INFECTION: HUMAN RIGHTS, PUBLIC HEALTH AND

THE AIDS PARADOX

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AUSTRALIAN ACADEMY OF SCIENCE

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HIV/AIDS: THE NATURE OF THE EPIDEMIC

In considering the implications of HIV/AIDS for human rights, it is important to have a clear understanding of the features of this target of our concern. Good ethics and just laws are more likely to emerge from a clear understanding of the features of the epidemic, it modes of transmission and its characteristics than from pre-conceived conceptions based upon fear, hysteria, religious conviction or other grounds. To ensure that we retain our sense of proportion and limit derogations from human rights in connection with HIV/AIDS to those strictly necessary, it is useful to know something about the present size and projected enlargement of the problem.[1] We should also be aware of the available therapies and prospects for a vaccine and a cure. Knowledge of the latter reinforces a sense of urgency about developing effective but just laws to protect societies and the individuals who make them up from the spread of the virus.

AIDS is a viral infection which suppresses the body's immune system.[2] In the worst cases it goes on to destroy that system leaving the patient vulnerable to opportunistic infections which would otherwise be readily resisted by a healthy immune system. The HIV virus invades and kills the body's white blood cells (called T-cells). As this occurs, diseases which rarely affect a person with an immune system which is intact can prove seriously debilitating (and later fatal) to those infected with HIV. AIDS, caused by HIV, is thus the end stage of serious and often fatal illnesses. The end-stage illnesses will typically involve one of a number of infections or malignancies, some of them otherwise quite rare.

The HIV virus has been isolated in most body fluids, including blood, semen, saliva, tears and urine. However, only blood and semen have so far been implicated, by substantial epidemiological evidence, as a cause of transmission of HIV. Mosquitoes, sneezing, casual contact, social interaction, toilet seats and door knobs can be ruled out as modes of transmission. Fortunately for humanity, the AIDS virus is not easily acquired. It is unstable out of the human body. It is important to make these points to repel the worst fears generated by beliefs to the contrary. Such fears have taken their toll in the past. There is no reason, in today's informed society, to repeat these errors.

There are other features of HIV/AIDS which have to be noted in designing legal responses to it. It is useful, for example, to have an idea of the dimension of the problem now and in prospect, and as clear a sketch as possible of the individuals and behaviours most at risk. The reported cases

of AIDS recorded by the World Health Organisation total more than 200,000.[3] AIDS has been reported in virtually every country of the world. The number of cases reported seriously under-estimates the number of actual cases. Furthermore, AIDS represents simply the end stage of the condition. It is the tip of the iceberg. Behind it lies a vast number of people infected with HIV, but presently symptomless: most of them apparently in perfectly good health.

The long first period of HIV infection may last indefinitely. However, typically, in the adult, it lasts about eight years. The second stage sees the onset of "AIDS-related complex" (ARC) with physical signs and symptoms usually accompanied in the significant drop in the T-cell count. It is the third stage which is AIDS, properly so-called. This is a condition diagnosed by reference to a number of now internationally accepted criteria. Although progress from one stage to the next and from AIDS to death can be interrupted in some cases by therapeutic drugs, the available therapies are imperfect, expensive and not universally available. Furthermore, they frequently cause serious side effects. In these circumstances, the WHO projection of the rise in cases of HIV and AIDS throughout the world produces various estimates. The most conservative suggests that 5 million people in all continents and most countries are already infected with HIV. By any estimate, the number is rising rapidly. In Australia, 2,494 cases of AIDS had been reported to the National Centre in HIV Epidemiology and Clinical Research by 1 March 1991. In the same time 18,025 cases of HIV infection had been reported. These figures obviously understate the dimension of the

Australian exposure to AIDS and HIV.

Although HIV and AIDS attack human beings in a common biological manner, different patterns of the infection have emerged in different countries.[4] An analysis of the patterns which have emerged from the first decade of the study of HIV/AIDS in different parts of the world discloses three principal patterns:

Pattern I sees most cases of infection amongst homosexual or bisexual males, and urban intravenous drug users. Typical of this pattern was an early spread through blood products (transfusions) between the late 1980s and 1985; but this has now largely ceased in developed countries by reason of procedures of blood screening. Heterosexual transmission, although increasing, is only responsible for a small percentage of cases. Australia, New Zealand, North America and Western Europe fall into this pattern.

