Law Discrimination and Human Rights - Facing up to the AIDS Paradox

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the basic rule & the aids paradox

HIV/AIDS has crept upon the world at an unpropitious time. It threatens to set back the important economic advances made in many developing countries, nowhere more than in Asia and the Pacific. It challenges cultural norms. It presents enormous difficulties to securing effective behaviour modification.

The advent of HIV/AIDS comes at a time when demands for the effective protection of human rights are also spreading throughout the world, encouraged by information technology and promoted by the United Nations. That movement has also reached this region.

For these remarks, I will draw on my experience as Special Representative of the Secretary-General for Human Rights in Cambodia,[1] my work on the Global Commission AIDS of WHO and as a judge, to derive lesson for the effective law reform which is needed to combat HIV/AIDS effectively. I do not under-estimate the difficulties - particularly because of the common resistance which exists to the measures necessary to confront the HIV/AIDS implications of illegal drug use, unprotected sexual activity and commercial sex workers. My basic thesis is simple. It is that, paradoxically, the protection of the human rights of persons at risk is the most effective way of arresting or slowing the spread of the virus. This is the AIDS paradox. Only by recognising this paradox can the confidence and attention of the relevant audience be won and held. Only by doing this can the behaviour modification, necessary to containing the epidemic, be achieved.

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 at risk of devastation than over-populated Asia. This conference in Chiang Mai is vital and well timed. 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 and ethical legal response to the AIDS epidemic. I now want to assert a fundamental rule and to return to the 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. 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. This is truly an area where the law can help shape the future of human health. One of the real dangers of AIDS is that it will produce a new virus of HIL - Highly Inefficient Laws.[2] 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 thus 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, sexual partners of those 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, including perhaps to the definition of their being. It is a tall order. It will not be achieved if the minds are alienated or disempowered. 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 in Asia, 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.

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 1

growth in aids legislation[3]

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 counter-productiveness - of many of the early legal measures. Another graph shows this decline.

figure 2

figure showing decline in countries introducing aids legislation[4]

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.[5] 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.

responding to epidemics

From primitive times rulers and societies have sought to protect themselves from epidemics and to prevent them spreading in their midst. The Bible records instances of quarantine. From medieval times, responses of banishment, isolation, branding and imprisonment have been taken in the attempt to defend society from the spread of disease.

When HIV/AIDS came along, particularly once its nature was defined and modes of transmission identified, it was inevitable that national and sub-national governments, as well as international agencies, should be called upon to provide responses which were effective in preventing the spread of HIV. A very small number of countries resorted to quarantine and quarantine-like responses.[5] Only Cuba has really adhered to this strategy, although it was toyed with in pre-reform Romania and the Soviet Union. Many countries, notably China and India, have introduced requirements that students and long-term resident workers must produce HIV-free certificates within a short time of their arrival. If there ever was a time when HIV/AIDS could have been isolated and contained by the procedures of quarantine, like ebola in Zaire, that time has long since passed. We are therefore now faced with the more complex and challenging problem of preventing the spread of HIV in a global environment where it is already widespread in every continent. It continues to penetrate populations everywhere, having moved beyond the sexually active mainly homosexual male communities which were the early targets in Western countries.

Because of the devastation which HIV/AIDS causes to societies and individuals, it is unsurprising that there should be pressure upon governments and sub-groups of specially vulnerable people in society, to do effective things to contain the spread of the virus. This is true in developed countries, such as Britain, the United States and Australia. It is also true in developing countries, now increasingly in the front line.

The response of many citizens to a new peril to life, such as HIV/AIDS presents, is quite often to demand a law.[6] There is, naturally enough, an insistence that something urgently should be done. In democratic countries, but also in autocratic ones, this demand is felt by governments. Well intentioned citizens, fanned by impatient media editorials, call for urgent responses. Many still call for isolation and quarantine, little realising the impossibility of this strategy except perhaps in remote parts of Nepal or the Galapagos. Demands for universal HIV testing are still heard, without considering the great cost involved, the need for constant repetition and the limited utility of the data once produced, to provide an effective response, still less a cure. Then the demands, quite often, turn nasty. There is a cry for punitive measures - to punish those who wilfully and knowingly spread such a deadly virus to others. Such demands have produced laws in many societies, including Australia.

