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THE UNIVERSITY OF THE WITWATERSRAND

CENTRE FOR APPLIED LEGAL STUDIES

JOHANNESBURG, SOUTH AFRICA

Thursday 25 June 1992

FIRST SOUTH AFRICAN CONFERENCE ON AIDS & THE LAW

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Michael Kirby*

"When in disgrace with fortune and men's eyes,
I all alone beweep my outcast state,
And trouble deaf Heaven with my bootless cries,
And look upon myself, and curse my fate,
Wishing me like to one more rich in hope,
Featur'd like him, like him with friends possess'd,
Desiring this man's art, and that man's scope,
With what I most enjoy contented least;
Yet in these thoughts myself almost despising,
Happily I think on thee,-and then my state
(Like to the lark at break of day arising
From sullen earth) sings hymns at heaven's gate;
For thy sweet love remember'd, such wealth brings,
That then I scorn to change my state with kings."

FROM GRANDGOR'S DISTEMPER TO HIV/AIDS

Five years after Columbus returned from his encounter with the New World, in the year 1497, there was an outbreak of a disease supposed to be venereal in the city of Edinburgh, Scotland. The books of the Town Council record how quickly the disease had progressed through Europe from its first report at the Siege of

Naples two years earlier. The King of Scotland and his council, terribly alarmed at this contagious "Distemper", issued a proclamation of the Sovereign Lord's will and command. The contagious sickness was named Grandgor. Those who had this plague were commended to pass far out of the Town to the island of Frith. If their bodies survived, they were obliged to take an unspecified cure. And everyone who did not comply with this command:

> *"Falle be brynt on the cheik with the marking of Irne that thai may be kennit in tym to cum and thair-after if any of tham remanis that thai fall be banift...*[1]

Panic. Alarm. Banishment. Cruelty. Public stigmatization. Law. These are the melancholy companions of disease and epidemics. The question for this conference is whether, in the five hundred years since King James IV issued his Proclamation against Grandgor we have advanced in our appreciation of the limits and opportunities of law in the face of a public health crisis. The Acquired Immune Deficiency Syndrome (AIDS) is new upon us. It presents many of the features of Grandgor. It has leapt around the world at fantastic speed. It is indifferent to national boundaries. It uses sexual and other pleasures as its vectors. It has entered our towns and our rural areas. Modern proclamations and laws have been made. We may not now burn the victims on the cheek. But the slim disease too often carries its own ultimate inscriptions. Discrimination and loathing are rife. They impede an effective response to the epidemic. They block the educational messages that are essential to behaviour modification and containment of the spread.

As with any new social crisis, it is inevitable that AIDS and the Human Immunodeficiency Virus (HIV) which causes it[2] will spawn a myriad of laws. People are as alarmed as were the Lieges and Inhabitants of Edinburgh five hundred years ago. They demand

responses of their Sovereigns. They call out for effective laws. Don't just hold conferences: do something! Prohibit the spread of AIDS! Punish those who spread it! Quarantine the people who present the risk! Protect us - especially our children - from the ravages of this unexpected affliction.

These are remarkable responses. We must not lack understanding of them. Humanity has not changed so very much in 500 years. Out there in the streets of Johannesburg, ordinary people are not so different from their counterparts in far-away Edinburgh in 1497. For all the benefits of modern education and the miracles of radio, television and other means of mass instruction, the knowledge of AIDS amongst the mass of people is superficial. Using that knowledge to prevent infection at critical moments of anticipated pleasure is notoriously problematical.

THE BASIC RULE AND THE AIDS PARADOX

So here stands our problem. In little more than a decade an extraordinary challenge to our species has struck the world. It has spread like wildfire. No continent is more devastated by it than Africa. We have photographed the virus that causes our affliction. We know the main modes of transmission. We have palliatives which will arrest some of its debilitating manifestations. But we have no cure. So remarkable is the proliferation of the virus in the host and so manifold its mutations that the prospect of a single magic bullet to cure an infected person seems extremely remote. The most that the scientists presently hope for, is that one day HIV will be like diabetes: controlled but never cured. Always a peril with the infected and to those they may infect.

Furthermore, there is no vaccine, although on this the scientists are more optimistic. Amongst all the mutations of the virus, they have found a section of the DNA that is constant. That

section may ultimately provide the target for to the provision of a safe vaccine. Perhaps a vaccine will eventually arrest the mysterious trigger which takes the already infected downhill, to the ultimate price which AIDS extracts. This is a terrifying condition. There is no point mincing words. Like many of you I have sat at the bedside of precious friends. AIDS makes us angry. But in law we must be rational. We must recognise the limitations of our discipline. We must acknowledge that law has only a partial success in achieving behaviour modification: particularly where sexual, drug-use or other human pleasures are involved. We must take as our guiding principle for law something more than the creation of a response to a dangerous epidemic. We must look for effective and just laws which contribute to slowing the spread of AIDS. We must seek to learn from the experience of others, whilst recognising the unique character of each legal jurisdiction.

I state these injunctions at the outset of this paper because they provide the touchstone for a rational legal response to the AIDS epidemic. I now want to assert a fundamental rule and a paradox.

The rule should apply to all lawmaking. But it is especially vital that it be observed in respect of laws on AIDS. It is that such laws must be based upon a thorough understanding of the target. In the case of HIV/AIDS this requires a detailed knowledge of the virus and its modes of transmission. AIDS laws must not be based upon ignorance, fear, political expediency and pandering to the demand of the citizenry for "tough" measures. There must be no more branding of cheeks. Good laws, like good ethics, will be founded in good data. Because this is a major health crisis, the least that we can expect from our politicians, bureaucrats and judicial officers is that they will inform themselves about the features of this epidemic before they make laws and policies or hand down decisions relating to

it. Nothing less will do. This is an area of the law's operation where people's lives are at risk and millions will die. The least we lawyers can do is to offer a useful contribution and not more worthless measures which pander to prejudice and ignorance. One of the real dangers of AIDS is that it will produce a new virus of HIL - Highly Inefficient Laws.[3] I said as much at the beginning of the epidemic. It remains true today.