Pattern II involves typical spread of the infection through heterosexual transmission. Here the male/female ratio is approximately 1:1. Mother to infant transmission is also common in this group. Intravenous drug use and homosexual transmission occur at a very low level. Some spread still occurs through contaminated blood. This pattern is observed in sub-Saharan Africa, Latin America and especially the Caribbean; and

Pattern III has a low level of infection with

homosexual and heterosexual transmission being documented with other cases involving persons having contact with those who have travelled from Pattern I or Pattern II countries. This is the pattern currently found in Central and Eastern Europe, most parts of Asia, North Africa and most of the Pacific. Countries are constantly moving from one pattern to another. For example, Thailand is presently experiencing a rapid increase in HIV infection spread through sexual activity and drug use. Among the estimated 60,000 intravenous drug users in Bangkok, the prevalence of HIV infection rose, by WHO figures, from less than 1% in August 1987 to about 40% in January 1989. Obviously, such users - whose sexual orientation will mirror that of the general population - may provide vectors to spread HIV infection rapidly; threatening that Thailand will move from Pattern III to Pattern II.

Isolation is a traditional response of fearful communities to the appearance of an infection or contagious condition. Quarantine existed in a primitive form in Biblical times, as the record of treatment of lepers mentioned in the Bible demonstrates. Leprosy was well established in Western Europe in the early Middle Ages. It became a relatively common disease in the 12th and 15th centuries.[5]

Under typical medieval regulation of leprosy, anyone who noticed a neighbour, or even a spouse, with a skin

infection, was obliged to inform the authorities, whether religious or secular. A Lepers' Court was then convened. Leprosy "trials" were numerous. Acquittals were exceptional. Lepers were obliged to submit to various forms of treatment, all of them useless to the patient because leprosy was at that time incurable. One treatment reported was that of castration: an entirely irrelevant response to containing leprosy. More frequently the sanction was ostracism - exclusion from the community of the faithful, then from all social life and finally being shut up in a leper house. The convicted leper led an austere life without the possibility of family connection. Typically he or she was subjected to long lists of privations. They were not allowed to bathe in rivers or go about bare-footed. They had to wear special clothing which singled them out. They were presented from encroaching on persons who were not contaminated. They had to attend church services from a distance and in special places. They lost civil rights. They could not make a will. They were not entitled to a normal funeral. They could not be buried in a Christian cemetery. Restriction and deprivation of rights such as these set the pattern for responses during the 14th century to the Plague, the Black Death and other epidemics.[6]

It is against the background of "public health" responses to epidemics in the past - the horrible deprivation of human rights, generally without commensurate return in containment of the epidemic - that we approach the problem of HIV/AIDS in the modern world. This is the first intercontinental epidemic. It is a wholly modern and apparently new viral condition. Although it had some simian

predecessors, HIV was not detected in human beings until less than two decades ago. It is the universality, novelty and incurability of HIV/AIDS which presents special challenges and particular fears. These fears have led to calls for mandatory universal compulsory testing; mandatory testing of particular groups or persons, legislation targeted at individuals, (generally those who cannot answer back), or who are already stigmatised by a frightened community. It is in just such moments that human rights matter most.

ON THE ROAD TO EQUAL OPPORTUNITY

Article 1 of the Universal Declaration of Human Rights, crafted in the despair and hope of 1945 declares:

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

Those words might be rewritten today in our new sensitivity to sexist language. Now we would say that we should act towards each other in a spirit of humanity - or of brotherhood and sisterhood. Even the Universal Declaration could not entirely escape the deep wells of attitudinal prejudice that lie hidden in every language. But of the dedication of the world to human freedom, equality and dignity we would not alter so much as a word. We would reaffirm its message and ask what lesson this pivotal assertion of human rights has for each succeeding generation in a world still troubled by war, poverty and injustice.

One of the great teachers of the century, Martin Luther King Jr, gave us a text of hope when he said:

> *"The 20th century is strewn with the victims of*

human cruelty, and it is also replete with examples of human triumph. The world-wide struggle against war, racism, poverty, colonialism and totalitarian repression all testify to the truth that while men may be oppressed by slavery, the urge for freedom will persist undiminished and while death may break men's bodies, it shall have no dominion over their souls."[7]

To Dr King's list of causes of human repression, others could be added including gender, disability and sexual orientation. Each generation requires teachers to lift the scales from the eyes of the people to see unjust discrimination wherever it exists. It is an unremarkable fact that, before such instruction, ordinary, decent people, who would never think of themselves as discriminatory or unjust, act out their prejudices doing great wrongs, without necessarily intending to.

