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INTERNATIONAL HEALTH LAW, INTERNATIONAL TRAVEL RESTRICTIONS, AND THE HUMAN RIGHTS OF PERSONS WITH AIDS AND HIV

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I. INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS), which is caused by the Human Immunodeficiency Virus (HIV),[1] is a global epidemic because it does not respect international borders. Cases of HIV have been reported in at least 138 of 176 reporting countries[2] and in 45 of the 46 countries in the Western Hemisphere.[3] However, as Professor Rob-

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1. PANOS INSTITUTE, AIDS AND THE THIRD WORLD 1 (1989). Although AIDS and HIV are commonly used interchangeably, technically AIDS refers only to the final stages of HIV infection where a collection of 70 or more conditions which result from damage to the immune system and other parts of the body become visible. *Id.*

2. *Id.* at 29.

3. Quinn, Zacarias, & St. John, *AIDS in the Americas: An Emerging Public Health Crisis*, 320 NEW ENG. J. MED. 1005 (April 13, 1989) [hereinafter *AIDS in the Americas*].

ert Jarvis has observed, "[w]herever there are people, there is AIDS,"[4] and countries that have not reported a case may report their first cases at any time. It may well be that some of these countries are afflicted with cases of AIDS and HIV which go unnoticed or unreported for a host of reasons: medical personnel may not be sufficiently trained or experienced to diagnose AIDS accurately; persons with AIDS may not seek medical care for financial or personal reasons, or because such care may not be available; there may be no effective reporting system; the government may not wish to acknowledge the presence of AIDS or HIV infection in order to avoid a panic in the population and a decline of tourism and commercial dealings.

Importantly, HIV infection alone, as opposed to AIDS, is probably not widely investigated or reported. However, attention desperately needs to be focused upon HIV infection because, as the Presidential Commission on the Human Immunodeficiency Virus Epidemic warned,

> The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic. Federal and state data collection efforts must now be focused on early HIV reports, while still collecting data on symptomatic disease.[5]

The HIV epidemic is so widespread that it is a global disease more appropriately identified as a "pandemic." A nation-by-nation analysis fails to convey the full economic and health consequences of this pandemic since countries are in various stages of development.[6] Countries in dire poverty with wholly inadequate health care suffer many other infectious diseases which distort the effects of the pandemic, while in countries enjoying a higher standard of living with more advanced health care its effects are more readily distinguishable.[7]

Nevertheless, while the HIV pandemic presents a major international crisis, individual countries have more immediate problems. Nicaragua, for example, had reported only two deaths from AIDS at a time when over fifty-thousand had died in that country's civil war.

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4. Jarvis, *AIDS: A Global View*, 12 NOVA L. REV. 979, 979 (1988).

5. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, XVII (June 24, 1988).

6. *AIDS in the Americas*, *supra* note 3, at 1005.

7. *Id.*

Widespread starvation constitutes national disasters in some African countries. In other developing nations, malaria, diarrheal disease, malnutrition, and tuberculosis present pressing health problems which also command attention and funding. In Bolivia, more than 40% of the people have no medical services and in the countryside nearly four out of ten children die before the age of five.[8] The search for a global cure for AIDS must not ignore the significant need to promote public health in these and other areas. One positive side-effect of the HIV pandemic may be the development of a more sophisticated and effective system for promoting the general health and well-being of people on a global scale.

The existence of other health or social problems does not detract, however, from the fundamental concept that AIDS cannot be eliminated in any one country until it is cured in all countries. There is a pressing need for international cooperation to advance medical research and health care. International cooperation is also needed to protect the legal rights and human dignity of people with HIV infection, people with AIDS, and people with an increased risk of contracting those conditions. Unfortunately, there is no supranational organization that is legally capable of dictating national health policies or promulgating international laws for public health control and the preservation of human rights and dignity. Consequently, each national government should make the necessary commitments to prevent, control, and deal with AIDS and HIV through humanitarian measures.

Such measures do not have to be costly because education still remains the best tool available to help contain the virus. The poorer nations should not allocate any of their limited resources for research on treatments, vaccines, and cures, but should defer to the wealthy, industrialized nations to lead the way in those areas. While science and medicine are not expressions of absolute truth or perfect knowledge,[9] national health policies should nonetheless reflect the consensus of the global medical community and be informed by epidemiologic, economic, and technological factors.[10] Furthermore, national policies and laws should extend notions of fairness and compassion to each country's treatment of its own citizens and foreign guests.

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8. *Bolivia: Toughing It Out*, THE ECONOMIST, May 13, 1989, at 48.

9. *See* Smeltzer, *The Effects of Liability Fears*, 320 NEW ENG. J. MED. 1221 (May 4, 1989).

10. Bayer & Healton, *Controlling AIDS in Cuba: The Logic of Quarantine*, 320 NEW ENG. J. MED. 1022, 1024 (April 13, 1989).

A. National Treatment of Citizens

Fighting AIDS and HIV rather than acting against its victims has come into general acceptance as the preferred course of public health activity in the United States and other countries, although the practice is often at variance with the theory. Some countries, however, have not embraced this theory and appear to be fighting AIDS and HIV by waging battle against their own citizens and foreign visitors. Three examples are the Soviet Union, South Africa, and Cuba.