The AIDS paradox arises from a reflection on the nature of this epidemic and the features of the virus. By a paradox, one of the most effective laws we can offer to combat the spread of HIV which causes AIDS is the protection of persons living with AIDS, and those about them, from discrimination. This is a paradox because the community expects laws to protect the uninfected from the infected. Yet, at least at this stage of this epidemic, we must protect the infected too. We must do so because of reasons of basic human rights. But if they do not convince, we must do so for the sake of the whole community which has a common cause in the containment of the spread of HIV.

The AIDS paradox derives from the lack of a vaccine and the lack of any prospect of a simple cure. Our only vaccine in these circumstances is knowledge. The only sure cure is prevention, by behaviour modification. The target is the decisions of billions of people on this blue planet, typically made at moments immediately prior to sexual or drug-use activities. Getting into the minds of people in such a way that they have the will to change their behaviour and reduce the risk of infection is not easy. But it is next to impossible unless the educational messages can be effectively spread. That will not happen if we do not win the confidence of the people most at risk. Such people include the young involved in sexual activity; homosexual and bisexual men; sex workers;

unempowered women, spouses of men who are infected; and injecting drug users. All of these groups have been the subject of centuries of prejudice and discriminatory laws. In their various ways they all feel alienated and remote from the messages of society. But the paradox is: if we are serious about the containment of the AIDS epidemic, we must enter their individual minds and get them to change behaviour which seems central to them to the definition of their being. It is a tall order. It will not be achieved if the minds are alienated or unempowered. It will only be achieved if the minds are won. That will only occur if a lot of shibboleths fall and if laws provide an umbrella for education and protection against discrimination.

I acknowledge that this is a paradox which is difficult to promote. Out there on the footpaths, many would regard it as an absurdity. Yet I hope it will be the result of this conference that we will be sent away with a cool-headed appreciation of the seriousness of our human predicament in the face of AIDS and a clear-eyed realisation of the limits - and paradoxical opportunities - of the law.

THE STATE OF THE GLOBAL EPIDEMIC

I must practise what I preach. It is essential to start with some data on the epidemic. Just before I left Australia, I received from the Global AIDS Policy Coalition at Harvard University a report on the "soaring number of cases of AIDS and infections with HIV" around the world. The coalition is headed by Dr Jonathan Mann, former Director of the Global Programme on AIDS of the World Health Organisation (WHO). It has concluded that the global epidemic is "spinning out of control".[4] The figures of estimated cases of HIV infection and of fully developed AIDS are as follows:

TABLE 1

GAPC Estimate and Projections

Cumulative number of adult HIV infections and AIDS

1992-1995

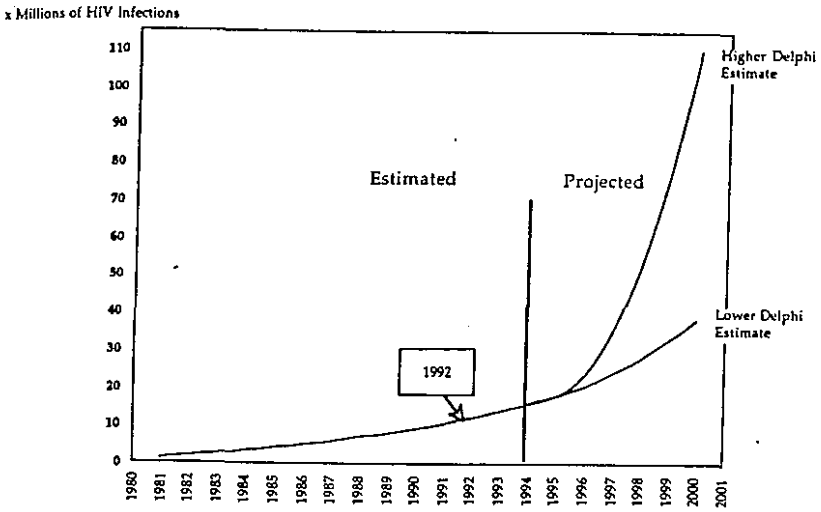
Geographic Areas of Affinity	HIV Infections			AIDS	
	All Adults 1992 estimate	Women 1992 estimate	All Adults 1995 projection	Adults 1992 estimate	Adults 1995 projection
1 North America	1,167,000	128,500	1,495,000	257,500	534,000
2 Western Europe	718,000	122,000	1,186,000	99,000	279,500
3 Australia/Oceania	28,000	3,500	40,000	4,500	11,500
4 Latin America	995,000	199,000	1,407,000	173,000	417,500
5 Sub-Saharan Africa	7,803,000	3,901,500	11,449,000	1,367,000	3,277,500
6 Caribbean	310,000	124,000	474,000	43,000	121,000
7 Eastern Europe	27,000	2,500	44,000	2,500	9,500
8 Southeast Mediterranean	35,000	6,000	59,000	3,500	12,500
9 North East Asia	41,000	7,000	80,000	3,500	14,500
10 Southeast Asia	675,000*	223,000	1,220,000	65,000	240,500
TOTAL	11,799,000	4,717,000	17,454,000	2,018,500	4,918,000

* Minimum estimate.

A graph produced by the same source shows the steady growth of HIV infections throughout the world since the first identification of the epidemic a little more than a decade ago. It also shows the projection of the graph both at the current rates and on a "worst case" scenario. The latter assumes that the epidemic takes a hold in India and South-Eastern Asia with the very high densities of population in those parts of the world.

FIGURE 1

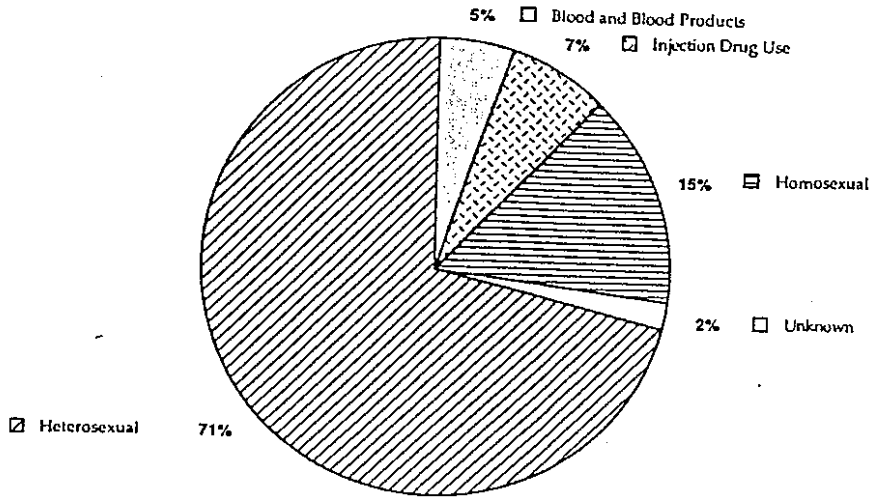
Cumulative Number of HIV Infections in Adults in the World



In many developed countries there is a widespread belief that HIV/AIDS is the wrath of God upon others: men who have sex with men; intravenous drug-users; and sex workers. But as anyone in Africa at least should know,[5] HIV is overwhelmingly a virus spread by heterosexual contact. World-wide, this mode of transmission accounts for 71% of cases as against 15% resulting from male to male contact.