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In my own State of Australia, New South Wales, a law was enacted to require that any person with HIV must inform potentially sexual partners of the fact or face a penalty of $5,000 fine for failure to do so.[7] In the State of Victoria amendments to the *Health Act* were made imposing a fine of up to $20,000 on a person who deliberately infects another with HIV. Needless to say, these statutes are rarely, if ever, enforced. Perhaps they have a symbolic value in stating the rudimentary duties of disclosure and protection of others which the law already requires. But they scarcely amount to effective criminal sanctions against high risk activity which determined people may still venture upon. Legislative amendments to permit the detention of people knowingly or recklessly spreading a proclaimed disease, such as HIV, may occasionally be useful for tacking a notorious case highlighted, typically, by banner headlines in the media.[8] I do not mock these provisions. Nor do I underestimate the pressure upon governments to do, and to be seen to do, something in the face of such a huge health challenge to society. Yet it is important to start with a clear sighted understanding of the limitations which such legislation presents. The plain fact is that there is no simple response, by laws, policies or otherwise, which governments can adopt to sweep away this major challenge.

For ten years I chaired the Australian Law Reform Commission. That task required me to look scientifically at the differential sanctions and remedies which are available to legislators and government (usually by law) to achieve defined objectives. It was surprising to discover that there is relatively little empirical examination of what sanctions and remedies actually work in particular cases. This will be astonishing to scientists, used to such differential studies. But in the law it has typically been assumed that a law will work to achieve its objectives, simply because Parliament or the courts say so. Alas! It is not so simple.

Least of all is it simple in the field relevant to the spread of HIV/AIDS. Given that the principal vectors of the virus include unprotected sexual activity and unsafe injecting activity, governments start from behind in trying to control such conduct and to modify it in ways to prevent the undesired spread of the virus. The problems are many. They include:

Therefore, governments and societies must respond to HIV/AIDS with more finely tuned strategy. Precisely what this will be will vary from one society to the next. The World Health Organisation, and now UNAIDS, may give a lead and provide guidelines. Some common themes will emerge. But each society and its government is the product of a complex history and cultural legacy. What works in one place is not so easily transplanted in another. Not least is this so because of the differing resources both of manpower and capital available to promote and sustain a programme of prevention and the differing inclination of the recipients of such a campaign to receive it. Even apparently very similar societies exhibit nuances which require differentiated social responses. We might think that the societies of Britain, the United States and Australia are very similar. So they are, as are their inherited legal and governmental systems. But there are important differences, eg in the power of central government and its agencies, the influence of religion, the public attitudes to sexuality, class divisions and drug use strategies. These make it dangerous to attempt to transfer, without modification, something which appears to work in one society to another.

How much more so is that true of a society with a significantly different culture, such as Thailand. Even as between Thailand and Cambodia, as I have found, it cannot be assumed that strategies are necessarily exportable.

the western model

Without indulging in excessive self-congratulation, I believe that the national HIV/AIDS strategy of the Australian Federal Government has been one of the most successful. The ministers were interested and committed. They turned up, without fail, to conferences such as this. In part, this can be attributed to a rare political chance that when the HIV/AIDS epidemic came along the Federal Health Minister (Dr N Blewett) was particularly enlightened and his opposition counterpart (Dr P Baume) was equally so. This led to the speedy acceptance of Federal Governmental responsibility in Australia to give leadership to the nation and to Australian society, despite the fact that health matters were principally, under the *Australian Constitution*, the law-making responsibility of the States. Fortunately, State governments, in a rare response of apolitical unity, accepted the Federal lead. Thus, whereas in 1983 approximately three thousand infections occurred, the rate of infection declined rapidly in the following five years. Yet each new year produces young recruits for risky sexual and drug using activity to whom the messages of reinforcing warning and education must be given. The object of the Australian strategy is to reduce the annual sero-conversion to a maximum of 300-350 per year by the year 2000. It looks as if this object will be achieved.