Many good illustrations of this truth can be seen in the early decisions of the courts responding to the claims of women to equal opportunity in society. How quaint, even weird, seem the judicial responses of the time. In 1873 - little more than a century ago - a Scottish judge rejected the claim of a woman, Sophia Jex Blake, who had applied to enrol in the Faculty of Medicine at the University of Edinburgh.[8]

Now the world is turned on its head. Not only are there women doctors, judges and barristers. Women are everywhere. In law schools in Australia, for example, the majority of new entrants are women. The Lord Ordinary of Scotland did not live to hear of Madam Curie or the great band of women doctors at Edinburgh and elsewhere who made - and continue to make - a marvellous and equal contribution to society.

The point to be made is that the lessons of human rights and equal opportunity are constantly being taught. But to teach them, we need courageous and forthright pedagogues who see more clearly than others wrongs being done. And who have the courage to protest and the will to change society for the better, often in the face of determined opposition. In a decade or so, the instruction of these teachers will seem trite, even self-evident. It will even seem surprising that such instruction actually had to be given, just as now it seems surprising that educated men of our civilization, and in the recent past, could hold such prejudiced and wrong-headed attitudes towards equal opportunity for women. But at the time of changing social attitudes, the task of the teacher can be painful, both for the teacher and the family and loved ones who are affected.

LESSONS FROM SYPHILIS & THE BOURBONS

We live at a time of human rights anniversaries. 1988 was the 400th anniversary of the Bill of Rights in England which accompanied the Glorious Revolution. 1989 was the bicentenary of the Declaration of the Rights of Man and of the Citizen which emerged from the French Revolution.

1990 was the bicentenary of the Bill of Rights which constitutes the first ten amendments to the United States Constitution. The crafting of the fundamental rights which so colour the law and life of that country had been postponed at the time of the American Revolution. James Madison had said: "Who will be so bold as to declare the rights of the people?". But declare them they did. Their incorporation in the constitution of the United States continues to influence the attitudes of that country and, thereby, the shape of the

odern world.

We now approach the 50th anniversary of the agreement by F D Roosevelt and Winston Churchill of the Allied war aims in the Second World War. These later came to full flower in the United Nations Charter (1948), the Universal Declaration of Human Rights (1948), the International Covenants on Civil and Political Rights and Economic Social and Cultural Rights (1976) and the regional treaties which declare and protect human and other rights in Europe (1953), the Americas (1978) and Africa (1986). In addition, there are more than twenty treaties, regional and international, which cover particular rights in more detail.[8] Among the basic human rights stated in these instruments, to be enjoyed without distinction of any kind, such as on the grounds of race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or other status are a number of fundamental rights of importance during the crisis presented by HIV and AIDS as Sieghart points out. They include:

- The right to life;
- The right to health;
- The right to liberty and security of the person;
- Freedom from inhuman or degrading treatment or punishment;
- The right to freedom of movement;
- The right to privacy;
- The right to marry and found a family;
- The right to work;
- The right to education; and
- The right to social security, assistance and

welfare.[9]

The body of international law on human rights is not simply a series of statements of pious platitudes drafted by politicians and then forgotten. It is part of international law. It is binding on the community of nations in differing degrees, depending upon the ratification of international instruments, whether the rules stated in them have become part of customary international law and part of the law of the country concerned.

Developing around the regional and international instruments of human rights is a jurisprudence stated by the courts and other institutions established to give effect to such instruments and by national courts. The most influential of these bodies has probably been the European Court of Human Rights. Its pronouncements bind the twenty-one member States of Europe which have ratified the European Convention on Human Rights.

Unfortunately, neither Asia nor the Pacific have a regional convention stating basic human rights. Nor is there a court, commission or other body to investigate, report on and redress human rights violations in this part of the world. An important challenge for lawyers committed to human rights in Australia should be the preparation of a regional convention and a proposal for a regional institution which could attract countries of our region, including our own.