1. The Soviet Union

In the Soviet Union, authorities can test any citizen for HIV antibodies at any time and can imprison someone with AIDS for spreading the disease. Infected persons are notified and required to sign statements promising not to spread the disease.[11] In 1987, a Soviet woman who was thought to be seropositive[12] signed a pledge to refrain from sex for five years. If she reneges, she could be sentenced to a prison term of up to eight years. In 1988, another seropositive woman in the Soviet Union was sentenced to four years in prison for defying a physician's orders to refrain from sex.[13] In 1989, twenty-seven school children under the age of twelve were found to be infected because medical staff at a hospital in the Kalmyk capital of Elista had used unsterilized syringes.[14] As a result of this incident, doctors began antibody testing of twelve-thousand local citizens.[15]

In 1987 the Soviet Union also issued a resolution to require "AIDS Certificates" from foreign travelers, but enforcement only began in February, 1989.[16] The test is reportedly limited to those foreigners who

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11. *AIDS Spurs Soviet-U.S. Cooperation*, N.Y. Times, Oct. 10, 1988, at B1, col. 5.

12. A person is said to be "seropositive" or "HIV-positive" if a test reveals that HIV antibodies are present in that persons' blood. Since the virus itself is extremely difficult to detect, blood tests for HIV antibodies is the standard method of determining if a person is an HIV carrier. PANOS INSTITUTE, *supra* note 1, at 5.

13. Advocate, Jan. 31, 1989, at 19, col. 1. *See also Angst vor Aids in der Sowjetunion*, Frankfurter Allgemeine Zeitung, Feb. 22, 1989, at 9, col. 6.

14. *Children in Kalmyk Republic Infected with AIDS*, Radio Liberty, 1 *Report on the USSR* (No. 5), at 44 (Feb. 3, 1989).

15. *Director of Elista Hospital Reportedly Dismissed*, Radio Liberty, 1 *Report on the USSR* (No. 6) at 38 (Feb. 10, 1989).

16. *New AIDS Policy Announced*, Radio Liberty, 1 *Report on the USSR* (No. 3), at 31 (Jan. 20, 1989); *Soviets Say Foreigners Will Need AIDS Certificates*, N.Y. Times, Jan. 12, 1989, at A13, col. 1. The authors are familiar with an Intourist Guide whose arms are full of needle punctures from repeated testing after returning from accompanying tour groups outside the Soviet Union.

want to stay in the Soviet Union for more than three months. People who try to avoid the test may be expelled from the country.[17]

2. South Africa

In South Africa, all foreigners, as well as citizens, may be required to have an HIV antibody test performed on demand, but the measure is reportedly being applied only to foreign black applicants seeking work permits.[18] The South African mining industry imports 40 percent of its workforce from high-risk AIDS countries like Angola, Burundi, Malawi, Zaire, and Zambia.[19] Over two-thousand miners from Malawi tested positive under a compulsory state-supported non-confidential program and were "declared prohibited persons" to be deported.[20] Author Susan Sontag has described AIDS as "a gift to the present regime in South Africa . . . ."[21]

3. Cuba

The world's worst violator of the human rights of people infected with HIV is Cuba.[22] Cuba has implemented a controversial policy of testing every single citizen for HIV antibodies, and isolating those who test positive.[23] As of January 1989, at least 259 Cubans who tested HIV-positive are being held in a guarded sanitarium on a farm outside Havana.[24] Infected persons must leave their homes, uninfected family members, friends, and places of employment to live in housing re-

17. *New AIDS Policy Announced*, Radio Liberty, 1 *Report on the USSR* (No. 3), at 31 (Jan. 20, 1989).

18. PANOS INSTITUTE, *supra* note 1, at 178.

19. Seftel, *AIDS and Apartheid: Double Trouble*, AFRICA REPORT Nov.-Dec. 1988, at 17, 20.

20. *Id.*

21. S. SONTAG, AIDS AND ITS METAPHORS 62 (1989). The government of South Africa is using AIDS as a tool of apartheid. One example is that when hemophiliacs began to develop AIDS in South Africa, the government funded tracing and counseling of only white hemophiliacs who tested positive. *See* Seftel, *supra* note 19, at 21. Another example is the Baragwanath Hospital serving Soweto, where black patients sleep on hospital floors while two-thirds of the fully-equipped 2,000 bed white Johannesburg General Hospital have remained empty for over twelve years. *Id.* at 19.

22. *Cf.* Henkin, Camejo, Hiller, Posner, Ritchin & Roth, *Human Rights in Cuba: Report of a Delegation of the Association of the Bar of the City of New York*, 20 U. MIAMI INTER-AM. L. REV. 211, 215 (1988) (Noting that there is no independent bar in Cuba to protest abuses of human rights).

23. *AIDS in the Americas*, *supra* note 3, at 1007.

24. *Rights Group Reports Continued Abuses in Cuba*, N.Y. Times, Jan. 29, 1989, at 8, col. 1; *see also* W.H. MASTERS, V.E. JOHNSON & R.C. KOLODNY, CRISIS: HETEROSEXUAL BEHAVIOR IN THE AGE OF AIDS, 175 (1988); *Cuba's Quarantine for AIDS*, N.Y. Times, Feb. 6, 1989, at 14, col. 1 [hereinafter *Cuba's Quarantine*].

ported to be a barracks or dormitory-like setting.[25] Those who refuse to cooperate are reportedly hauled into custody with nylon bags pulled over their heads.[26]

The massive national mandatory testing program includes each of the forty-seven thousand Cuban mercenaries returning from duty in Angola, who are incarcerated if their tests are positive.[27] Soldiers, technicians, and foreign aid workers who have contracted HIV in Angola may not manifest symptoms or HIV antibodies until they return to Cuba, where they will be imprisoned as a "reward for their patriotic service."[28] The accuracy of the Cuban antibody testing procedures has only been tested once by international groups and from that test it is estimated that between 21 and 53 persons of the 259 persons who tested HIV-positive may have been mistakenly designated positive as a result of inaccurate testing.[29]

