Every 18 seconds someone, somewhere is infected with HIV. The scale of the epidemic has not been exaggerated. On average, HIV-infected individuals have their immune system destroyed by this virus over a 9 year period, resulting in the acquisition after that time of an immune deficiency state (AIDS). Once defenceless, many organisms may seize upon the opportunity presented and infect an unresisting host in a way that would be impossible, if even meagre defensive forces were available. Patients with AIDS seldom survive for more than two and a half years from the onset of their first opportunistic infection.

During the long incubation period between infection and AIDS, those infected remain well, but infectious. Carriers of HIV can infect another during anal, vaginal and occasionally oral intercourse when infected sexual secretions move from one body to another. Particular cells of the immune system educated in an organ which lies on top of the great vessels coming out of the heart in the chest - the thymus gland - become infected with HIV. The specific cells involved are known as T4 lymphocytes. It is normal for sexual secretions to contain significant numbers of T4 lymphocytes. In an HIV-infected individual those T4 lymphocytes will contain virus. T4 cells are also found in blood and breastmilk, the only other biological fluids that are infectious in an HIV-infected individual.

Within three months of infection, virtually 100% of patients develop telltale antibodies in their bloodstream that reveal their infection and infectiousness. Commonly, such individuals are said to be "HIV-positive". HIV is never contracted during social intercourse. One cannot be infected by HIV from mosquitos, toilet seats, sitting next to an infected individual on an aeroplane, sharing household utensils or non-sexual intimacies such as the hugging and kissing enjoyed by friends and family members.

There is no vaccine to prevent infection and no cure. Twelve million people are now infected and that number is likely to reach 40 million by the Year 2000, unless successful intervention strategies are introduced urgently. The Asian region is destined to have more infected people than any other area but currently, it is Africa that has the most infected individuals. More than one million Americans are infected with HIV. Eighty per cent of the 12 million infections thought to have occurred so far have been contracted during vaginal intercourse. Overwhelmingly, HIV infection is a heterosexually-spread disease. Ten per cent of cases have been contracted through infected blood while 6% of cases have occurred in homosexual men. Anal intercourse is an effective way of spreading the infection particularly to the passive partner but it is obvious from the above figures that it is sexual activity, not sexual preference, that spreads HIV. The AIDS pandemic is composed of a series of mini-epidemics. The major reservoir of the virus in San Francisco is in gay men, but in India and increasingly elsewhere, it is in heterosexual women.

Prevention strategies known to be successful when implemented intelligently involve two major programs. For those as yet uninfected, educational messages that personalise the
information have a chance to moderate potentially dangerous behaviour and are all important. For those already infected, education that helps them to realise that their lifestyle or medical encounters (for example, a blood transfusion) may have put them at risk of infection is critical. In the western world, HIV infections remain pocketed in particular high-risk groups and it would not be cost-efficient to test everybody to find all those infected. Such a strategy, which unfortunately is desirable in some developing countries, is impractical because of the cost involved. Thus, in both the developed and developing worlds, we are totally dependent on having those people who may have been infected realise that fact and come forward for testing and counselling. Ten years of study make it perfectly clear that the vast majority of those who know they are infected will not infect anybody else.

That same ten years of experience tell us that individuals will not come forward to be tested if they feel that in so doing they will subject themselves to discrimination (he must have done something wrong or why would he want to be tested?) and breaches of confidentiality that will often result in the subsequent loss of family, friends and often, employment. If ignorance, prejudice, a judgmental attitude and the withholding of the compassion that eases pain confront the individual found to be HIV-infected, suffering is added to immeasurably and so too, is the suffering of the society in which such people live. The AIDS epidemic highlights (in a unique manner) the truism that countering discrimination not only protects individuals but entire societies. Public health policies and any laws that might strengthen those policies must focus on the creation of an environment that facilitates voluntary testing programs.

Superficial observers of the AIDS scene frequently ask why HIV/AIDS is not treated like 'other diseases'. Usually it is other sexually-transmitted disease that are the subject of the query. Sometimes people refer back to the well-remembered campaigns of the 50's where many, quite appropriately, were required to have chest x-rays and perhaps a period of isolation if found to be infected with tuberculosis. Why are we not equally vigorous in searching for HIV-infected individuals? Why not hand over of the names of those infected to public health authorities? Why not quarantine those who are infected to prevent them from infecting others? In many western countries where homophobia is far more frequent than HIV infection of homosexual men, it is often suggested that health authorities are being 'soft' on HIV-infected individuals because homosexual lobby groups have "hijacked the public health agenda".

