

AIDS and the Ghana legal system: absolute ignorance or denial syndrome?



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The emergence of the Human Immuno-deficiency Virus (HIV) and its end-stage Acquired Immune Deficiency Syndrome (AIDS) has opened a new chapter in world affairs. The nature of the infection, and the modes of transmission, are giving birth to a new culture in all spheres of life. No longer are issues pertaining to human sexuality considered unworthy of mention in decent society, and no longer is an individual's sexual lifestyle a private matter. No longer are children to be kept ignorant of sexual matters as a means of offering moral protection to them. Quite to the contrary, moral protection, at the present time, lies in openness about human sexuality and the levels of responsibility that should accompany the individual's sexual self-expression. The school curriculum now contains information about AIDS as well as the use of condoms for prevention. Contraceptives are advertised openly and even on prime-time television. Partners in relationships are keeping a lookout for evidence of infidelity out of fear of what such infidelity could mean to their own lives. Suddenly, individuals in Ghana are willing to stand up and identify themselves as sufferers from a dreadful disease knowing full well the implications of such publicity (see *Mirror* 9 October 1993:1). All these changes in attitudes began to occur within a period of eight years since the first official sufferers of the disease were discovered in this country. Indeed, it is no exaggeration to characterize it as a social revolution.

With all revolutions comes the realization that institutions and rules based upon tenets that are no longer valid must give way to new ones that are required to handle the emergent problems of the day. Thus, a social revolution such as has been described, has brought with it a need to re-examine the social institutions, in order to develop a response to the emerging concerns. Just as the bubonic plague in twelfth-century Europe wrought such social changes that social ideas and institutions had to be refashioned, so it is that the current medical emergency of AIDS may assume the proportions of a social emergency and so require responses that may fundamentally change our attitudes in all of life.

The social institutions that have to be looked at include the legal system of Ghana. For these purposes, 'Legal System' refers to the whole range of activities beginning with law-making, through the judicial system, to the institutions responsible for the execution of the laws (Dias 1985: 60-62). All these institutions together are responsible for the social function of regulating behaviour and are therefore all the subject of this discussion. A consideration of the pertinent issues would reveal that all these different sectors of our national life, subsumed under the expression 'legal system' have to develop an adequate response to new challenges engendered by this social revolution or risk being marginalized in current efforts to fight the disease AIDS.

In order to assess what the appropriate response ought to be, it is necessary to look at the responses so far, to determine what more needs to be done, or done differently. However, the question 'What is the response of the legal system in Ghana to this onslaught by an incurable disease?' elicits no response other than the exchange of baffled looks. It appears that at the

current time, the response is one of total silence. The legal system is operating as if there were no new issues to which it ought to address itself. Is this attitude born out of ignorance of the social consequences of the disease, or the belief that stoically denying the existence of this disease in our country will make the issues disappear? Many other countries, even in the West African sub-region, have enacted legislation on various aspects as far-flung as changing the health requirements for immigrants, surveillance on sufferers from HIV, and even quarantining them (Tomasevski et al. 1992)¹. Whatever the individual merits of the various pieces of legislation, there is at least an indication, in those countries, that something happened in the decade of the 1980s which required a response of sorts from the legal system. Not so with Ghana, which has taken no discernible steps, in any direction, despite the frightening statistics emerging from the medical experts who have been charged with the monitoring and control of AIDS².

The aim of this paper then, is to expose some of the more obvious issues that require responsive action on the part of the legal system. The experiences of other countries are cited and relied upon to show what directions the law could take in developing these responses. At the same time, the problems inherent in some of the modalities adopted by other countries are highlighted, so that efforts can be made to avoid those pitfalls when we finally come round to tackling the legal issues thrown up by the advent of this disease.

General issues

The infection

The condition of HIV infection and its final product, the disease AIDS, presents problems that are altogether new in the world of epidemics. Various described as 'epidemic' or 'pandemic', AIDS has characteristics that make the challenge of its control a serious one for any legal system. But first, the incidence. The HIV infection which results in AIDS is a condition that is now recognized as having the notable features of suppressing the immune system of a sufferer. This suppression permits the onset of opportunistic diseases leading eventually to death (see Begg 1989:2). It is insidious in nature and an infected person can remain healthy for years. Its progress has now been recognized as consisting of four main stages (Kirby 1993:356):

1. Acute initial infection during which many people suffer a viral illness with fever. During this period, however, any tests would show negative results.
2. Asymptomatic infection, when infected people are healthy but would test positive for antibodies. This interval is of uncertain duration. Estimates have varied from five years to upwards of ten years. Recent research shows that even when exposed to the risk to the same extent, some people do not contract the virus.
3. Persistent Generalized Lymphadenopathy. This stage is characterized by night sweats, weight loss and enlarged lymph nodes.
4. Full-blown AIDS resulting in death, often from opportunistic disease.