FIGURE 2

Proportion of Global Adult HIV Infections by Mode of Transmission



The Global Programme on AIDS at WHO disputes some of Dr Mann's gloomy estimates. It does not agree that there are 13 million people already infected with up to 120 million likely to be infected by the year 2000. It takes a more optimistic view that, at most, 40 million people will be infected by the year 2000. But that figure is grim enough. And both estimates agree that the greatest rate of increase appears to be in sub-Saharan Africa. Only by the awfulness of his projections in Asia does Dr Mann predict that Africa will fall into second place.

A description of the predicament in another publication by Dr Mann is arresting:

> *"HIV is continuing to spread to countries and parts of countries that had little or no evidence of HIV infection just a few years ago. For example, in Africa 5 years ago, HIV seemed to be affecting mainly urban areas of central and eastern Africa. Today HIV has reached into*

western and southern Africa; in the general adult population of Abijan, Côte de Ivoire, HIV sero prevalence increased from less than 1% in 1987 to more than 7% today and in the Republic of South Africa more than 300,000 people, largely black Africans, are now estimated to be HIV infected. Ominously, HIV is also spreading rapidly into rural areas of Africa where most of the people live."[6]

In my own country, Australia, the epidemic is monitored by a monthly HIV surveillance report maintained by the National Centre in HIV Epidemiology. At the beginning of March 1992 the report recorded that the number of Australian diagnoses of HIV infection was 16,075. The total number of notified cases of AIDS was 3,192. The total number of deaths attributed to AIDS was 2,044. Of the notified new cases of HIV infection 48.4% were known to have occurred through male to male sexual contact. Heterosexual cases numbered only 2.6%.[7] All of these estimates are likely to be understatements because of the social pressure towards attributing illness and death to conditions other than HIV/AIDS by reason of the prejudice still attaching to that condition.

Australia is a federation. Most of the responsibility for laws on public health relevant to HIV/AIDS rests with the States. Yet for a decade there has been a strong national strategy, led by the Federal Government. A largely bipartisan policy has been adopted. The strategy has been generally addressed towards containment. Even the single-minded policy against illegal drug use gave way to a national scheme for syringe exchange at local pharmacies. There is now widespread public and school education about HIV/AIDS. There is much more open discussion about sexuality and drug use. In most prisons, without change of prison regulations, condoms are discreetly provided and even cleaning bleach is left available to sterilise illicit syringes.[8] There is a general feeling in Australia that this honesty and candour in confronting HIV/AIDS has helped to

diminish the spread of the epidemic. Yet still the cases of needless sero-conversion flow in, although at a diminished rate.

In South Africa a recent report has suggested that over 5 million citizens will have been infected with HIV by the turn of the century. According to the report more than 666,000 people will by then have died from AIDS.[9] Other estimates are even more gloomy. The Development Bank of Southern Africa predicts that no fewer than 12 million South Africans will be infected by the year 2000 - nearly a third of the entire population. Upon this projection, over 5.2 million AIDS related deaths will have occurred by the turn of the century. In a recent frightening estimate by the Minister of Health, it was suggested that 300 South Africans were currently being infected with HIV every day.[10] If this is so, the terrible infliction of the continent of Africa is now reaching down to South Africa. It is doing so at a time when so many other challenges face this country. The burden of individual stress, suffering, pain and death is bad enough. But to this must be added the enormous dislocation of the economy at a time when it will need to be in top gear to rebuild a prosperous South Africa for all its citizens in the future. Even if the gloomy estimates of the Minister and the experts prove unduly pessimistic, there is no doubt that South Africa, like other parts of Africa and the world, faces a tremendous health problem with HIV/AIDS.

THE PROGRESS OF HIV INFECTION

The insidious nature of the condition of HIV/AIDS is well known. It can lay dormant in an apparently healthy body, which is nonetheless infected and infectious. Originally the disease was classified into three phases. Now it is normally described as falling into four identifiable conditions:

* **Acute initial HIV infection:** Up to three weeks after first infection about 70% of people experience an acute viral illness with fever. During this "window" period, antibody tests will usually be negative. The subject will appear to recover;
* **Asymptomatic infection:** Most people then follow a number of years when they are infected and antibody positive but have no apparent illness. This interval usually lasts from 8 to 11 years but in some it may last indefinitely;
* **Persistent Generalised Lymphadenopathy:** Then, following a trigger, the cause of which is not fully understood, a number of patients will begin suffering from enlarged lymph nodes. Illness, night sweats and weight loss will typically follow; and
* **AIDS and Related Conditions:** The final stage on this journey is AIDS. The immune system has so diminished that serious illnesses occur with increasing frequency. Most typical of these are the constitutional disease of weight loss, diarrhoea and persistent cough known as AIDS Related Complex (ARC). But there are also the neurological diseases including dementia, opportunistic infections such as pneumonia and the appearance of strange and previously rare cancers such as Kaposi's Sarcoma.