Cuba's theory of public health protection appears to be that by containing the movement of those infected with HIV, Cuba can control the spread of AIDS at least within its own borders. Approximately 140 students visiting from Africa have also been deported after testing positive.[30] Education plays only a limited role in the Cuban public health campaign, while identifying infected persons and bringing them under medical control are central to Cuba's policy.[31] As an island nation the Cuban theory might be "successful" in the eyes of the designers of this plan, but it comes at a great price and cannot be generally applied to other countries or situations.[32] The Cuban theory of isolation ignores the fundamental precept that AIDS cannot be cured in any country until it is cured in all countries. The rationale for the quarantine also assumes that since it is impossible to determine which infected persons can be trusted to behave responsibly, they all must be restricted and treated as a public hazard.[33] Through its own political and moral values, Cuba has decided to defend its society against pathogens rather

25. Bayer & Healton, *supra* note 10, at 1023. While being forced to leave their jobs, however, salaries are reportedly maintained by the government to protect the economic security of the infected individuals and their families. *Id.*

26. *Id.* at 1024 (statement by the executive director of Radio Martí, which is funded by the United States government).

27. *AIDS Spreading Into Border Areas of Angola*, N.Y. Times, Feb. 19, 1989, at 10, col. 1.

28. *Cuba's Quarantine*, *supra* note 24, at 14, col. 1.

29. Bayer & Healton, *supra* note 10, at 1023.

30. Letter to the editor from Jeanne Smith, M.D., and Sergio Piomelli, M.D., N.Y. Times, Jan. 22, 1989, at E24, col. 5.

31. Bayer & Healton, *supra* note 10, at 1022.

32. *AIDS in the Americas*, *supra* note 3, at 1007.

33. Bayer & Healton, *supra* note 10, at 1024.

than criminal or tortious behavior, and has discounted the vitally important role of education.[34]

B. International Travel Restrictions

As part of the attempt to combat the spread of AIDS, the nations of the world now seem to be reverting to a pattern of quarantine and restrictions against international travelers, foreign workers, and foreign students.[35]

1. Examples

In Belgium, "[f]oreign students receiving . . . scholarship[s] from the Ministry of Foreign Affairs, Foreign Trade and Development Cooperation must take an HIV-antibody test in their country of origin."[36] Belize requires applicants for naturalization, work, or residence permits to take an antibody test.[37] Bulgaria requires a test for all aliens applying to reside in Bulgaria for more than one month, except for diplomatic personnel and persons coming to Bulgaria under the auspices of the Ministry of Foreign Affairs.[38] In Cyprus, African students and "foreigners seeking work in cabaret/night clubs" must take an HIV antibody test.[39] Czechoslovakia requires a test for foreign students from developing countries.[40] In Egypt, "foreign defense contractors working at military establishments must carry an HIV-antibody test certificate."[41] Qatar requires an "AIDS certificate" of foreigners applying for residence and work permits.[42]

In addition to testing blood bank donors, the Syrian Arab Republic requires routine antibody tests of: (a) aliens residing in Syria for work purposes at the time of their initial application for a work permit, except those persons residing in Syria who possess no specific nationality; (b) foreign students, who are to be tested upon arrival and again at the time of their enrollment in academic institutions and colleges; and (c) students sent abroad on scholarships, who are to be tested upon

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34. *Id.*

35. Nelson, *International Travel Restrictions and the AIDS Epidemic*, 81 AM. J. INT'L L. 230, 230-31 (1987).

36. PANOS INSTITUTE, *supra* note 1, at 176.

37. *Id.*

38. *Id.* at 145, 176. Legislation is reportedly being developed to protect asymptomatic carriers from discrimination and to guarantee their personal dignity.

39. *Id.* at 154, 177.

40. *Id.* at 146, 177.

41. *Id.* at 177.

42. *Id.* at 178.

their return to Syria and prior to rejoining the agencies that sent them.[43] Iraq requires foreigners to be tested within five days after the date of entry to the country.[44]

India requires foreign students to be tested within one month of their arrival, and deports seropositive students.[45] Foreign students who were in India prior to this practice are not required to undergo the test unless they leave India and return later to complete their studies.[46] India also requires tests of all foreigners, except the staffs of diplomatic missions, who intend to stay in India for more than one year.[47] Indians returning from abroad do not have to be tested.[48]

Mongolia requires foreign students to take an HIV test upon arrival, to be repeated several months later.[49] Indonesia excludes foreigners with AIDS from entering the country, but visitors are generally not required to take an antibody test.[50]

Under Japanese law, people who refuse to be tested can be fined up to $800. While foreigners entering Japan are not required to take the antibody test, entry may be denied to anyone believed likely to engage in sexual or drug-use activities that are likely to transmit HIV to Japanese residents.[51] "The Japanese government has determined that female prostitutes, male homosexuals, and intravenous drug users are the high risk groups"[52] subject to exclusion, but "[no] substantive provisions for the detection of these high-risk candidates have been posited."[53] In the United States, certain foreigners are now required to submit to antibody testing before they are allowed to enter the country,[54] and positive test results are grounds for exclusion.[55]

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43. World Health Organization, 39 DIG. OF INT'L HEALTH LEGIS. 369-70 (1988) (interpreting Regulatory Order No. 36/T of 26 Oct. 1987 of the Minister of Health).

44. *Resolution No. (229)*, 30 OFFICIAL GAZETTE OF THE REPUBLIC OF IRAQ, (21) 5 (May 27, 1987).

45. *See AIDS Control in India*, II LANCET 1035, 1035 (1989).