The guiding principles accepted by the Australian government[8] reflect the 1986 *Ottawa Charter*:

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Transmission of HIV is preventable through changes in individual behaviour. Education and prevention programmes are necessary to bring about such changes;

Each person must accept responsibility for preventing themselves becoming infected and for preventing further transmission of the virus;
.
The community as a whole has a right to appropriate protection against infection;
.
The law should complement and assist education and other public health measures;
.
Discrimination against HIV positive people must be eliminated and their human rights protected;

Public health objectives will be most effectively realised if the cooperation of people with HIV infection and those most at risk is maintained.[9]

The Australian Government strategy has involved the establishment of Federal and State AIDS bodies; support for relevant non-governmental organisations and volunteers and subventions for scientific, medical and healthcare professionals. The educational and

prevention programme has included messages addressed to the general public as well as to particularly vulnerable groups. These messages have been constantly reinforced and evaluated for their effectiveness. Research has included enquiries into medical treatment but also into education strategies and study of the typical circumstances of seroconversion. There is also an active international programme to share Australian experience with its neighbours in Asia and the Pacific and to learn from their experience.

In addition to such governmental strategies, mention must be made of the social responses which have occurred in the wake of the epidemic. In a number of cases, magnificent support was given by hospitals and other healthcare institutions suddenly faced with a major challenge affecting mainly young people becoming profoundly ill with repeated serious illnesses. Carer institutions of wonderful humanity sprang up to sustain the sick in their homes. In the primarily affected communities, particularly amongst gay men, there was a response of rare unity. In fact, the epidemic was turned, in Australia, into an instrument to combat discrimination and to demand equal rights for homosexuals and bisexuals. Even stigmatised sex workers and IV drug users acquired their public representatives who called for reform of the law and social attitudes, in part because it was right and in part because it was necessary to combat the spread of HIV. There have also been outstanding groups, mobilised into action by the epidemic. People Living with HIV/AIDS. The angry voice of ACTUP with its legitimate demand for a greater sense of urgency. The representatives of women's groups and of Aboriginal and Torres Strait Islanders who are so vulnerable to the epidemic in Australia.

Legislation continues to be enacted both by the Federal and State Parliaments of Australia. Thus to overcome the provisions of the Tasmanian *Criminal Code*, which remain the only criminal legislation in Australia which continues to punish consensual adult sexual conduct, the Federal Parliament enacted the *Human Rights (Sexual Conduct) Act* 1994 (Cth) based on an international human rights treaty. The New South Wales Parliament in the same year enacted the *Anti-Discrimination (Amendment) Act* 1994, s 49ZXC which makes it an offence, by public act, to incite hatred towards or serious contempt for a person or persons on the ground that they are (or are thought to be) infected with HIV/AIDS.

This AIDS paradox works because, for effective behaviour modification, it is central to governmental and social responses to HIV/AIDS that for those whom you would target you must first gain their confidence and attention. Alienation, stigmatisation and even criminalisation put the vulnerable out of the reach of society. If we are serious about governmental and social strategies of prevention we must engage and actively involve the vulnerable and their communities. Only in that way will we get into their minds for the crucial act of behaviour modification at a moment of pleasure that will cause them to protect themselves - and by protecting themselves to prevent the spread of the virus to others.

developing countries

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As a result of my work as Special Representative of the Secretary-General for Human Rights in Cambodia, I have secured a rare insight into governmental and social responses to the epidemic in a developing country. Until the elections sponsored by the United Nations (UNTAC), Cambodia was largely isolated from the world. Its terrible suffering, revolution, genocide, invasion and civil wars to some extent cut Cambodia off from HIV/AIDS. But no longer. Now the cases are spreading rapidly. The first testing of the blood supply in 1991 found less than 1% HIV positive. In every successive year there has been a 1% increase. The Government has established an inter-Ministerial Committee. But total funding for healthcare and education is extremely low, only $1 per head per annum. The monitoring of the national blood supply was, until recently, inadequate. A particular phenomenon of non-formal medicine, including the administration of glucose and like injections with unsterile equipment, presented grave risks of the rapid spread of the virus. In several hospitals, and even amongst private medical practitioners, reports were received of the use of unsterile needles by workers untrained in the risk of HIV/AIDS.

In a well-meaning response to the realisation of the sudden increase in the spread of the epidemic, the Cambodian Government ordered police to close brothels on the perimeter of Phnom Penh, the capital. Obviously, this did not stamp out prostitution. It merely helped to drive it temporarily underground. It made sex workers vulnerable to official oppression and bribery, distancing them from educational messages and provision of condoms. In the name of sexual modesty, the government has also censored media advertisements calling attention graphically to AIDS, its causes and means of prevention. Such messages continued to come into Cambodia in foreign language broadcasts and journals. But not in Khmer. The combined United Nations agencies concern to tackle HIV/AIDS and to assist the government and Cambodian society in prevention were frustrated by a general lack of willingness to discuss the issue openly and candidly and to take action in accordance with the AIDS paradox.