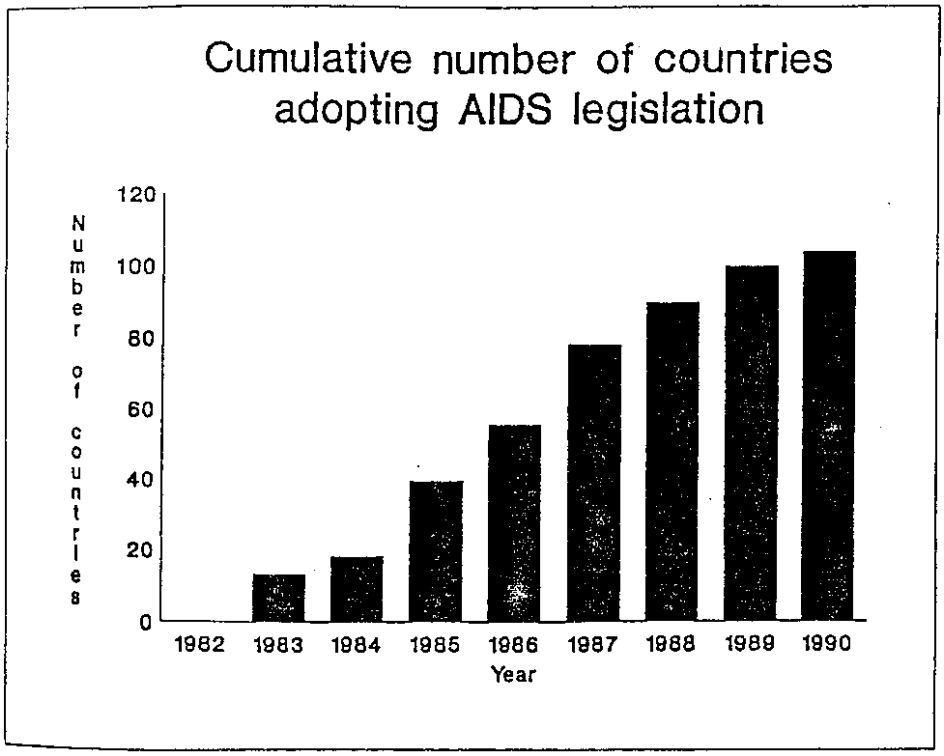
We must all know these things. But we must teach them to our families, our friends and colleagues. Lawyers must know them and recognise them in clients and litigants who have a range of ordinary, but some special problems, related to their infection.[11] We must keep the features of the viral condition and the size and dynamic of the global pandemic in mind when approaching the design of laws to respond.

LEGAL RESPONSES TO THE EPIDEMIC

The World Health Organisation publishes a regular analysis of the legislation produced in member countries dealing with health related issues and specifically with AIDS. These show the rapid growth of the number of countries which have introduced special legal measures to respond to AIDS is seen in the attached graphs.

FIGURE 3

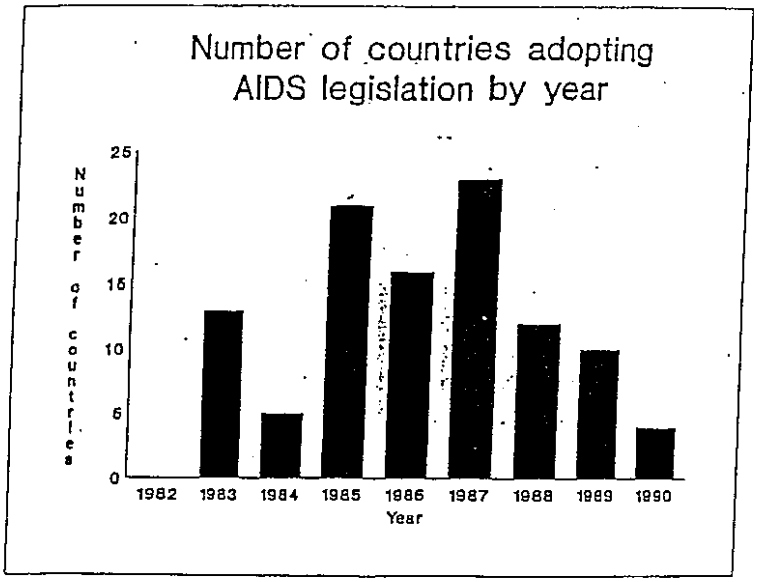
Growth in AIDS Legislation[12]



The number of countries introducing legislation peaked in about 1987. Having responded to the initial, and understandable, local pressure, there has now been a fall away as countries realise the futility - and even counterproductiveness - of many of the early legal measures. Another graph shows this decline.

FIGURE 4

Figure Showing Decline in Countries Introducing AIDS Legislation[13]



Of course, these are merely unanalysed gross figures. Some of the legislation may be entirely appropriate. Others may be oppressive and ineffective. Many deal with disease classification. A very long list now records countries which have enacted laws classifying HIV/AIDS as a sexually transmitted disease. A large number of countries have adopted legislation giving public health authorities powers to carry out surveillance in specified cases.[14] Some countries, mainly in the former Eastern Block and in countries under military régimes have provided for mass screening of high risk groups including prostitutes, prisoners, drug dependent persons and homosexuals. Others have enacted laws targeting migrants and travellers for mass screening. Provision is made for such screening of returning nationals, immigrants, applicants for long-term residents, foreign residents, migrant workers, foreign students, asylum seekers and refugees. In many countries users of health services are targeted for HIV screening.

In others, screening has been provided for particular occupational categories such as seafarers, the military, police, civil servants, scholarship holders, airline personnel and students. In Sierra Leone and the Sudan, for example, truck drivers may be screened. In a number of countries health personnel are subject to screening. Interestingly, "entertainers" are subject to the powers of compulsory HIV screening in Cyprus, North Korea and Indonesia.

Only Cuba has introduced mass HIV screening of the whole population. In Bulgaria, before the overthrow of the Communist régime, 45% of the population had been subjected to general screening. In parts of the former USSR, it was estimated that 30% of the population had been screened. Most countries have not embarked upon this response. They have refrained not because of special sensitivity to human rights but because of the prohibitive costs involved.