46. *Id.*

47. *Id.*

48. *Id.*

49. PANOS INSTITUTE, *supra* note 1, at 178.

50. *Id.* at 177.

51. Advocate, Jan. 31, 1989, at 18, col. 3.

52. Voss, *Re-evaluating Alien Exclusion in Light of AIDS*, 6 DICK. J. INT'L L. 119, 132 (1987). For more information on AIDS in Japan, see Ohi, Terao, Hasegawa, Hirano, Kai, Kobayashi, Inaba, Muramatsu, Miyama, Ashizawa, Kamakura, Uemura & Niimi, *Notification of HIV Carriers: Possible Effect on Uptake of AIDS Testing*, II LANCET 947 (1987).

53. Voss, *supra* note 52, at 132.

54. 42 C.F.R. § 34.4 (1988).

55. 8 U.S.C. § 1182(a)(6) (1982). For a comprehensive discussion of the United States law and its development, see Comment, *AIDS and Immigration: The United States Attempts to Deport a Disease*, 20 U. MIAMI INTER-AM. L. REV. 131 (1988).

2. Comments on the Policies of the Example Countries

Adoption of mandatory HIV testing and international travel restrictions are ineffective ways to control the spread of AIDS and HIV infection. The mentality behind these policies seems like that attributed by some to the military establishment, which occasionally responds to uncommon, complicated, or difficult problems by painting over them. Just as painting over rust or putting a bandage on a symptom of a terminal disease will not make it go away, AIDS and HIV infection will not go away merely because some countries adopt irrational and discriminatory internal and border practices.

HIV testing is worthless in many cases. First, the test results may not be accurate. Mistakes can be made at each stage of the process: when samples are drawn and labeled; when the laboratory tests are conducted; and when the test results are recorded. Undoubtedly, the poorer the country, the less accurate the testing process will be. It simply makes sense that developing countries will not have equipment as sophisticated or people as well trained as richer countries do, and inevitably, this will result in more mistakes.

The inaccuracy of HIV testing is further compounded by the possibility of fraud because persons may try to buy "AIDS certificates" that show negative blood test results. Bribery and corruption have been known to be rampant in countries at all levels of wealth on matters of far less significance than AIDS. If people will pay bribes to government officials to deal with parking tickets, for example, is there reason to doubt that they will do likewise with regard to HIV testing and its documentation? There is a market for phony passports and other international documentation, why not for AIDS certificates as well?

Second, accurate negative test results are largely worthless. Such results are valid, if at all, only as of the time the blood is drawn and tested. If the individual tested has only recently been exposed, he or she will be in the window period that precedes the time the body will have had a chance to react enough to produce an antibody reaction for testing purposes. One recent study has confirmed that this window period may be three years or longer.[56] Whatever the time period until seroconversion, the person tested may engage in risk activity and become HIV infected subsequent to submitting to the HIV test, and such an infection will not be disclosed by the earlier blood test. How

56. Imagawa, Moon, Lee, Wolinsky, Sano, Morales, Kwok, Sninsky, Nishanian, Giorgi, Fahey, Dudley, Visscher & Detels, *Human Immunodeficiency Virus Type 1 Infection in Homosexual Men who Remain Seronegative for Prolonged Periods*, 320 NEW ENG. J. MED. 1458 (June 1, 1989).

often would governments propose to retest people in order to accurately monitor and characterize one as negative for HIV antibodies and therefore as "safe" for international travel? Regular testing to establish an accurate profile for individuals would be both prohibitively expensive and prohibitively complicated to coordinate.

Travel restrictions are extremely underinclusive. They do not commonly apply to the great mass of a country's population that does not travel internationally. Additionally, they do not apply to movement within a country. In large countries, the national spread of AIDS may be far more significant in actual numbers than the international spread of AIDS to some smaller nations.

Discrimination and persecution were on the agenda of some persons and groups against other groups prior to the recognition of AIDS and its growth to pandemic proportions. The authors have previously observed that

> the AIDS crisis is providing an excuse for some anti-gay individuals and groups to further their aims. Under the guise of concern for public health, such people and groups hope to suppress the gay community. That was their agenda before the AIDS crisis, and they are enlisting some additional support because of the crisis. We must be cautious because, without a cure or vaccine, AIDS control is really people control.[57]

On the international scene, such tendencies and abuses are likely. For example, the South African government may well use HIV testing and the fear of AIDS and HIV as devices to further oppress the black population. The Soviet Union may do likewise with its numerous ethnic minorities. Both of those countries, Cuba and other countries may use testing, irrational fear, and travel restrictions against political opponents and dissidents.

Mass quarantine is not the answer either. First, it would simply be too expensive given the number of people in the world who have AIDS and HIV infection. Starvation, malnutrition, unemployment, underemployment, poverty, and economic underdevelopment are staggering problems in many parts of the world. Yet some people are seriously proposing quarantine measures. With many millions infected with HIV, how would it be possible to finance such mass quarantine efforts? The answer is simple, it cannot be afforded.

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57. Closen, Connor, Kaufman & Wojcik, *AIDS: Testing Democracy — Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835, 848 (1986) [hereinafter *AIDS: Testing Democracy*].

Second, mass quarantine measures would be both an underinclusive and an overinclusive approach to the problem. Quarantine efforts would be underinclusive because not all persons with AIDS and HIV infection can be identified and confined. Some persons will attempt and succeed in evading efforts of the government to confine them. Some persons who have AIDS or HIV infection will not be identifiable because they will not show symptoms or a positive antibody test result.