There is no tradition in public health for isolating infected individuals unless they can infect others through casual contact. To quarantine someone because somebody else, usually of their own free will, might engage in behaviour that would see them infected with HIV makes no sense, violates human rights and is impractical. Only Cuba has a policy of quarantining those found to be HIV-infected. Where would a country house its thousands of HIV-infected men, women and children? For how long would they be incarcerated? Quarantining someone who by inadvertently coughing over a group of people in a crowded train may infect many with tuberculosis makes sense. Quarantining those infected with HIV does not. In fact, any such attempts may only delude those whose behaviour puts them at risk that quarantine laws are protecting them from an encounter with an HIV-infected individual. The nonsense of such an argument is further compounded by the realisation that infected individuals can be infectious but not have tell-tale antibodies in their bloodstream for three months after infection. The strict adherence of an isolation policy would require the entire population to be tested every three months.

AIDS is not like any other disease of modern times. You have to look back to the fear, ignorance and prejudice that added so much to the suffering of people with leprosy in
earlier centuries to find a parallel. Ironically, leprosy also had a totally undeserved reputation as a highly infectious disease. If Jack contracts syphilis and tells his friend Bill about his painful penicillin injection, Bill's reaction is likely to be a slap on the back or a punch on the arm while with a wink he exclaims "Jack you rascal you!" The exact same behaviour that may see someone infected with HIV may result in that person being despised, ostracised, regarded as evil and subjected to discrimination.

A country doctor received a notice from the Red Cross Transfusion Service, recommending that his patients who were transfused with a blood product between 1980 and 1985 be tested for HIV; the risk of infection for any individual was low but finding those infected was important. When Tom came for his annual check-up, his doctor ordered an HIV test for antibodies to HIV, but Tom was not informed as the doctor did not wish to worry him. Tom had been given a blood transfusion in 1983 after a car accident. Two weeks later, on a Friday afternoon, the doctor was amazed to receive the news that Tom was infected with HIV. He called Tom on the telephone and spoke to his wife Mary for Tom was still working in the fields. "Mary" he said "You are going to have trouble believing this, but Tom has AIDS". Tom in fact did not have AIDS, he was infected with HIV. A shocked Mary turned to her friend Susan who was in the kitchen at the time and said "Oh my God Susan, Tom's got AIDS". She continued her conversation with the doctor who suggested that both Tom and Mary should come and see him on Monday, when they could discuss what it all meant.

There were many tears in that family that night and when Mary went to shop at the supermarket in town on the Saturday morning, an embarrassed store manager asked her if she would shop elsewhere. The news that Tom had AIDS was all over town. Tom did not have adequate life insurance. He would lose his property, lose his friends and lose his respected position in his small community. This case illustrates why it is so important that informed consent be obtained before HIV testing, why results should never be given to patients over the telephone, how cruel communities can be if they are ignorant and uncaring and how we must continue to strive to make sure that the medical profession is adequately educated about this disease.

Robert had been infected with HIV for three years when he needed some dental care. He visited his dentist, who had an office in the city building where Robert worked as a middle-level executive with an accountancy firm. Robert told his dentist he was HIV-positive. The work was done and Robert returned to his office. Subsequently, it was revealed that the dental nurse heard Robert's conversation with his dentist and in one of those "Now-Jane-you-won't-tell-another-soul-will-you-but-can-you-believe-that" type stories, the dental nurse told another person of Robert's problem. The second person told a third and when Robert arrived at work the next morning, he found his desk in the corridor outside his firm's offices. Although anti-discrimination laws prevented Robert from being fired, his working conditions soon became intolerable and within six weeks he gave up the fight and escaped from his sufferings by jumping off the top of that very same building.

In Kentucky a prisoner found to be HIV-positive is burned to death in his cell by terrified inmates. In Florida three little HIV-infected children appeal to the courts for help when parents at their local school refused to allow them to attend. The court rules in their favour and the parents and friends association reluctantly acquiesce, but purchase a caravan that they place at the back of the schoolyard. Each day when the children come to school, they must attend classes in the caravan where volunteer teachers attend to them. In some parts of India, a law is current that allows HIV-infected individuals to be locked up without trial indefinitely. AIDS is not just another infectious disease.
Lawyers do have a major role to play in reducing the human and socio-economic toll associated with 10,000 of us being infected with HIV every 24-hours. For all the reasons described above the protection, and in much of the world, the institution of basic human rights may well decide who wins the battle between HIV and humans. If this is a championship fight, we are in Round 10 already and well behind on points. Those who trivialise human rights are helping to fuel this epidemic.

In India, it is certain that unless the status of women is promoted, improved and protected, it will be the country most affected by HIV. Increasingly, it is women and their children especially, but not exclusively in the developing world, who are suffering the worst of this epidemic. HIV could be referred to as the 'poverty' virus for increasingly inequalities related to gender, race and wealth are contributing to the spread of HIV. Clearly, there is a vicious cycle involving poverty, hunger, the desire to feed one's children, drugs and entrance into the world of commercial sex that fuels the epidemic.