If human rights arguments are unpersuasive, it is much more likely that politicians and bureaucrats will come to appreciate the ineffectiveness and costs of laws imposing obligations of general or widespread mass screening. The screening can only be partly effective. The people in the "window period" will slip through. False positives and false negatives will give misleading results. Constantly repeated testing will be needed to catch these. The territory would have to be rendered secure from intruders. All tourists and visitors would need to be repeatedly screened. And then the problem would have to be faced as to what could be done with people found positive. Even in Australia there would not be barbed wire enough, nor institutions strong enough to contain all of the infected. Yet the infected are in many cases highly productive to the economy, to themselves and their family for more than a decade. As such, they are no risk to their fellow citizens. Only certain

intimate conduct is risky. AIDS is *not* contagious. The arguments for quarantine of HIV patients are therefore completely unpersuasive. Such a strategy amounts to a totally disproportionate response.[15]

If the figures of South African infections are correct you would need a new, very large multicultural "AIDS Homeland" for the infected and their families. The idea is preposterous and it is dangerous. Only in Cuba has this strategy been tried. It has attracted condemnation by World Health Assembly resolutions. Unsurprisingly, Cuba has resisted expert external evaluation of its programme. It continues to lock up its citizens with HIV whilst stepping up the programme for the visit of tourists, some of whom doubtless bring the virus.[16]

Laws and policies to do with AIDS must be efficient and cost-effective. Mass screening - even screening of particular groups - is not an efficient strategy. If it does not lead to quarantine, it certainly does not lead to treatment. It is not an efficient expenditure of the public health rand in the struggle against AIDS. This simple truth should have been learned from the earlier United States experiments with premarital screening for sexually transmitted diseases. The State of Illinois began a mandatory programme of such screening in 1988. In the first eleven months only 23 of the 150,000 tested (ie 1:6,500) were found HIV positive. The effective cost per person tested ranged from $25 to $125. The estimate for finding each of the 23 persons was $228,000. Meanwhile, there was nothing that could be done to prevent such persons getting married. And the number of couples seeking marriage licences in the State decreased by 25%. The mass screening was abandoned at the end of its first year.[17] Had it been mandated for the whole of the United States it would have incurred an annual

cost to that country of $100 million. The marginal utility of finding those infected who would otherwise not have been discovered was certainly outweighed by the marginal cost of such a wasteful programme. Yet in South Africa, as in Australia, calls are often heard for the introduction of mandatory testing. Often, it is part of a punitive syndrome. You are certainly not immune from this syndrome in South Africa. When four ANC members, imprisoned for alleged terrorism, were diagnosed as HIV positive, the Minister for Foreign Affairs, Mr R F Botha declared that:

> *...[t]he terrorists are now coming to us with a weapon more terrible than Marxism: AIDS."*[18]

In preventing the proliferation of laws on compulsory HIV screening, we have in one hand the shield of human rights and in the other the sword of efficiency. Probably for most lawmakers, it will be arguments of efficiency and economy that will ultimately carry the day against proposals for mandatory testing, quarantine and mass screening. Where does it lead? It leads to no cure. What do we do with them? There is no prison camp big enough. But we can expel the foreigners. Overwhelmingly AIDS is in our midst and is spread by our citizens to each other.

In South Africa you have a special reason for remembering the requirements of basic human rights on this subject. Universal human rights include the right to life. No one has a human right to spread a health-threatening virus. But the measures of public health and private law in response to an epidemic such as AIDS must also conform to the requirements of fundamental human rights. Such measures must be expressly provided. They must not depend upon the whim or idiosyncratic opinion of an individual. They must be consistent with the legitimate needs of a democratic society. And the intrusion into the rights of others must be strictly proportionate to the actual

achievement of public health objectives.[19]

South Africa's recent past requires of it a heightened sensitivity to the fundamental rights of the growing number of its citizens who are living with AIDS or who are at risk of infection. In South African law, as in the law of my own country, the attempts of the state to intrude into the private sexual activities of individuals are to be found in the law books. Such cases often provide pathetic reading of gross intrusions into privacy and individual autonomy. In South Africa you had the anti-miscegenation laws intruding into adult sexual conduct. The result was ruined lives and shattered families. Professor Cameron and Mr Swanson have painted an illuminating historical analogy for those who would punish private sexual acts between adults in an attempt to save society from a perceived social threat. They draw a parallel between anti-miscegenation and AIDS:[20]

> *"In both cases the community is seen as imperilled by a degenerating threat to its health and ultimately its survival. In both the threat is embodied in and transmitted by sexual conduct. In both a realm of intimacy between adults is invaded in the interests of community well-being and survival. In both cases discovery and exposure result in extreme stigmatization. The fact that in the case of AIDS the danger is real, while in the other the threat is now recognised as having been a product of racist obsession, does not affect the suitability of the means selected to deal with the peril which seemed as real to the racists of 40 years ago (and of today) as is the threat from HIV. In neither case is criminal sanction likely to eradicate or even inhibit the proscribed conduct. In both cases criminal penalties are in fact futile and counter-productive. Ultimately their enforcement brings the law and its personnel into disrepute."*

To these wise words I say amen. They carry lessons for lawmakers far beyond South Africa. But South Africa, having suffered greatly from unjust laws in the past, must do better in this coming test - the real AIDS test. The protection of the right to life is primary. But it must be achieved with the protection of other relevant human

rights: such as the right to privacy, the right to liberty and security, the right to freedom of movement, the right to marry and found a family, the right to work and to be educated and the right to freedom from inhuman or degrading treatment or punishment. It is essential that we harmonise our legal responses with these fundamental values. They will endure even after the AIDS peril has been overcome.

CRIMINAL & PUBLIC HEALTH LAW

Since exposure to HIV infection may lead to AIDS which is plainly life-threatening, it is a legitimate purpose of the law to endeavour to protect individuals, communities and nations from the spread of the virus. Although the criminal law operates imperfectly, it sometimes has a symbolic value. It can state conduct which is punishable and hence is not approved of by society. Various theories exist to justify the stigmatization of conduct by criminal law. According to one theory it is enough that the conduct offends the moral sense of most members of society. This was the traditional basis for laws penalising adult homosexual conduct, even though there was no complaining victim. With the spread of HIV there is the risk of serious actual harm to individuals. This invokes the other goal underpinning criminal law: to protect the individual and the community of individuals from serious harm.

It is possible, both in South Africa and Australia, that the knowing or reckless spread of HIV to another might amount to murder, manslaughter or assault occasioning grievous bodily harm.[21] But in Australia at least the general criminal law has been considered as, at once, over-inclusive and under-inclusive. A Federal Government Working Party has presented a Discussion Paper on legislative approaches to the public health control of HIV infection.[22] Its object was to promote and reinforce existing

public health initiatives being taken in Australia to combat HIV/AIDS, such as education and counselling for those particularly at risk. The authors of the Discussion Paper have adopted a two-fold principle, namely that individuals have a personal responsibility to protect their own health but equally they owe a duty to others to prevent the further spread of HIV/AIDS.