Recently it has been suggested that the basic culture of societies still influenced by the Confucian ethic is fundamentally different from the culture of a country like Australia, which is sympathetic to the notion of human rights.[10] However that may be, it is undeniably desirable

at we should have, in every region of the world, an ter-governmental institution to safeguard human rights and spread the word of departures from internationally agreed ms. There is no obvious reason why it should be propriate to have a convention and an inter-governmental stitution for Europe, the Americas and Africa but not for sia and the Pacific. If it is thought that Asia presents pecial problems, we should at least venture upon an stitution for Oceania. Recent events in this part of the orld, quite apart from AIDS, demonstrate the urgent need for uch an institution. Human rights, by their definition, nhere in human beings. They are not confined to people in a particular culture. They are universal. They are part of he attribute of being human. Respect for them should be niversal. Machinery should be provided to enquire into and ddress alleged derogations.

Self-evidently, the great collection of human rights law which has been such a feature of world history in the ast fifty years especially, transcends in importance even such a serious epidemic as HIV/AIDS. Human rights are accompanied by human duties. Obviously, human rights have limits. The limits were once expressed in terms of the rule hat the right to swing your arm ceases when you hit me. Obviously, there is no human right to spread a life-threatening virus, such as HIV. On the contrary, there is a human obligation not to do so and a legitimate entitlement of the State, representing humans who are at risk of becoming infected, to take measures designed to limit that risk, if not to eliminate it.

All national and international statements of human

rights allow for derogations from the human rights declared in them. Typically, such derogations are permitted if they conform to three requirements listed by Paul Sieghart in his analysis.[11] They must be expressly provided by law so that the derogations do not depend upon arbitrary administrative power. This is a requirement of *form*. They must be derogations which are manifestly necessary in a democratic society to achieve a pressing social need. This is the limitation of *necessity*. And they must be strictly proportional to the need to tackle the defined object in hand when weighed in the balance against the adverse effects they may have upon people whose rights will be affected by them and by society itself which has its own interest in the exercise of human rights. This is the requirement of *proportionality*.

If we remember the basic human rights and the criteria for derogations from them, we are provided with a very useful system for measuring proposals designed to deal with the HIV/AIDS epidemic. Contrary to the opinion of some public health officials, many politicians and most lay citizens, the protection of public health does not provide a *carte blanche* to override fundamental human rights. There is a danger that public health and other laws will be drawn in panic, and overlook basic human rights. Especially in the face of such a serious and dangerous virus as HIV, it is inevitable that there will be impatience with the talk of human rights and that this will invade popular, political and even medical thinking. It is important that lawyers, with long social memories, should remind those who have the responsibility for lawmaking of the mistakes that have been

made in the past when, in panic, societies have departed from the foregoing basic rules.

A good illustration of the departures can be seen in the treatment of syphilis discussed by Sieghart.[12] There is quite a good historical analogy between HIV/AIDS and syphilis, although syphilis is not spread by a virus. Syphilis first appeared in Europe about four hundred years ago. It took four hundred years for the discovery of a blood test for it and the development of specific curative drugs. Both syphilis and HIV/AIDS are mostly transmitted by sexual intercourse. Both conditions can be acquired neonatally and through the sharing of blood. Both conditions, untreated, produce a substantial period of severe suffering. Each has a high ultimate mortality. In both cases the person infected (especially, in the case of syphilis, in a female) may be unaware for many years of the infection. In both cases the person will be infectious to others during parts of that period. In both cases the condition is (or was in the case of syphilis) incurable. In both cases early treatment involved radical measures with severe side effects (such as the use of arsenic in the early treatment of syphilis). In both cases there are stages to the development of the infection although the intervals are longer in the case of syphilis than in the case of HIV/AIDS. Both conditions evoke public fear and condemnation. We should therefore strive to learn, in the case of HIV/AIDS, from the earlier strategies used to deal with syphilis before it could be cured.

In the United States, many mistakes were made in the early legal regulation of syphilis. During the First World War, after the American entry into the War, naval regulations

were changed to require the removal of doorknobs on all United States vessels. This move was based upon the fear that syphilis would be spread by hand contact. We now know that such a fear was totally unfounded.[13] The case demonstrates the danger of basing public health strategies on fear rather than sound scientific data.

