

HIV/AIDS and law reform in the Pacific

JUSTICE DANIEL V. FATIAKI *

Introduction

The HIV/AIDS pandemic has continued to be the subject of global press coverage. No other health or medical phenomena has galvanised the public's imagination and fear to the same extent. At the same time HIV/AIDS has also brought out the worst of the human ignorance, irrationality and outright prejudice. Faced with what appears to be a death sentence for humanity, substantial funding and expertise has been directed at finding a cure - but there is nothing on the horizon - indeed even the prospect of a vaccine seems remote. In the Pacific, we may have been accused of complacency in responding to the problem because of our relative isolation and perhaps the perception that *"it couldn't happen here"*. The statistics speak for themselves - there is an increase in case reporting and the trend will no doubt continue. The opportunity to take stock, weigh all the issues involved and carefully consider what is appropriate for each of our individual nations now presents itself. The issues are substantial and involve constitutional, ethical and human rights considerations. Underpinning all these is the balancing of the rights of individuals with HIV/AIDS against the rights of society as a whole.

The Fiji situation: a case in point

In my position as Acting Chairman of the Fiji Law Reform Commission I am not here in my usual capacity - to judge. We in the Pacific have taken little, if any action on the legal problems associated with all aspects of HIV/AIDS. The International and Comparative Law Quarterly Volume 43/1994 states that *'law reform, particularly in the health field, has been subject to procrastination, bringing in its wake a*

reluctance to enforce what is in place and a total disregard of the role of law in the health sector ... the two priorities in the health law field are to review and update the laws and to allocate adequate resources for their effective implementation'.

The role of legislation as part of an overall strategy has been largely unrecognised and untapped. We have the opportunity for a multi-disciplinary approach to begin to come to terms with the problem. The legal, moral, psychological, religious and cultural aspects of the problem needs to be addressed.

“Underpinning all these is the balancing of the rights of individuals with HIV/AIDS against the rights of society as a whole.”

In Fiji, as in most Pacific countries, there is no HIV/AIDS - related legislation. Our health legislation is a product of our colonial legal legacy with its primary focus being the control of infectious diseases through

public health provisions. Its applicability to the situation today is questionable. *'Infectious disease'* is defined in the Fiji Public Health Act Cap III to mean *'any disease enumerated in the First Schedule and any other disease which the Minister may declare temporarily or permanently to be an infectious disease within the meaning of this Act.'*

This legislation first came into force in 1936 with several amendments since then, the last being in 1977. That was before the first reports of HIV/AIDS. HIV/AIDS is therefore not listed in the First Schedule. Conditions such as Cholera, Plague, Food poisoning (chemical or bacteriological), Smallpox, Typhus, Yellow Fever, etc remain on the schedule and require immediate notification. The schedule also stipulates diseases that require weekly notification such as Brucellosis, Dysentery, Tuberculosis, Venereal Diseases, Dengue Fever, Chickenpox, Influenza and Measles. Upon diagnosis of a Venereal Disease the law, as it stands, imposes mandatory examination and treatment, forbids employment in certain industries and makes it an offence for the affected individual to infect another be it *'wilfully or by culpable negligence'*.

These latter provisions are essentially punitive requiring isolation and therefore, have the potential or deterring individuals from seeking diagnosis and treatment. If HIV/AIDS were added to the schedule, under the present law,

* Acting Chairman, Fiji Law Reform Commission, Suva, Fiji. Paper presented at HIV/AIDS Law and Law Reform Workshop, Fiji Mocambo Hotel, Nadi. 22-25 May, 1995

these provisions would have to apply in a similar manner. The important distinction here is that all the conditions named are treatable but for the time being HIV/AIDS is not. The Act goes on to define "persons subject to isolation" to mean "persons suffering or suspected to be suffering from any infectious disease or who may otherwise in the opinion of the Permanent Secretary or of a medical officer of health be or become sources of infection with an infectious disease". In the latter part of the 20th century there is a strong body of opinion which feels that classifying HIV/AIDS in this manner is counter-productive to its effective detection and control.

The role of the law is, in the final analysis, a policy debate resulting in a legal (regulatory) response to the HIV/AIDS pandemic. The debate will focus on public health versus individual rights. I am sure that the relative weighting placed on each of these mirrors the behavioural characteristics of individual societies and cultures.

Law making and law reform are relevant to an understanding of how best to manage the interests of persons with HIV/AIDS and the interests of society at large. In this regard there is a need to clarify and redefine legal rights and thus the need to reform the law as it stands. Concepts that served society well in the 1930s may not be relevant as we approach the millennium. The approach to patient management and the technology involved has changed so dramatically during this time that a new legal framework is required.