Fortunately, the focus of the Australian proposals is upon high risk *activities*. It is not upon individuals or groups as such. It does not seek to stigmatize or reinforce prejudice against homosexuals, the promiscuous young, sex workers or drug-users. Yet, in Australia, we still have some rather strange laws with criminal penalties. In Western Australia, under sanction of a criminal penalty, a person with HIV infection must inform the driver of any public bus of his or her condition.[23] In New South Wales it is a requirement that any person with HIV inform potential sexual partners of that fact on penalty of a $5,000 fine for failure. This requirement is unrealistic, generally unknown, if known further stigmatizes people with HIV infection, is impossible to police and takes no account of safe sexual practices. Needless to say there have been no prosecutions to date. But it made politicians feel a whole lot better having enacted it.[24] In the State of Victoria amendments to the *Health Act* were introduced in 1987 to provide a fine of up to $20,000 for a person who deliberately infected another with AIDS or with any other infectious disease. There are similar laws in most of the States of the United States. They are subject to the same criticism as I have mentioned in respect of the law of my own State. If there is a symbolic value in such laws it is minor. The trouble with enacting such laws is that they divert attention from really serious measures which are needed if we have hope of achieving real behaviour modification and reducing the spread of the

epidemic.

In all jurisdictions of Australia there are provisions for the compulsory detention of a person knowingly or recklessly spreading a proclaimed disease, of which HIV is one. Every society has a right to isolate such persons. True it is, the media coverage of such cases tends to dramatize the exceptional individual and to bring forth feelings of loathing towards them which flow on to others who are infected. Such cases do a great deal of harm to the overall strategy of HIV containment.[25] In Victoria, there is an innovative protocol. Where it is thought that a person with an infectious disease is likely to transmit it, there is the provision for the Head of the Health Department to require the person to be tested for HIV. Only if the test is positive may the person be ordered to undergo counselling where appropriate. Only if the counselling seems to be ineffective may an order be made restricting the person's behaviour or movements. Only if such an order is inappropriate may the person be isolated and detained. In South Africa, under the *Health Act* regulations, a medical officer may order an HIV "carrier" to be removed to a hospital or other place of isolation when "satisfied on medical scientific grounds that the danger exists" that the carrier might transmit the disease to other people. This provision has been criticised as importing a subjective test which may prevent judicial review against standards of reasonableness.[27] Obviously, the facility of review by the judiciary - the impartial organ of government - is essential. Perhaps the problem has not presented because of the rare use, in South Africa as in Australia, of measures of this kind.

ANTI-DISCRIMINATION LAW

The Australian Constitution contains no Bill of Rights. An attempt in 1988 to introduce some fundamental rights was defeated at

referendum. The provision of basic rights is overwhelmingly left to State legislation. Australia's recent subscription to the *First Optional Protocol* to the *International Covenant on Civil and Political Rights* may change this. Already a gay activist in Tasmania has complained to the United Nations Human Rights Committee against the laws of that State which criminalize consensual adult homosexual conduct.[28] Tasmania is now the only State of Australia which retains these laws inherited from colonial times. A recent decision of the High Court of Australia in a case involving Aboriginal landrights includes a suggestion, in the leading judgment, that the Australian common law will itself have to adapt to international human rights standards, being now under the discipline of international scrutiny.[29] Perhaps in this way we will secure the protection of basic rights supplementing the common law.

All jurisdictions of Australia except Tasmania and the Northern Territory have particular laws which protect people from discrimination on the grounds of HIV or AIDS. New South Wales, South Australia and the Australian Capital Territory include sexual orientation as a prohibited ground of discrimination. The Federal Human Rights and Equal Opportunity Commission may investigate and conciliate complaints of discrimination on the basis of physical disability and sexual orientation in employment. However, no binding determination may be made by that Federal Commission.

In April 1992 the Anti-Discrimination Board of New South Wales issued an important new report of an Inquiry into HIV and AIDS Related Discrimination.[30] This was the most extensive investigation of such discrimination in Australia. It records many cases setting out detailed but anonymous information on hundreds of complaints received by the Board. Amongst the recommendations made to meet the problems identified by these complaints are:

* To make the definition of "impairment" in the Act cover assumed or imputed impairment;
* To add trans-sexuality as a prohibited ground of discrimination;
* To make vilification on the ground of homosexuality of HIV infection, real or assumed, unlawful; and
* To step up education of judges, healthcare workers, police and others both as to the facts of HIV infection and transmission and as to the features of discrimination and prejudice.

I am sure that there would be much in this report which would strike a familiar chord in South Africa. It is impossible, by law, to prevent people having their own private prejudices and attitudes. Yet, as we have found in Australia (and as has been discovered in many other places), the law can have a supportive rôle to play in promoting education and informed attitudes based on fact, not prejudice. All civilized and educated people know that to have prejudice against a person because he or she is homosexual or bisexual is like having a similar prejudice because that person is left-handed. It is totally irrational. But it is difficult to stamp out. Similarly, to exhibit prejudice because a person is sick, though that person as such presents no risk, is irrational and morally wrong. It adds to the heavy burden of illness. Anti-discrimination laws can help to rectify such wrongs and to set the standards of proper social conduct. In many countries such as my own, such laws began with useful work on racial and religious prejudice. They then moved into prejudice on the ground of gender. Now they are tackling other causes of prejudice: such as age, handicap, disability and sexual orientation. There is a common enemy here. It is stereotyping. In the context of HIV/AIDS that enemy

impedes the spread of educational messages and the self-esteem of those who must receive them. To be successful in combating HIV/AIDS we must begin at the source of the problem: in the minds of those whose behaviour we must hope to modify for their own protection and for the protection of others. So look to the need for anti-discrimination laws.