Quarantine measures are also overinclusive because almost everyone who knows that he or she is infected with AIDS or HIV would not constitute a risk to others. With proper education, the vast majority of people who realize that they harbor a communicable and fatal virus will act so as not to spread the virus any further. Furthermore, most people in the world should now have at least heard of AIDS and its primary routes of transmission (sexual intercourse and needle sharing) and should be engaging in activity that will not involve the risk of spreading the disease.

Third, quarantine programs would so threaten people as to drive them, and any accompanying AIDS and HIV disease, underground. If that happens, there will be all sorts of dire consequences. People will not seek out proper medical care, and will therefore die more horrible deaths and will die more quickly. Efforts to scientifically study the disease and treatment protocols will be inhibited. Thus, quarantine is medically unjustified, unworkable, inhumane, and unfair.

II. THE WORLD HEALTH ORGANIZATION'S RESPONSE

In response to the disturbing national developments against international travelers, the World Health Assembly (the legislative body of the World Health Organization) adopted an important resolution on May 13, 1988 against discrimination in relation to HIV-infected persons and persons with AIDS.[58] Among other measures, the WHO resolution urges its Member States:

> (1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS through information, education, and social support programmes;
> (2) to protect the human rights and dignity of HIV-infected people and people with AIDS, and members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment, and travel;

58. World Health Assembly, *Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS*, WHA41.24 WHO/GPA/INF/88.2. (Adopted May 13, 1988).

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling [sic] and other support services to HIV-infected people and people with AIDS; and
(4) to include in any reports to WHO on national AIDS strategies information on measures being taken to protect the human rights and dignity of HIV-infected people and people with AIDS.[59]

The WHO resolution also calls on governmental, nongovernmental, and international organizations and voluntary bodies engaged in AIDS control programs to ensure that their programs take full account of the health needs of all people as well as the health needs and dignity of HIV-infected people and people with AIDS.[60]

Although noble in its humanitarian spirit, the WHO resolution cannot legally bind its Member States. The resolution is not a treaty, and far too many national practices have arisen in contravention of the spirit of the WHO resolution to argue that the resolution is evidence of customary international law. WHO is not a supranational organization capable of dictating national health policies. While the WHO resolution cannot provide a remedy for those in the world who are subjected to discrimination, the WHO resolution is a tool for change. It provides an international consensus on the theory that the most appropriate means to combat this disease is not to combat its victims, but rather the virus which causes this terrible and fatal disease.

III. "LEGISLATIVE HISTORY" OF THE WHO RESOLUTION

A. United Nations General Assembly Resolution 42/8

Before the WHO Assembly adopted its resolution, the United Nations General Assembly adopted its own resolution for the prevention and control of AIDS:[61]

Deeply concerned that [AIDS] . . . has assumed pandemic proportions affecting all regions of the world and represents a health threat to the attainment of health for all, . . .

Recognizing the established leadership and the essential global directing and coordinating role of [WHO] in AIDS prevention, control, and education, and related research and public information and, in this context, the vital importance of the [WHO] Special Programme on AIDS, [the United Nations General Assembly:]

1. Commends [WHO] for its efforts toward global AIDS prevention and control, and in particular, for its support for national AIDS

59. *Id.*
60. *Id.*
61. G.A. Res. 8, 42 U.N. GOAR Supp. (No. 49) at 12, U.N. Doc. A 42/49 (1987).

programmes and regional activities, including the meeting of Ministers of Asian and Pacific Governments at Sydney, and the [then] forthcoming meeting of Ministers of Health on Programmes for AIDS prevention to be held in London;

2. Confirms that [WHO] should continue to direct and coordinate the urgent global battle against AIDS;

3. Commends those Governments which have initiated action to establish national programmes for the prevention and control of AIDS in line with the Global Strategy of [WHO], and urges other Governments to take similar action;

4. Calls upon all States, in addressing the AIDS problem, to take into account the legitimate concerns of other countries and the interests of inter-State relations;

5. Invites [WHO] to facilitate the exchange and promotion of national and international research for the prevention and control of AIDS through the further development of Collaborating Centres of [WHO] and similar existing mechanisms;

6. Requests the Secretary-General, in view of all aspects of the problem, to ensure, in close co-operation with the Director-General of [WHO] and through the appropriate existing mechanisms, a co-ordinated response by the United Nations system to the AIDS pandemic, and urges all appropriate organizations of the United Nations system, including the specialized agencies, bilateral and government agencies and non-government and voluntary organizations, in conformity with the world-wide struggle against AIDS; [and]

7. Invites the Director-General of [WHO] to report to the General Assembly at its forty-third session, through the Economic and Social Council, on new developments in the global AIDS pandemic, and requests the Economic and Social Council to consider the report in accordance with its mandate.[62]

The United States' delegation to the General Assembly's plenary session for Resolution 42/8 included the highly respected former Surgeon General of the United States, Dr. C. Everett Koop. Dr. Koop addressed the Assembly "not as a diplomat, but as a physician."[63] In that role, he addressed the Assembly with a "physician's plea:"[64]

> My plea is for greater compassion and for intensified international cooperation under the WHO. It is a plea for all the nations of the world and all their component parts — in the health community, the educational community, the social services community, industry, non-governmental organizations — to mobilize their energies and their resources and to escalate their common fight against AIDS.

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62. *Id.*

63. *UN Consideration of the AIDS Pandemic*, 88 DEPT. OF STATE BULL. 56 (Jan. 1988) (Text of Dr. Koop's Statement of Oct. 20, 1987).