Tackling HIV/AIDS in Cambodia is a high priority of my human rights mission for the United Nations. The right to life is central to United Nations human rights instruments.[9] Those instruments require that that right shall be protected by law. They also require protection of the health and well being of every individual including in their working conditions.[10] These fundamental rights bring HIV/AIDS within my mandate. With the full cooperation of the United Nations agencies and the inter-Ministerial Committee, I have endeavoured to give a new impetus to effective governmental and social responses to HIV/AIDS in Cambodia. Fortunately, HM King Sihanouk has lent his entire support to my endeavours. At last report, I understand that a number of my recommendations are being put into practice.

I do not pretend that AIDS is an easy thing to tackle in a society with quite strict taboos on open discussion of sexuality, as Cambodia has. In this respect, Cambodia is quite a contrast to its neighbour, Thailand, where we are meeting. Some only of the magnificent strategies pioneered in that country by Dr Mechai Viravaidya would work in Cambodia. The lesson is that in each country, governmental and social strategies must be adapted to the community affected. But clearly there is a need, by dramatic strategies and urgent interventions to arrest

the apathy about HIV/AIDS which is the product of Cambodia's earlier isolation. Unless a much more dynamic approach is adopted, Cambodia runs the risk of exposure to a killer even more lethal than the Khmer Rouge in year zero.

conclusions

This paper has pointed to the role of government and of society of law and respect for human rights in preventing the spread of HIV/AIDS. In the face of such an epidemic people in society demand immediate and even draconian action. Those who know about HIV/AIDS must explain to lawmakers and policy leaders the complex nature of the epidemic and its principal vectors. They must win acceptance of the principle that all laws and strategies must be based on sound data, particular to the society concerned. All such laws and strategies must take into account the AIDS paradox. This teaches that, in many case, the best policies to attain essential and necessary behaviour modification are those which are addressed to removing the impediments of discrimination and alienation that often stand between the groups vulnerable to the penetration of HIV/AIDS and the necessary educational and behavioural strategies to prevent the spread of the virus.

By rare political unity and social mobilisation, the Australian response to the epidemic has been comparatively successful; although much remains to be done and constant reinforcement is essential. The activities of community groups, in a generally supportive governmental and social environment, have been an important part of this strategy. These phenomena are not easily exported to other societies. But their lessons can be taught.

By contrast, in Cambodia and in many other countries of this region, there are many impediments to adopting an effective governmental and social response to HIV/AIDS. Knowledge of the existence of the virus is widespread. But, faced with so many other challenges, governmental and social responses remain generally primitive. Countries such as Britain, the United States, Thailand and Australia have a responsibility to share their experiences with countries such as Cambodia and other countries of the Asian region. Preventive strategies, if they are to work, must be adapted to the society targeted and its cultural, religious and political norms.

The universality of the challenge, and of the fundamental human rights which are imperilled, makes it essential that we continue to share our experiences and learn from each other.

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. Personal views

1. See United Nations, Economic and Social Council, *Report of the Special Representative of the Secretary-General on the Situation of Human Rights in Cambodia* (E/CN.4/1994/73, p 30);

ibid, Report of the Special Representative of the Secretary-General for Human Rights in Cambodia (E/CN.4/1995/85/add.1, p 4).

2. 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.

3. 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.

4. *Ibid*.

5. See P Pogano, Quarantine Considered for AIDS Victims" (1984) 4 *California Law* 1; M D Kirby, "AIDS and Law" (1989) *Daedalus* "Living with AIDS, Part II", vol 118, no 3, 101, 109f; M D Kirby, "AIDS Legislation - Turning up the Heat?" (1986) 60 *Aust LJ* 324, 327.

6. J Godwin *et al*, *Australian HIV/AIDS Legal Guide*, second ed, Federation, Sydney, 1993, 367.

7. *Public Health Act* 2903 (NSW), s 29A.

8. Australia, *The National HIV/AIDS Strategy 1993-94 to 1995-96*, Canberra, AGPS, 1993, 10.

9. *Universal Declaration of Human Rights*, Article 3; *International Covenant on Civil and Political Rights*, Article 6.

10. *Universal Declaration*, Article 25; *International Covenant on Economic, Social and Cultural Rights*, Article 7(b).

11. Act V, sc 3, 324