OTHER LEGAL ISSUES

There are countless other legal issues which have arisen in Australia and which will arise for consideration in this conference. Insurance is important amongst these. In Australia, life insurance companies were reported to be denying HIV negative men cover on the basis of their sexual orientation. A code of practice was thereupon drawn up. Under it no adverse decision may be based solely on the known or suspected sexual orientation of a proposed insured. Any previous consultation about HIV infection or testing for the virus with a negative or unknown result must likewise be excluded. This policy has been adopted as part of the strategy to encourage any person concerned to take the HIV test voluntarily without the risk that doing so will have adverse consequences. For constitutional reasons in Australia, State anti-discrimination and equal opportunity agencies cannot deal with complaints relating to insurance which is federally regulated.

There have been a number of cases in Australia as in South Africa[31] where confidentiality of persons infected with HIV has been breached. It is imperative that confidentiality is assured in healthcare services, especially about a condition such as HIV/AIDS. If it is suspected that confidentiality cannot be assured, some people will not seek services especially about a condition such as HIV/AIDS. Others will keep secret facts which should be revealed for good treatment. In making decisions on confidentiality issues,

courts and other bodies must keep their eye on the social utility of society as a whole, of preserving the general assurance of medical confidentiality. They should resist the breakdown of the duty of confidentiality, even in hard individual cases.

Also in Australia, as in South Africa issues have arisen relating to access to drugs and therapies.[32] Australia has strict laws on drug importation and registration requiring extensive testing in Australia. This can delay the availability of new drugs. But now, up to three months supply of unapproved drugs may be imported by an individual by mail. Buyers' clubs help members import experimental drugs for personal use. State laws prohibit promotion of such drugs by referring to the suggested properties or benefits of such compounds. Unfortunately quack doctors and false "remedies" gain modern adherents amongst people in a vulnerable situation.

In a number of Australian cases, infection by blood transfusion in hospitals has led to claims for compensation. These have been brought on ordinary tort principles.[33] In some States, government funds have been provided to provide compensation to persons infected in this way. But not without criticism that this causes stigmatization and alienation of those who are infected, unsuspectingly, in perfectly lawful sexual activities and who have just as much need for social support and public charity.

An important area for lawyers acting for patients with HIV/AIDS necessarily concerns wills and powers of attorney. In some parts of Australia family provision legislation has provided for dependency including in homosexual relationships. In this way (although not yet by intestacy laws) surviving partners have been able to recover where there is no will or no adequate provision by the will. The difficulty of getting young, dying people to execute a will is often referred to.[32] The problem of AIDS dementia and of will

contests cannot be ignored. Practical issues such as the expedited hearing of cases for litigants living with AIDS must be addressed by practical lawyers.[35] Prisoners with HIV have had the sentences reduced because of shortened life-expectancy.[36] Many are the faces of AIDS in the courts of Australia. In one enlightened decision, a District Court judge in New South Wales quashed a conviction on a resident on a remote rural farm of cultivation of marijuana for personal use on the basis that the user had AIDS and should be left alone by the law.[37]

CONCLUSIONS - THE BIG AIDS TEST

There are many other legal issues presented by HIV/AIDS. In employment, schooling, housing, social security and otherwise there have been cases of discrimination which require legal redress.[38] In family law there have been terrible cases of discrimination in custody orders upon the basis of HIV infection, without any rational or justifiable ground save from abject surrender to community prejudice and ignorance.[39] In the case of the dying there has been the operation of laws against suicide or assisting suicide. Even in death there have been added burdens. Until recently, in New South Wales, funeral regulations required that a person, known to have died with AIDS, was to be placed in double plastic bags heat sealed with the words "Infectious Disease - Handle with Care" placed in large letters of prescribed colour and height.[40] Recently, there was an unedifying spectacle in which the family of the deceased son insisted upon a religious funeral ceremony against wishes expressed in his will to the exclusion of the friends who had been closest to him in his final struggle. Sometimes in bereavement the grieving family and friends come together. But often they do not.

"There is no country for old men.
The young in one another's arms, birds in the trees
- Those dying generations - at their song,
The salmon-falls, the mackerel-crowded seas,
Fish, flesh or fowl, commend all summer long
Whatever is begotten, born and dies
Caught in that sensual music all neglect
Monuments of unageing intellect."[42]

In the face of AIDS - this new, unheralded global crisis, we should all be humble. But we should be resolute. We should think of the many who this day will become infected and those who will learn of their infection. We should think of their families, parents, lovers, friends. We should spare thoughts for the healthworkers who will toil courageously over them: often with no drugs, always with no cure. We who are lawyers should be humble about our small part in this great crisis of humanity. Learning from the past errors of cruel and inefficient laws we should resolve, this time, to do better. On our cheeks should be tears for the people who carry the heavy burden of infection and for those who have died. There should be no brand marks on our cheeks. Stigma should have no dominion. And our eyes should be bright with the resolve to do practical things to slow the spread of this infection.

In the little part which the law has to play in this great drama we should be protectors of basic rights. They matter most when they are most at risk. That is when lawyers and lawmakers have a special responsibility. South Africa, with its beautiful land and people, has had occasion to learn from the great wrongs of discrimination and the burden of the viruses of ignorance and prejudice. As South Africa now faces a new and special test with the advent of AIDS, there will be many observers who will hope that, learning from its past, it will do better in its future.

FOOTNOTES

* The Hon Justice Michael Kirby AC CMG. President of the New South Wales Court of Appeal, Sydney, Australia. Former Chairman of the Australian Law Reform Commission and Member of the World Health Organisation Global Commission on AIDS. Commissioner and Chairman of the Executive of the International Commission of Jurists. Member of the Fact-Finding and Conciliation Commission of the International Labour Organisation on South Africa.

1. Extract from letter to the President of the Royal Society, Royal Society, *Phil Trans*, 42, 420-421 (1743). The letter extracts the books of the Town Council of Edinburgh, 1497.
2. In April 1992, Professor P Duesberg, a Californian chemist, secured widespread publicity for his view that AIDS is not an infectious disease and that HIV is harmless. Since then, three Nobel Prize winning scientists have written to the *Independent*, an English newspaper, affirming that "the great majority of scientists who have acquainted themselves with the facts [believe] that HIV is the cause of acquired immunodeficiency syndrome". (1992) 6 *[Aust] National AIDS Bulletin* 4.
3. See M D Kirby, "The New AIDS Virus: Ineffective and Unjust Laws" in France, Ministry of Foreign Affairs, Symposium Internationale de Reflexion sur le Sida, *Papers* (version anglaise), October 1987, 209ff.
4. The Global AIDS Policy Coalition, *AIDS in the World*, 1992, issued 3 June 1992.
5. Roy Anderson and Robert May, "Understanding the AIDS pandemic", 266 *Scientific American* #5 (May 1992) 20.
6. J M Mann, "AIDS - The Second Decade: A Global Perspective", in *J Infectious Diseases* 1992: 165: 245f.