In order to address the law reform implications of HIV/AIDS I have identified certain areas for consideration and I might add that this list is not exhaustive. There are:

- Privacy and confidentiality;
- Public health issues;
- Society: culture and attitudes;
- HIV testing; and
- High risk groups and discrimination.

Privacy and discrimination

The issue here is disclosure. The common law provide for some protection of privacy. The special relationship which give rise to a 'duty of confidence' are not absolute and may be over-riden or limited by statute. In Fiji there are examples of persons with HIV/AIDS finding out that personal information is disclosed or made available to those who have no conceivable right to it. The full implications of confidentiality are not grasped or practised by medical and health workers or those in positions of trust.

The concept of individual rights needs to be addressed in the local context where group and societal rights are often paramount. In a society as small as our island states, it is imperative that we respect the privacy of those who request or need it, even if this may seem to run counter to what we accept as the cultural norm.

The arguments **against** upholding this confidentiality has been put forward in the medico-legal literature and is referred to as the "*Tarasoff doctrine*". This states that where another person's safety is at risk the duty of confidentiality must be breached. Justice Clark, in his dissenting opinion, put forward the following counter arguments based on public policy:

“ Law making and law reform are relevant to an understanding of how best to manage the interests of persons with HIV/AIDS and the interests of society at large. ”

- without substantial assurances of confidentiality those seeking treatment will be deterred from seeking assistance;
- the guarantee of confidentiality is essential in eliciting the full disclosure necessary for effective treatment; and
- an assurance that the confidential relationship will not be breached is necessary to maintain the patient's trust.

These ethical arguments are not new and present the perennial practical problem of who does or does not pose a risk and the legal limits of duties of confidence. Value of judgements by those qualified and not so qualified continue to be made in the public interest. It is perhaps timely for this issue to be re-examined and laws and policies clarified so that the courts, the health professions and others involved in the care of persons with HIV/AIDS can be given guidance on this issue.

Public health issues

The common long-standing approaches to any public health threat is based upon the notion that the rights of the infected or at-risk individual must be sacrificed for the rights of the wider community. This suggests that the two rights are inevitably in conflict or irreconcilable and that one has to be subservient to the other. But what is increasingly emerging is the consensual view that the interests of the wider community is dependant upon respects for the rights of the affected individuals. Instead of being confrontational or demanding human/individual rights above all else, it would be more constructive to acknowledge that preventive measures reduce the spread of HIV/AIDS and will ultimately save lives and money. Treating the survivors of the epidemic costs far more in economic and social terms than primary prevention.

The present law copes with these public health issues by stipulating that a disease is infectious and therefore notifiable or by defining the disease as quarantinable under the Quarantine Act Cap 112. HIV/AIDS is not included under either classification. Public health arguments have also been used to justify the prohibition of certain immigrants. Section 11 (2)(d) of the Immigration Act Cap 88 prohibits any person from entering Fiji if he or she has refused to submit to an examination, test or investigation by a Government medical officer, or who at the time of entry into Fiji is certified to be suffering from a contagious or infectious disease. HIV/AIDS in this country is not classified as such under Act but some countries in the region have done so under similar legislation.

Methods of control such as quarantine and social marginalisation are the traditional response of a health care system that has evolved in developing countries. In Fiji our public health system has slowly changed since the advent of the HIV/AIDS epidemic. There is little recognition of the *individual's* rights in the existing system which is essentially geared to dispensing health to the masses.

Society, culture and attitudes

The media can be accused of sensationalism. To some extent it has promoted the image of HIV/AIDS as a disease of sinners, homosexuals, prostitutes and intravenous drug abusers. This reflects society's desire to attribute blame and laments the negative aspects of modern culture. However it is essential to realise that beliefs, traditions and laws are not sufficient in themselves to produce or alter behaviour. This lies in the province of individual decision making. A non-judgemental attitude and cultural sensitivity to special needs are important cornerstones in the process of law reform.

It is vitally important to recognise that law impacts on patterns of economic support, access to health care, legal aid and education in reducing reliance on sexual activity as a source of income. The process of law reform must therefore involve socially disadvantaged groups and those persons with HIV/AIDS. This would help redress the non participation of these groups in the formulation of laws. Laws ultimately reflect the social and cultural values of our society and law reform can be a very effective catalyst for changing society's values and attitudes.

The impact on the family

The reality in Fiji and many Pacific countries is that there is no state run or funded social welfare system. This gap is filled by the family. With increasing urbanisation however there is a trend away from the extended family to a more nuclear structure with a corresponding loss of a broad family network of care and support. The ability to cope with change and adapt to what may be considered drastic changes such as HIV/AIDS will have a significant effect on our concept of the family.