64. *Id.*

> In each of our countries, we must start with an understanding of the disease and an acceptance that it is a risk to the entire society and not just to one or more narrow groups. I recognize that the political and public health leaders in some countries may not have wanted, at the start, to collect and publish data on an epidemic such as this.[65]

Dr. Koop also emphasized the devastating effect of AIDS upon the "families" of the developing nations, identified children as "innocent" victims of AIDS, and urged the use of "good sense and good science" to "show the world how compassion and enlightenment can triumph over disease."[66] Dr. Koop went on to say that:

> while AIDS is a global problem, it is potentially more destructive to the developing world than it is to the industrial world.
>
> In developing nations, the people stricken with AIDS are primarily those we look to for support of the children, the aged, and the sick. Deaths among these breadwinners cause both family income and nutrition to decline, while poverty and disease increase, making AIDS a major threat to family life. But there is more.
>
> Because AIDS strikes the healthy and usually the young productive adult in the prime of life, AIDS is also a hindrance to development. Developing nations will be losing workers in agriculture, industry, and many other vital economic areas, not to mention teachers, engineers, physicians, health workers, government officials, and many other professionals. These are talented people that no country — and especially not a developing country — can afford to lose.
>
> And beyond that, there are the innocent victims — the children, the future of our world — who are and will continue to be afflicted with AIDS. The sad fact is that AIDS can roll back the global child survival efforts of both UNICEF [United Nations Children's Fund] and WHO and undermine all of the hard-won victories in reducing infant mortality.[67]

While urging compassion and enlightenment, Dr. Koop's statement to the General Assembly calls for its own "enlightenment" in two ways. First, Dr. Koop's definition of family did not recognize the tremendous change in the status of the family. In the United States and other countries, the traditional notion of a single-family home excludes non-traditional families in all of their various manifestations. The failure to recognize that the traditional notion of "family" has undergone substantial change will exclude many who believe that their own living arrangement cannot be the "family" contemplated in health literature or AIDS education materials.

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65. *Id.*
66. *Id.* at 57.
67. *Id.* at 56.

Second, Dr. Koop's reference to the "innocent" victims of AIDS implies that some with HIV-infection are "guilty." If the war against AIDS is to be won, the battles against AIDS discrimination must first be won. Eliminating the distinction between "innocent" and "guilty" victims is a necessary first step. It is equally important to reach and educate intravenous drug users, who may respond better by being called a drug user rather than a drug abuser.[68]

In adopting its resolution, the General Assembly addressed neither of the United States delegation's concerns of "family" and "innocent victims." The General Assembly expressed continued confidence in WHO's work, commended governments which have initiated actions against AIDS, and called upon all nations to account for the "the legitimate concerns of other countries and the interests of inter-State relations"[69] in addressing the AIDS problem.

What the General Assembly meant by "legitimate concerns" of other nations is diplomatically vague. It would certainly exclude actions such as the consideration once given to a plan in Bangladesh to ban imports of used clothing from the United States because of an irrational fear that the clothing itself might spread AIDS.[70] Would it also exclude actions such as requiring immigrants, refugees, business travellers and tourists to present an "AIDS-free certificate" or undergo HIV antibody testing at the port of entry?[71]

B. London Declaration on AIDS Prevention

Also endorsed in the WHO resolution against discrimination of those infected with HIV is the final declaration of the World Summit of Ministers of Health on Programs for AIDS Prevention.[72] Health ministers from 148 nations met in London in January of 1988 to discuss each nation's experiences and approaches to the AIDS pandemic. The meeting opened royally with a welcoming address from Princess Diana, and concluded with unanimous adoption of the following declaration:

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68. *See AIDS: Testing Democracy*, *supra* note 57, at 848.

69. G.A. Res. 8, 42 U.N. GOAR Supp. (No. 49) at 12, U.N. Doc. A 42/49 (1987).

70. *AIDS Scare: Bangladesh to Ban Used Clothes Imports*, Advocate, Oct. 29, 1985, at 22, col. 2.

71. *See generally* Note, *The AIDS Pandemic: International Travel and Immigration Restrictions and the World Health Organization's Response*, 28 VA. J. INT'L L. 1043 (1988).

72. World Summit of Ministers of Health Issues, London Declaration on AIDS Prevention, *reprinted in* WHO Press Release, WHO/LUN 4 at 1 (Jan. 28, 1988) (Copies are available for purchase from the United Nations bookstore or the World Health Organization's publications office in Geneva, Switzerland).

The World Summit of Ministers of Health on Programmes for AIDS Prevention, involving delegates from 148 countries representing the vast majority of the people in the world, makes the following declaration:

1. Since AIDS is a global problem that poses a serious threat to humanity, urgent action by all governments and people the world over is needed to implement WHO's Global AIDS Strategy as defined by the Fortieth World Health Assembly and supported by the United Nations General Assembly.

2. We shall do all in our power to ensure that our governments do indeed undertake such urgent action.

3. We undertake to devise national programmes to prevent and contain the spread of [HIV] infection as part of our countries' health systems. We commend to all governments the value of high level coordinating committees to bring together all government sectors and relevant nongovernmental organizations in the planning and implementation of such programmes in conformity with the Global AIDS Strategy.

4. We recognize that, particularly in the absence at present of a vaccine or cure for AIDS, the single most important component of national AIDS programmes is information and education because HIV transmission can be prevented through informed and responsible behavior. In this respect, individuals, governments, the media, and other sectors all have major roles to play in preventing the spread of HIV infection.