7. The figures are taken from (1992) 30 *[NSW] Law Soc J* #4, 59.

8. See M D Kirby, "AIDS Strategies and Australian Prisons", South Aust Justice Administration Foundation 1990 Annual Oration. See also D Buchanan "An Unusual Twist to Criminal Case Work" in (1992) 30 *[NSW] Law Soc J* #4, 59 at 60f.

9. J Broomberg *et al*, "The Economic Impact of the AIDS Epidemic in South Africa", Centre for Health Policy, Department of Community Health, University of the Witwatersrand Medical School, July 1991. Cited E Cameron and E Swanson, "Public Health and Human Rights - The AIDS Crisis in South Africa", unpublished paper, April 1992 (hereafter Cameron and Swanson).

10. As recorded in *Star*, 10 October 1991. The Minister's statement reflected the terms used some months earlier by a government official. See *Star*, 22 May 1991 cited Cameron and Swanson, 2.

11. A Anderson, D Buchanan and J Godwin, "Practical Observations in Representing Clients with HIV or AIDS" (1992) 30 *[NSW] Law Soc J* #4, 56 (hereafter Anderson, Buchanan and Godwin).

12. K Tomasveski, S Gruskin, Z Lazzarini, A Hendriks, "Human Rights", chapter 3.4 of *AIDS in the World 1992* International AIDS Center, Harvard School of Public Health, (forthcoming).

13. *Ibid*.

14. *Id*.

15. Cameron and Swanson, 17.

16. J M Mann and K Kay, "Confronting the Pandemic: The World Health Organisation's Global Programme on AIDS, 1986-1989" in (1991) 5 *AIDS* 1991 (suppl 2) s 221 at s 226.

17. J E Osborn, "Public Health and the Politics of AIDS Prevention" in The American Academy of Arts and Sciences, *Dædalus*, 1989: *Living with AIDS*, Part II, 123 at 135.

18. R F Botha cited S Sontag, *AIDS and its Metaphors*, 1989, 62. See also C Visser, "Foundering in the Seas of Human Unconcern: AIDS, its Metaphors and the Legal Axiology" (1991) 108 *S Af LJ* 619, 627.

19. P Sieghart, *AIDS and Human Rights: a UK Perspective*, BMA Foundation for AIDS, 1989, London; L J Moran "HIV, AIDS and Human Rights" (1990) 12 *Liverpool Law Rev* 3; M D Kirby, "AIDS and Human Rights" (1992) *Aust Gay and Lesbian LJ*, 1.

20. Cameron and Swanson, 11.

21. S H Bronitt, "Criminal Liability for the Transmission of HIV/AIDS" (1992) 16 [Aust] *Crim LJ* 85.

22. See D Patterson, chapter 20, "The Law" in E Timewell, V Minichiello and D Plummer (eds) *AIDS in Australia*, Prentice Hall, Sydney, 1992, 366.

23. Western Australia, Department of Health, *Infectious Diseases Legislation in Western Australia - Legislative Proposals*, Perth, 1990. See Patterson *op cit*, 367.

24. See Patterson, 367.

25. Cameron and Swanson, 23.

26. See Patterson, 368.

27. Cameron and Swanson, 24.

28. The complaint has been brought to the Human Rights Committee by Mr N Toonen. It was lodged one day after the *Optional Protocol* began to apply to Australia on Christmas Day, 1991.

29. See *E Mabo and Ors v The State of Queensland* (1992) 66 *Aust L J Reps* 000 (HCA), per Brennan J.

30. New South Wales, Anti-Discrimination Board, *Discrimination - the Other Epidemic*, 1992. See also Visser (above) 639.

31. See *McGeary v Kruger and Joubert*, unreported judgment of Levy J, Supreme Court of South Africa (Witwatersrand), 16 October 1991. For contrast see Anderson, Buchanan and Godwin (above) 57.

32. See *Schmidt v The Adminstrator of Transvaal, Director of Hospital Services (TVL) and Chief Medical Superintendent, Johannesburg Hospital*, unreported, Myburgh J, Supreme Court of South Africa (Witwatersrand), 3 April 1992. For Australian cases see J Hamblin "Healthcare: Rights and Responsibilities" (1992) 30 *[NSW] Law Soc J* #4, 66 citing *Rogers v Whittaker* (1991) 23 NSWLR 600 (CA); *F v R* (1983) 33 SASR 189 (SAFC).

33. See *H v Royal Alexandra Hospital for Children & Ors* (1990) *Aust Torts Reps* 81-000 (NSWSC). Cf *E v The Australian Red Cross Society & Ors* (1991) 99 ALR 601 (FCA-Wilcox J).

34. Anderson, Buchanan and Godwin, 58.

35. *Loc cit.*

36. Buchanan, (above), 60.

37. *R v Falconer*, District Court of NSW, Lismore, 22 March 1991, Saunders DCJ, unreported.

38. See M D Kirby "AIDS and Law" in *Dædalus, op cit* n 17, 101 at 114. Cf N Arendse "HIV and AIDS Infected Employees: Some Legal Implications for the Work-place" (1991) 11 *[S Af] Industrial LJ* 218; E Cameron, "AIDS - Some Problems in Employment Law" (1991) 12 *[S Af] Industrial LJ*, 193.

39. See M D Kirby in *Dædalus* above n 38 at 115. See also M D Kirby, "AIDS Legislation - Turning up the Heat?" (1986) 60 *Aust LJ* 324.

40. Public Health (Funeral Industry) Regulation 21(2) (NSW Aust), 1987 (now repealed).

41. M D Kirby, "AIDS: A New Realm of Bereavement", unpublished paper for the Third International Conference on Grief and Bereavement in Contemporary Societies, University of Sydney, Aust, 4 July 1991.

42. W B Yeats, "Sailing to Byzantium" in W B Yeats, *Collected Poems*, Macmillan, London, 1982, 216f.