Also in the United States during the First World War, the President authorised the rounding up of 30,000 prostitutes on the basis that they might be a risk to the war effort. Congress allocated huge sums for their detention. The case is one of the untold derogations from human rights which occurred during the United States in wartime.[14] Another involves the detention of Japanese Americans under an order issued by President F D Roosevelt. That order was challenged in the courts by Mr Korematsu, an American of Japanese origin. In time of war, the United States Supreme Court by a vote of 6 to 3 upheld the Constitutional validity of the President's action. One of the dissents was by Justice Roberts. He said that, if the law were upheld, there would be no telling where this kind of excess would go beyond what was needed to deal with a specific problem in hand. If, for example, the United States were hit by an epidemic, a President might see it within his power to round up all suspect groups and deprive them of their liberties as American citizens.[15]

In the United Kingdom between 1864 and 1869 three *Contagious Diseases Acts* were passed. They enabled suspected prostitutes in certain designated towns and ports to be detained, subject to a statutory medical examination and, whilst in detention, treated under compulsion. The

scheme was, of course, very well intentioned. However, it evoked a great deal of opposition, including from the medical profession itself which had no desire to become "medical police". The Acts were repealed in 1886. However, procedures for compulsory report and contract tracing remained in place until, in 1916, the Royal Commission on Venereal Diseases recommended, instead, the establishment of special clinics offering free and confidential treatment. These clinics would operate on an entirely voluntary basis. They would guarantee complete anonymity and confidentiality. The Royal Commission set as its goal the uncompromising policy of minimising the spread of venereal disease. It asserted that this goal was more likely to be achieved by voluntary and confidential cooperation of the patients themselves than by Draconian measures based upon compulsion.[16] The United Kingdom experience was paralleled in Australia. The approach of the Royal Commission was vindicated. In the treatment of venereal diseases generally, it is still in operation in the United Kingdom, Australia and elsewhere. It is important that we should not forget the lessons from the earlier experience. Let us not be like the Bourbons - learning nothing from history: forever condemned to repeat its mistakes.

QUARANTINE, EARRINGS & OTHER THINGS

A recent Australian report in the *Sydney Morning Herald* indicated that almost 50% of Australians surveyed supported the quarantine of "AIDS victims". The survey was conducted amongst 2,800 people around Australia by the George Patterson Advertising Group. It showed that support for quarantining persons with AIDS - by which I assume it is

people with HIV - have risen by 10% in three years. When the survey was conducted in 1988, 39% favoured quarantine. In the recent survey, 55% of men and 43% of women (49% overall) supported quarantine. A like survey in the United States found that only 26% of people in that country surveyed supported quarantine for people with HIV/AIDS.

In the Australian survey the group most in favour of quarantine were those 55 years and over. Of them, 62% expressed their support. Of those in the 18 to 24 year age group, 34% favoured quarantine. The strongest votes for quarantine came from Tasmania and South Australia.[17]

The President of the New South Wales AIDS Council, responding to the survey, declared that it was "dramatic evidence of how appallingly [ill] educated the public is about AIDS". He said that "the views supported by this survey amount to ignorance and bigotry". Just as sombre was the comment of a representative of the Federal AIDS Policy & Strategy Branch within the Australian Department of Community Services and Health. He said that he found it "disturbing" that so many Australians advocated quarantine.[18]

We should not really be surprised about the response to the survey. Earlier generations of Australians were quite fierce in their strategies of quarantine whenever public health epidemics broke out. Usually it was Chinese or other immigrants who were put in hulks off the coast, in shocking conditions, with little advantage in the control of the epidemic. Out of fear are born extreme reactions. Quarantine has been a typical response to public health crises of the past. Why not with AIDS?

It is true that, if every person in Australia who had

the HIV virus could be accurately found and isolated and the country thereafter hermetically sealed from the entry of any person with the HIV virus, this would amount to one way to reduce the spread of the virus in our society. Of course, we would have to be quite ruthless for those quarantined. They could never come out; not even for a day - not even for an hour. Barbed wire would be needed to lock in these fellow citizens. Because there is no cure, there could be no prospect of their release. They would be there for good. We would also have to be quite ruthless and rather rude at airports. It would not be good enough just to test young men with long hair, bright clothes or earrings. We would have to test everyone. The queues are quite bad at airports now. But we would have to add to them or require a HIV-free certificate before a visitor received a visa. But even this would not be good enough. The visitor might acquire the virus in Honolulu on the way. So there would be no alternative to testing everybody at every point of entry anywhere on the thousand miles of coast around Australia. We would become fortress Australia. Of course, if anyone were found HIV positive at the airport they would simply be turned away, unceremoniously. If they were Australians they would go straight behind the barbed wire.

But even that would not be enough. We would have to limit overseas travel for Australians because, thereafter, it would be overseas that that danger lurks. The cost of keeping 11,000 prisoners in Australian prisons would be nothing to the cost of keeping an estimated 50,000 quarantined patients with HIV and AIDS. We could not lump them into Victorian edifices. There is no chain of closed

quarantine hospitals ready-built. So we would have to build them and provide staff 24 hours a day, 3 shifts, 366 days a year.