5. We consider that the information and education programmes should be aimed at the general public and should take full account of social and cultural patterns, different lifestyles, and human and spiritual values. The same principles should apply equally to programmes directed towards specific groups, involving these groups as appropriate. These include groups such as:

—policy makers;
—health and social service workers at all levels;
—international travellers;
—persons whose practices may place them at increased risk of infection;
—the media;
—youth and those that work with them, especially teachers;
—community and religious leaders;
—potential blood donors; and
—those with HIV infections, their relatives and others concerned with their care, all of whom need appropriate counselling.

6. We emphasize the need in AIDS prevention programmes to protect human rights and human dignity. Discrimination against, and stigmatization of, HIV-infected people and people with AIDS and population groups undermine public health and must be avoided.

7. We urge the media to fulfill their important social responsibility to provide factual and balanced information to the general public on AIDS and on ways of preventing its spread.

8. We shall seek the involvement of all relevant governmental sectors and nongovernmental organizations in creating the supportive social en-

vironment needed to ensure the effective implementation of AIDS prevention programmes and humane care of affected individuals.

9. We shall impress on our governments the importance for national health of ensuring the availability of the human and financial resources, including health and social services with well-trained personnel, needed to carry out our national AIDS programmes, and in order to support informed and responsible behavior.

10. In the spirit of United Nations General Assembly Resolution A/42/8, we appeal:

—to all appropriate organizations of the United Nations systems, including the specialized agencies;

—to bilateral and multinational agencies; and

—to nongovernmental and voluntary organizations;

—to support the worldwide struggle against AIDS in conformity with WHO'S global strategy.

11. We appeal in particular to these bodies to provide well-coordinated support to developing countries in setting up and carrying out national AIDS programmes in the light of their needs. We recognise that these needs vary from country to country in the light of their epidemiological situation.

12. We also appeal to those involved in dealing with drug abuse to intensify their efforts in the spirit of the International Conference on Drug Abuse and Illicit Trafficking (Vienna, June 1987) with a view to contributing to the reduction in the spread of HIV infection.

13. We call on the World Health Organization, through its Global Programme on AIDS, to continue to:

(i) exercise its mandate to direct and coordinate the worldwide effort against AIDS;

(ii) promote, encourage and support the worldwide collection and dissemination of accurate information on AIDS;

(iii) develop and issue guidelines in the planning, implementation, monitoring and evaluation of information and education programmes, including the related research and development, and ensure that these guidelines are updated and revised in the light of evolving experiences;

(iv) support countries in monitoring and evaluating preventive programmes, including information and education activities, and encourage wide dissemination of the findings in order to help countries to learn from the experiences of others;

(v) support and strengthen national programmes for the prevention and control of AIDS.

14. Following from this Summit, 1988 shall be a Year of Communication and Cooperation about AIDS in which we shall:

—open fully the channels of communication in each society so as to inform and educate more widely, broadly and intensively;

—strengthen the exchange of information and experience among all countries; and

—forge, through information and education and social leadership, a spirit of social tolerance.

> 15. We are convinced that, by promoting responsible behavior and through international cooperation, we can and will begin now to slow the spread of HIV infection.[73]

A strong theme throughout the final declaration is the need for tolerance, education, and avoidance of discrimination and stigmatization of HIV-infected people and people with AIDS. Given this broad affirmation of the power of knowledge and the threat of ignorance, intolerance, and discrimination, WHO was well-placed to adopt its own anti-discrimination resolution based on the collective expertise and experience of the world health ministers.

IV. THE BREADTH OF THE WHO RESOLUTION

The WHO resolution urges its Member States to protect the human rights and dignity of HIV-infected people and people with AIDS, as well as members of "population groups," and to avoid discriminatory action against and stigmatization of them in the provision of services, employment, and travel.[74] The term "population groups" should extend to any discrimination related to HIV infection.[75] With increased public awareness of the disease, we should anticipate and prevent all of the prejudice, disinformation, and victimization that will come to be associated with it.[76] Both the infected and uninfected need to be protected against disinformation, prejudice and discrimination.[77]

The basis of discrimination has, in the past, largely stemmed from an uninformed or irrational fear that AIDS is easily spread. The global campaign of education on the means of transmission of AIDS, and in turn of available preventive measures, will continue to weaken ignorance and fear as reasons for discrimination. The remaining factors underlying discrimination, unfortunately, can be generally classified as a lack of confidence in the medical community and simple hatred against those perceived to be members of affected population groups.

The distrust of the medical community stems from a perception that doctors cannot know everything, that there must be some room for reasonable doubt, and that many cases of AIDS have gone unexplained to the satisfaction of some members of the general public. Doctors may avoid giving unequivocal answers to direct questions, perhaps in part

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73. *Id.*
74. *Id.*
75. *See, e.g.*, Poirer, *AIDS and Traditions of Homophobia*, 55 SOCIAL RESEARCH 461 (1988).
76. Okware, *Planning AIDS Eduction for the Public in Uganda*, in WORLD HEALTH ORGANIZATION, AIDS PREVENTION AND CONTROL 32, 36 (1988).
77. *Id.*

because of a fear that lawyers will later come to haunt them in a malpractice action for failing to deliver promised results or to avoid unanticipated developments.[78] The medical community cannot identify risk factors for every single case of AIDS.[79] In some cases the patients were uncooperative, lied to hide past drug use or extra-marital sexual activities, or simply became too ill before they could answer questions about their high-risk behavior. The important factor, however, is that although every single case cannot be explained, no new modes of transmission have been discovered.[80] This means that the education efforts can continue to stress the means already known to avoid contracting the disease, and that public health education programs should be continued.

