously dismissed the application for relief.[15] It held that, despite the drastic consequences for the gay minority in Jamaica, like himself, they were well and truly "left behind" by the law courts; the legislature; and society at large in of Jamaica. In part, the reason given by the Jamaican judges was that the Judicial Committee of the Privy Council in London, last year, had enforced the alleged exclusion and denied relief under the otherwise universal protections of the *Charter*. [16]

On my return to Australia a letter was awaiting me containing an article "*Farewell to Jamaica*", written by a human rights lawyer from Jamaica, Maurice Tomlinson. He reported the dismissal, in September 2023, of a challenge had had raised against the criminal laws of Jamaica that criminalised him and reduced his rights and dignity on the grounds of SOGI, despite the provisions of the local human rights Charter, upholding equality under the law of all.

[15] *In re Thomlinson* [2023] JMFC, Full per Shelley-Wilman SPJ Ag; Batt J and Pettigrew-Collins J.
[16] *Chandler v State [No.2]* (Trinidad and Tobago) (2022) UKPC 19.

REALITIES AND RECOMMITMENT

As a measure of the silence evidenced from many country reports at the ESCAP conference, it is worth quoting from the letter written by Mr Tomlinson to his fellow citizens in Jamaica:[17] The same letter could undoubtedly have been written by members of the SOGI minority in Asia and the Pacific, complaining about the inaction in law reform and the pain of being left behind by a hostile or indifferent society:

> "The Supreme Court upheld our country's archaic anti-sodomy law and claimed that only parliament could repeal this discriminatory edict. This British colonially imposed statute condemns consenting gay men to 10 years in prison with hard labour for any acts of indecency, even holding hands in the privacy of their bedroom. And upon their release, convicted gays must also register as sex offenders and always carry a "pass" or face a nearly $US 7,000 fine, plus spend a year behind bars every time police catch them without said pass.
>
> … In a pathetic concession to powerful religious extremists, the court allowed nine church groups to enter the case in support of the Government's position. However, the judge rejected the public defender's application to join and assist me. … Despite this shameful start, as an attorney, I still believed that our courts would protect vulnerable LGBT+ people like me against the homophobic tyranny of the majority. Yet, time and time again our judges have hidden behind politics and public opinion to rule against LGBT inclusion. …
>
> I am a Jamaican by accident of birth. But like the victim of an abusive relationship, I have struggled to remain faithful to my country despite suffering multiple attacks. I naively kept hope that my own land would one day live up to its moto: "Out of Many One People". However, it is now painfully clear that my dream of inclusion has been a nightmare, and I am unabashedly unwanted.
>
> I see little hope of justice for LGBT people from the Jamaican courts. Also, the political movement for inclusion faces steep odds as the last public poll showed

[17] M. Tomlinson, "Farewell, Jamaica", https://76crimes.com/2023/10/30/jamaican-court-again-rejects-lgbt-rights-jamaican-activist-bows-out/

> that over 90% of Jamaicans are homophobic. This is largely due to fundamentalist Christian ideology imported from North America. May those who choose to continue the Island's LGBT liberation struggle eventually have success. Meanwhile, I will remain where I am wanted in Canada. Here I now work as a nurse, caring for other bruised and battered people. I try to ease their pain, while I hope to end my own."

Too many people, including in the Asia Pacific Region, have been rebuffed by lawmakers in courts and by the legislature. At an occasion for reflection on populations and development (as well as the relevance of the UDHR@75) sexual minorities may have been rebuffed. Too often this has been the reality of countries in the region and of SOGI people in the minority. This is a serious affront to universal human rights principles. It is a rejection of justice and human dignity. Yet justice and human dignity are the foundations for health law and practice everywhere. Mr Thomlinson has terminated his engagement with the law, being now convinced that it offers him no redress. Unsurprisingly, he has turned to a healthcare profession, nursing, where stigma and hatred are controlled by legal and bioethical requirements. He dreams of an ethical society where he is not excluded and is not left behind. We must all recommit ourselves to that objective. It is set for us by the UDHR and by the principles of human rights, medical law, and human bioethics.