Any law reform will consider this group membership and its important support mechanisms. These mechanisms however will not doubt change with time and therefore the law will have to be flexible to take this into account.

HIV testing

The issue of testing for HIV is contentious and yet the detection and control of the spread of the virus is largely dependant on it. For testing to be carried out effectively, counsellors have to be specially trained, laboratory resources made available, procedures clearly defined and specific funding earmarked. The justification for testing is that early identification of an infected individual allows counselling and management to begin as soon as possible (in fact counselling should begin before an individual has undergone the test). The necessary modification of behaviour and lifestyle together with further testing of contact individuals can then begin. The flow on effects of a positive test has both short and long-term planning and resource allocation implications. All this is put into perspective by the fact that an individual

may be most infectious even *before* his HIV blood test changes from negative to positive (Window Period). This highlights even more the importance of public education to prevent primary exposure to the virus.

In formulating public policy on HIV/AIDS the type, role and indications for testing of individuals need to be stated explicitly. The question of who to target and whether testing should be mandatory or voluntary has to be addressed. For immigration purposes, some countries already demand mandatory testing. Could the tourism industry survive such a requirement? Furthermore there needs to be consensus on who should have access to the information. Should the sexual contacts of affected individuals have an automatic right to know? The argument here is that information empowers individuals such as partners to minimise high risk

“ Instead of being confrontational or demanding human/individual rights above all else, it would be more constructive to acknowledge that preventive measures reduce the spread of HIV/AIDS ... ”

behaviour. In anonymous testing only the affected individual and the counsellor know the identity and result of the test. This is the model which is accepted in many Western countries. Public health officials will argue that access to information is required because of the need to allocate resources and determine the effectiveness or otherwise of educational and preventive programmes.

The testing of donor blood is vital for the control of HIV/AIDS and is an area which has given rise to much litigation. Donated blood is subjected to mandatory HIV screening which is usually anonymous. A distinction has to be drawn however between testing the donated blood and the actual donor.

Testing for HIV, even if the result is negative, often results in a series of adverse outcomes. For example, the act of merely taking an HIV test may result in loading of a life insurance policy or even its rejection. There are well documented cases of individuals being subjected to various discriminatory practices because of taking the test. It seems counter-productive than an act which may lead to the long term control of HIV/AIDS is rewarded in this manner. All the issues raised have to be taken into account for legal and administrative reform.

High risk groups and discrimination

Certain groups in society have shouldered a disproportionate burden of the HIV/AIDS epidemic. These include homosexuals, prostitutes and intravenous drug abusers who were, and still are, subjected to official and unofficial discriminations. An alarming increase has been noted in the number of affected women including those who are pregnant. When HIV/AIDS first surfaced 'high risk groups' were identified and targeted for educational intervention in order to control the epidemic. Certain key factors which resulted in an increased risk of exposure were identified. The groups were given this information which empowered them to minimise high risk behaviour and reduce the chances of acquiring the virus.

Now that HIV/AIDS is also firmly entrenched in the heterosexual population a similar strategy has to be employed for prevention and control in women, babies and children. As this group of individuals are usually **passive** and almost always involuntary recipients of the infection and tend to be less heterogeneous, the strategy for prevention in these cases may have to shift from identifying high risk group to identifying risk **factors**. The passive acquisition of the HIV virus, especially in babies and children, could lead to drawing of a distinction between the **infector** and the **infected**. Any attempt at law reform will have to take this

into account, especially where it may impact on criminality. In addition, the increase in the number of so called innocent victims has led to a focussing on broader constitutional issues. Most constitutions and laws includes the right to life but with the advent of HIV/AIDS they may need

to be amended to stipulate the right to live with dignity and health. In other words there may need to be constitutional safeguards to protect those who are vulnerable and to provide legal redress should they be subjected to acts of discrimination.

Conclusion

Each Pacific country will need to implement laws that are specific to their own resources, personnel and socio-cultural setting. I wish to leave you with the message that the law not only exists to control and punish but is a very useful vehicle for effecting change in society. The law cannot determine the life an individual but it can prescribe and proscribe behaviour and thereby protect all vulnerable individuals including those with HIV/AIDS. If I have been able to provoke you I would have succeeded in what I set out to do, if not, then I can only apologise for my limitations.

References

References are available from the author on request □

“ The law cannot determine the life an individual but it can prescribe and proscribe behaviour and thereby protect all vulnerable individuals including those with HIV/AIDS. ”

The claim that HIV/AIDS education promotes promiscuity is pure fiction. Far from encouraging any one set of values or assumptions, safe-sex education is pro-choice — “if you are going to have sex, have safe sex”.

Leanne Joyce, Executive Director AFAO