Hatred, the other remaining factor underlying discrimination, can be expressed variously in forms of racism, xenophobia, or homophobia. Because many who do not understand the medical aspects of AIDS are consequently frightened about the disease, there may be a tendency for people to focus on their irrational fears.[81] An ill-informed public can easily combine AIDS and homosexuality,[82] for example, while ignoring the devastating spread of the disease through intravenous drug use. Similarly, nations of the world have pointed to each other as the "source" of AIDS and diverted precious attention and resources from education, medical research, and treatment toward needless blame. HIV is an indiscriminate virus which strikes without regard to race, nationality, or sexual identity. Where discrimination is likely to result, strict confidentiality of medical data and patients' records must also be assured.[83] "[A]ll HIV testing must be accompanied by stringent institutional and societal safeguards of confidentiality and privacy."[84]

International travelers may be at increased risk of contracting HIV because the travelers' behavior may change when they are abroad.[85] Education and changes in individual behavior, not discrimination, are

78. *Cf.* Smeltzer, *The Effects of Liability Fears*, 320 NEW ENG. J. MED. 1221 (May 4, 1989).

79. *Update: Acquired Immunodeficiency Syndrome - United States*, 1981-1988, 38 MORBIDITY & MORTALITY WEEKLY REP. 230, 234 (Apr. 14, 1989).

80. *Id.*

81. *AIDS: Testing Democracy*, *supra* note 57, at 846.

82. Ruffie, *AIDS: Punishment from the Gods?*, Windy City Times, Apr. 24, 1986, at 11, col. 1, 4.

83. *See* Comment, *Confidentiality, Warning and AIDS: A Proposal to Protect Patients, Third Parties, and Physicians*, 4 TOURO L. REV. 301, 310-11 (1988).

84. Rhame & Maki, *The Case for Wider Use of Testing for HIV Infection*, 320 NEW ENG. J. MED. 1248, 1248 (May 11, 1989).

85. *See* Feachen & Phillips-Howard, *Risk to UK Heterosexuals of Contracting AIDS Abroad*, II LANCET 394, 394-95 (1988).

the common denominators for any responsible course of action to control further spread of the disease.[86]

V. CONCLUSION

Under the variety of national laws recently enacted in the hopes of combatting AIDS, testing positive for antibodies to HIV makes it difficult, if not impossible, to work abroad, immigrate, and travel.[87] The protective purpose of these restrictions is illusory and will not control the spread of AIDS. Until the time when these restrictive travel and immigration laws are repealed or their application waived, foreign travel must not be restricted if the purpose is to obtain medical treatment in a better hospital or access to helpful drug therapies that are unavailable in the home country.[88] The purpose of testing for non-clinical reasons must be to promote the early detection of asymptomatic HIV infection which will provide an important health benefit to those who would otherwise fail to seek medical attention promptly when symptomatic HIV illness appears, and to identify candidates for medical research studies.[89]

Discrimination against persons infected with HIV increases the emotional and economic costs of the disease. Because so much is known today about transmission of the disease, there is absolutely no medical justification for discrimination in any form. To the contrary, the disease is easier to control in the absence of discrimination.[90] Much of the crisis deals with individual choices to be encouraged after adequate and accurate education in the medical aspects of transmission. Political leaders of every nation must also be educated by the international medical community on the appropriate means to control AIDS.

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86. *See, e.g.*, AIDS IN THE AMERICAS, *supra* note 3, at 1007.

87. *See* S. SONTAG, *supra* note 21, at 33 ("testing positive now makes one ineligible to immigrate everywhere").

88. *See* Kessler, *The Regulation of Investigational Drugs*, 320 NEW ENG. J. MED. 281, 285 (Feb. 2, 1989). *See also* Comment, *The Right of Privacy in Choosing Medical Treatment: Should Terminally Ill Persons Have Access to Drugs Not Yet Approved by the Food and Drug Administration?*, 20 J. MARSHALL L. REV. 693 (1987); *FDA Proposals to Ease Restrictions on the Use and Sale of Experimental Drugs: Hearing Before a Subcomm. of the House Comm. on Government Operations*, 100th Cong., 1st Sess. (1987).

89. Rhame & Maki, *supra* note 84, at 1249-51. Many people apparently benefit from early institution of zidovudine or another therapy specific to opportunistic infections. *Id.* at 1249-50. Horrendous side effects from drugs, however, may counsel against unnecessary early treatment. *See, e.g.*, Goldfarb, *Intravenous Saline as Adjunctive Therapy for Patients With AIDS Given Pentamidine*, 320 NEW ENG. J. MED. 1281 (May 11, 1989).

90. *See Attitude Helps AIDS Victims*, Atlanta Journal and Constitution, Jan. 16, 1989, § 1, at 1, col. 1; *Research Hints at Link Between Patient's Attitude and Progress of AIDS*, N.Y. Times, Jan. 16, 1989, § 1, at 6, col. 1.

AIDS requires public education and responsible actions. No person has the right to make another the victim of his or her own ignorance. Combatting AIDS in the developing countries also requires technical and financial help from the industrialized nations. Furthermore, AIDS cannot be eliminated in any country until it is cured in all countries.

While the United States has rehabilitation laws and a constitutional right of privacy that might be applied to combat some types of discrimination,[91] there is as yet no international law to combat discrimination.[92] In the absence of an international anti-discrimination law, the WHO resolution is a constructive and valuable international expression of the need for tolerance, education, and avoidance of discrimination and stigmatization of HIV-infected people and people with AIDS.

91. *See AIDS: Testing Democracy*, *supra* note 57, at 880-903.

92. Some existing tribunals, however, might be used as fora for the exercise of human rights that are fundamental under international law. *See* Jarvis, *Advocacy for AIDS Victims: An International Law Approach*, 20 U. MIAMI INTER-AM. L. REV. 1 (1988).