Most of the quarantined patients would be young. Most of them would be working and have 10 or more productive years in them. We would just have to forego that. The cost in emotional deprivation of their parents, friends, to say nothing of their own stress would be enormous. But just the withdrawal of such a valuable resource from the economy, in difficult economic times, might be all our hard-pressed economy needed to send it to the bottom of the ocean.

And then there would be the danger of people who had escaped the test. The only way we could safely quarantine people would be to subject our whole population to the test. You never could be quite sure as to whether anybody had the virus. We would probably need special policing teams to deal with escapees who tried to avoid the test. Certainly we would have to repeat the test many times over because of the "window period". A person might not be producing antibodies; yet be positive. The test might have produced a false positive or a false negative. And, naturally, there would have to be procedures for appeal, review and reconsideration. At least out of this, lawyers would find a bonanza contesting authority. The cost of all these tests and all these institutions, of the special police and of the units at every point of entry on our vast coastline would be enormous. After we had paid for it, our depleted economy would have little over for other health problems, let alone the multitude of other needs, including education of the young and vulnerable.

It is necessary also to spell out the kind of world in which such a response to the HIV/AIDS epidemic would reduce other countries as well as our own. If one country adopted the fortress mentality, others would surely follow. International movement, which is such an important contribution to peace, would be sharply curtailed. And what of the families and friends who insisted upon sharing their lives with the infected? The horrors of the picture of strict quarantine have only to be painted to demonstrate how totally unrealistic is this response to the HIV crisis. Yet one in every two of our fellow citizens in Australia believes that it is the right thing to do with HIV and AIDS. Clearly, we have failed in an important aspect of public education. It is therefore necessary to go back to fundamentals.

I fully realize that quarantine, in order to be judged "successful", does not need to be *totally* effective. The isolation of most, but not all, cases of infection may slow the rate of exposure of members of the community and be counted worthwhile for that reason. But it is obvious that the respondents to the survey of Australian public opinion contemplated a total (or as near as possibly total) isolation of *all* people infected with HIV. That is what many of our fellow citizens think. And any thesis is properly tested by taking it to its logical extreme. In this case this is the total quarantine of *all* infected people. A half-way house by which some infected people only were quarantined would (flagrant cases apart) raise serious issues of equity and effectiveness.

Past history shows that epidemics and quarantine do not, typically, bring out the best in society. Quarantine

takes on its own dynamic - with an army of officials dedicated to its success and expansion. That is the nature of bureaucracy. An appreciation of the peculiar features of HIV and especially the limited modes of transmission, teaches us the gross disproportion of the quarantine response. In AIDS and HIV we must, above all, keep our sense of proportion. It is an anchor for moral but also for effective decisions. Good laws and policies on AIDS and H IV will be fashioned not by copying ignorantly irrelevant models of the past, not by pandering to the fears of Biblical times - but by examining scientifically the nature of the virus, the modes of its transmission and targeting them in our strategies. This time, with this epidemic it behoves an informed world to do better.

OUT OF THE GHETTOS OF DISCRIMINATION

Cuba alone has adopted a national solution of quarantine. It could more readily do so because of the authoritarian nature of its society, its relative isolation from other countries in its own region and the world, the virtual drying up of tourist travel and the comparatively small number infected when the regime of quarantine was adopted. A society like Australia with more than 18,000 reported cases of HIV infection, and more than 2,400 reported cases of full-blown AIDS has to ask itself the question Paul Sieghart poses: whether a proposal such as quarantine would satisfy the tests necessary to warrant such a deprivation of basic human rights and freedoms.

A person who is infected does not, as such, present any risk of spreading the virus to others. It is the act of unprotected sexual relations, the sharing of needles or

giving birth when infected which may spread the virus from one human being to another. Laws which are respectful of human rights must be addressed to relevant activity, not to individuals, still less to groups. And in accordance with the basic rules which international law recognises, such laws, derogating from human rights, can only be tolerated to the extent that they are *necessary* in a democratic society. They must be required because of a *pressing* social need for them. The restrictions adopted by them must be strictly *proportional* to the needs of society when weighed against the adverse effects which they necessarily have on persons whose rights are restricted and upon the community itself, with its own interest in the free exercise of the rights of all its members.