An apparent dilemma is currently injected into many legal discussions of the way AIDS may be minimised using legal manoeuvres. "How can we protect the rights of the individual and simultaneously protect the rights of society when a fearsome epidemic is upon us?" In fact there is no conflict at all. At the moment the only way to protect society is to protect the individual. Punitive laws, which their designers hope will protect society, do exactly the opposite if they prevent us from building a bridge to reach commercial sex workers, drug-users and, in many a society, gay men who in their disenfranchisement are particularly vulnerable to HIV. Women who have no rights when it comes to negotiation in a sexual situation are unable to protect themselves against HIV. For them laws such as those dealing with rape within marriage, the age of marriage, or indeed the age of sexual consent, become particularly important.

Only laws that establish and protect a supportive environment for people affected by the epidemic contribute positively to the fight against AIDS. Health officials should frequently sit down with lawyers to look at any existing legislation that is hindering efforts to stop the spread of HIV. Often, the removal of unenforceable and destructive laws is far more important than the introduction of new measures. For example, in a number of countries there are laws that restrict the availability of condoms and condom promotion. Laws may determine what can and cannot be discussed in the media. If such laws interfere with the dissemination of safer sex information, they are destructive in the context of the HIV epidemic. Laws that make it difficult to commence needle and syringe exchange programs need urgent attention. Using what many people would regard as a "lesser of two evils" approach, a very effective strategy has been developed that, when implemented, minimises the rate at which HIV infection increases among intravenous drug-users. It is the equipment used by intravenous drug-users, not the drugs, that spreads HIV. Giving them clean needles and syringes will facilitate the fight against HIV. The contact between drug-user and the supplier of needles and syringes they require has had very positive effects, often leading to the establishment of self-help groups among drug-users and diversion of many into a methadone program.

Laws which proclaim homosexual acts to be criminal offences represent legal barriers to better public health policy. Misguided laws related to the immigration and travel of HIV-infected individuals in the United States have had serious side-effects. A major
international meeting on HIV was moved from Boston to Amsterdam simply because of such laws. America has a far more significant AIDS problem than Holland.

Many conferences in many countries have resulted in HIV-infected individuals producing declarations which specify the rights of people infected with this virus. The law can most certainly play a role in ensuring that legislation does protect the rights demanded for example the right to privacy, the right to protection against unlawful search and seizure and the right to protection against unlawful detention. The true incidents related above surely emphasise the need for anti-discrimination laws that can act as a deterrent and help us redress wrongs done to people who are so often and so cruelly denied employment, housing, access to health care, etc.

**Prisons**

No discussion of AIDS and the law should ignore the problem of HIV spread in prisons. Conditions in prisons are conducive to the spread of HIV. Shared needles and failure to adequately clean injecting apparatus are the norm in prisons and injecting drugs of various kinds is common. Anal intercourse is less common than intravenous drug use, but when it occurs it is nearly always unprotected and sometimes accompanied by violence and lack of consent. Overcrowding of prisons is a growing problem which favours these activities. While these problems should be addressed regardless of HIV, its presence in the prison population makes action particularly urgent.

Prison officers and administrators are placed in an impossible situation when prisons are overcrowded, when resources are inadequate and they are expected to stamp out illegal sexual and drug using behaviour. The fact is that they are unable to do so, and this difficulty they share with every prison system is the Western world.

Under these circumstances, there must be a recognition of the need to minimise harm. A lesser of two evils approach recognises that illegal activities are going on in prisons and that prisoners ought to have both the knowledge and the capacity to protect themselves against HIV infection. There is, both for society and for individual health and prisons workers, a serious practical dilemma in making the means available to prisoners to do this without appearing to sanction what is very often illegal behaviour. And yet, if the public health problem is to be seriously addressed, those engaging in these behaviours in prison should have access to condoms and to bleach for cleaning injecting apparatus.

The obligations of prison authorities to provide prisoners with access to reasonable medical care and treatment necessary for the promotion and preservation of health should be set out in legislation.

In developing supporting policies, the following issues need to be included:

- Provision of extensive and continuing education about HIV transmission to prisoners and prison officers;
- Prisoner access to condoms combined with appropriate condom disposal systems;
- Provision of access to appropriate sterilising material and information about sterilising injecting equipment;
- Access to a range of drug treatment programs including methadone;
- Provision of access to medical treatment at the same standard as that available to those outside prisons; and

- Information on HIV status should be recorded separately from other prisoner details. Prison authorities should be responsible for devising systems to keep this information secure.

Prison authorities should not be immune from liability for breaches of common law or statutory duties.

In most societies, lawyers are particularly influential not least because of their interest in and capacity to become involved in legislative processes. Without doubt, informed lawyers can do more than most to argue for sensible laws and policies and help communities generate the appropriate response to this epidemic.

Justice Michael Kirby at the 1st South African Conference on AIDS and the Law in June 1992, talked about lawyers and the AIDS epidemic and noted "our eyes should be bright with the resolve to do practical things to slow down 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". At this moment, in many countries, HIV has put basic rights at risk and therefore the protection of those rights matters enormously.