The World Health Organisation has expressed itself in strong opposition to quarantine and isolation in the case of HIV and AIDS:

> *"There is no public health rationale to justify isolation or quarantine based solely on the fact that a person is suspected or known to be HIV infected. The modes of HIV transmission are limited (sex, blood, mother to child) and HIV spreads almost entirely through identifiable behaviours and specific actions which are subject to individual control. In most instances, the act of participation of two people is required for HIV transmission, such as sexual intercourse and in sharing contaminated needles or syringes ... HIV is not spread through casual contact, routine social contact in schools, the workplace or public places, nor through water or feed, eating utensils, coughing or sneezing, insects, toilets or swimming pools. ... Persons suspected or known to be HIV infected should remain integrated within society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others. Exclusion of persons suspected or known to be HIV infected would be unjustified in public health terms and would seriously jeopardise educational and other efforts to prevent the spread of HIV."*[19]

The expenditure of millions of dollars in campaigns of public education in Australia appears to have had some good results. Many experts believe that the rate of infection with HIV has slowed. That is not a reason for dropping our vigilance. There is a particular need to address the education of new generations of young homosexual men, of inexperienced intravenous drug users and of the growing number of heterosexual citizens who are contracting HIV through sexual activity. A report published a few days after the Australian quarantine survey suggested that the number of people in New South Wales who have contracted the HIV virus through heterosexual activity could now exceed the number of people who have been infected through intravenous drug use.[20] There is, of course, no reason to believe that the heterosexual majority of the community is immune in some miraculous way, from this human virus. In Africa, the Caribbean and Latin America HIV/AIDS has always been a problem of the general community spread principally by heterosexual intercourse. We should not believe that heterosexual people in Australia, Europe or elsewhere are somehow immune from the fundamental features of the epidemic. A belief in immunity among young heterosexual people engaging in unprotected sex presents a serious danger, the true measure of which we have yet to see.

Yet despite the expenditure of great sums in public education about risky activities, it seems that the efforts to educate the community in the proper response to HIV/AIDS has, in large part, fallen upon barren ground. Prejudice and ignorance, not rationality and effectiveness mark the

response to HIV/AIDS which calls for quarantine even in a comparatively well educated and well informed society such as Australia. If appeals to the requirements of international human rights law and the proportionality of derogations from basic human rights do not convince, it is necessary for the appeals to be reinforced in terms of cost effectiveness and cost to the community of the strategy which half the people of an educated Western country are said to favour.

THE NEED FOR CLEAR LEGAL STANDARDS

The Australian National HIV/AIDS Strategy has recommended that anti-discrimination legislation should be extended or clarified in each Australian jurisdiction to provide redress for people living with HIV, those imputed with the infection and their family, associates or carers in basic areas such as employment, education and training, accommodation and the supply of goods and services. It has also recommended that anti-discrimination legislation cover the ground of sexual orientation or imputed sexual orientation in those jurisdictions where this is not already provided. A major concern about the scope of the New South Wales anti-discrimination legislation is whether asymptomatic HIV infection is provided for by the statutory definitions of "impairment". The Victorian and South Australian legislation, on the other hand, appear to cover this case. It would seem curious that in the chief Australian jurisdiction affected by HIV and AIDS - where many good things have been done by people and governments - that clear laws to deal with unwarranted discrimination have not been enacted. And by unwarranted, I mean discrimination based on ignorance of scientific data about the modes of transmission

of HIV.

In the United States, which was reached by this epidemic earlier than Australia was, there have been numerous cases under anti-discrimination law of complaints by people who are HIV positive.[21]

Many legitimate questions arise concerning the shape of legislation designed to redress and discourage discrimination and vilification on the grounds of HIV status. But there is clearly a need to provide an effective means of redress. A just and humane society should do no less. Standards must be set. The law has a role to play in setting those standards.[22]

Furthermore, it is the paradox of HIV/AIDS that the best way, at present, to deal with the epidemic would seem to be to gain the confidence and attention of those individuals who are most at risk from activity which may spread the virus. At the moment this includes mainly young people engaging (or at the risk of engaging) in unprotected sexual activity and young people exposed to intravenous drug use. Because such people are frequently in minorities stigmatized by society, it is especially difficult for society to reach out to them with educational messages which will have sufficient force to affect their behaviour. Yet change their behaviour we must. By protecting them, we protect the whole of the society from the spread of the HIV virus.

There being no vaccine and no silver bullet cure, changing behaviour is the most effective weapon we presently have for the containment of the virus. Changing behaviour is notoriously difficult to do and not least in respect of sexual and drug-taking activities which can be important to

the identity of people and to moments of intense pleasure for them. That is why, in our present paradoxical situation, our society does well to gain the confidence of the people at risk, to secure their attention and to protect them from vilification and discrimination. It is vilification and discrimination which cuts them off from the social messages and casts them into ghettos of ignorance where HIV and AIDS are waiting.

The recent result of the survey of Australian opinion shows how large is the ghetto of ignorance and prejudice in our community. If the survey is accurate, it suggests that the educators have a mighty task ahead of them. And every year brings young recruits to risky activities of which they must be warned and protected as best society can.

It is thus the paradox of HIV and AIDS that the protection of human rights is, at present, one of the chief weapons which we have for the fight against the spread of the virus. That is why lawyers, at this moment in the history of the epidemic, have as important and useful role to play as scientists. It may change when a vaccine is developed. It may change if ever a potion or pill is provided to cure people of the virus or to control its progression. But at the moment, it is essential that lawyers speak out with a clear voice. And the message they should proclaim is simple. If we want to contain the HIV epidemic, we must protect the human rights of those who are infected and at risk. We will do so because it is right. But we will also do so because it is the most effective means of winning the confidence, improving the education and changing the behaviour of those whose lives are most in peril.

FOOTNOTES

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1. P C Sieghart, *"AIDS and Human Rights: A UK Perspective"*, BMA Foundation for AIDS, 1989, London, 7. See also L J Moran, "HIV, AIDS and Human Rights" (1990) 12 *Liverpool Law Rev*, 3 and United Nations, Centre for Human Rights, *Report of an International Consultation on AIDS and Human Rights*, Geneva, July 1989, UN, NY, 1991.

2. See K Mutton and I Gust, "Acquired Immune Deficiency Syndrome" (1983) *Medical Journal of Australia* 540.

3. J Mann, *"Global AIDS into the 1990s"*, World Health Organization, Geneva, 1, (being an address presented on 4 June 1989 at the Vth International Conference on AIDS, Montreal, Canada).

4. World Health Organization, *"The Health of Youth: Youth and AIDS"*, Geneva, 1989, 1.

5. Council of Europe, *"Criminal Law and Criminological Questions Raised by the Propagation of Infectious Diseases, Including AIDS"*, Paper for the Sixteenth Conference of European Ministers of Justice, Lisbon, June 1988 Strasbourg, 1988, 3) (Paper M J E-16 (88) 1).

6. *Ibid*, 6. See also K M Sullivan and M A Field, "AIDS and the Coercive Power of the State" in 23 *Harvard Civil Rights-Civil Liberties Law Rev* #1,

139, 155 (1988).

7. M L King Jr, cited in M Einfeld, *"One Lawyer's Musings on the Morality of Medicine"*, address to the Australian Jewish Medical Federation, July 1990, *mimeo*, 55.

8. See Lord Neaves (Lord Ordinary) in *Jex Blake v Senatus of the University of Edinburgh* (1873) 11 *McPherson* 784, 799.

8. Sieghart, above n 1.

9. *Ibid*, 6.

10. R Little and W Reed, *The Confucian Renaissance*, Federation, Sydney, 1989, 83.

11. Sieghart, above n 1, 25.

12. *Ibid*, 20f.

13. A M Brandt, "AIDS - From Social History to Social Policy", 14 *Law, Medicine and Health Care* 233 (1986). See also M D Kirby, "AIDS and Law" in S Graubard, *Living with AIDS*, MIT Press, Cambridge, Mass, 1990, 387ff.

14. K M Sullivan and M A Field (above), 155.

15. *Korematsu v The United States* 323 US 214 (1944).

16. *Sydney Morning Herald*, 21 February 1991, 7.

17. *Loc cit.*

18. Cited Sieghart, 44-5.

19. Social Aspects of AIDS - Prevention and Control Programme (WHO, Geneva, 1987).

20. *Sydney Morning Herald*, 25 February 1991.

21. See eg *Doe v Centinele Hospital* 57 USLW 2032 (CD Cal 1988); *Doe v Attorney General of the United States* 840F 2d 701 (1988).

22. See R C O'Brien, "Discrimination: The Difference with AIDS", 6 *Jl Contemp Health Law and Policy* 93, 119 (1990).