During the whole of this period however, the virus can be passed on to others, even though the sufferer may show no outward signs of illness.

This disease is thus one which can lie hidden in an individual for years, without any obvious signs of illness unlike the other epidemics that have afflicted the world in the past.

¹ The list of countries with AIDS legislation at the end of 1990 included the following in West Africa: Liberia, Niger, Togo, Guinea, Mali, Senegal, Guinea-Bissau, Chad.

² In 1986, two cases of the disease were reported. This number had grown to 11,872 by September 1993.

The manner in which the disease manifests itself is not the only problem with serious implications for the world in general. Another serious problem is that, unfortunately, despite heavy investment in research, there is as yet no recognized cure.

Modes of transmission

The modes of transmission have also now been determined to be specific excluding accidental contacts, and other unintentional modes of communication. The specific modes of transmission are sexual contact; contact with infected blood through contaminated equipment or transfusion of blood; and perinatal transmission, that is, from infected mother to baby during childbirth.

The social epidemic 'AFRAIDS'

The three factors outlined above—the nature of the disease, incurability and its modes of transmission—have determined social attitudes to the disease. These attitudes have been characterized as another epidemic dubbed 'AFRAIDS'. Thus any discussion of the social dimensions of the disease must recognize that there are in fact two epidemics: the first epidemic is a medical one and the second a social one; but the social one is dictating the pace and spread of the medical one. The major problem for us in Ghana is that whilst the medical experts are grappling with the medical epidemic as well as trying to manage the non-medical problems of the infected, the social epidemic is spreading unchecked. The profound way in which the second epidemic can affect the life of the ordinary citizen and thereby frustrate the efforts of the medical experts is the major reason why, among other institutions, the legal system should concern itself with the social epidemic and in that wise assist the efforts of those tackling the medical epidemic. The danger posed to the enjoyment of the individual's civil rights, the opportunities offered for the exploitation of the infected and affected, as well as the possibility of affecting time-hallowed ethical rules of all the major professions, call for the Law's intervention.

The need for Law to intervene would be served by an examination of the nature of the second epidemic. There are good reasons for the emergence of the social epidemic 'AFRAIDS'. The most potent of them is that HIV infection means eventual death, preceded by a period of prolonged misery and suffering. Human beings react instinctively to the prospect of death despite the certainty of it as an event for all mortals. Thus any condition which means certain death for the individual is unlikely to be courted by the average person. Although every human being expects to die some day, the fact that the day is not known does not torture all of one's waking moments. This disease, however, puts one in a position where one is forced to confront the certainty of death and to await the event in misery and physical torture. This psychological torture is more than ordinary human endurance can contemplate. The other consideration is the knowledge that contracting the disease carries a social stigma of immorality which would be hard to explain away. For these reasons, the disease AIDS strikes terror in everybody's heart. The terror in turn produces all manner of irrational actions:

AIDS... is spreading inexorably... stamping with terror the honest faces of rational people, church-going people, charitable people who would give their bank rolls - their lives even - to help victims of flood or fire, but who turn their backs on neighbours with [the disease] (Waltzer 1990)

It is indeed ironical that people who would be willing to risk their lives saving others would shun those with the disease because of the risk of catching the disease, and consequent death. One would have thought that the truism observed by the sages in pidgin English that

'All die be close eye' (i.e. death is death however caused) would hold sway. Not so with death through AIDS. This attitude has serious consequences for the whole society, and is thus the modern issue with which the society must grapple.

A second reason why this AFRAIDS epidemic is rising is the mode of transmission of the disease AIDS, as well as the tag of immorality associated with it. Apart from those acquiring it at birth or through blood transfusions — and it is acknowledged that they are generally few in number — the other modes involve sexual activity, heterosexual or homosexual, or drug addiction. These two latter modes thus have associations of immorality or at least suggestions of loose and licentious living. Despite the fact that there is evidence that even one sexual encounter is enough to cause an infection, the tag of moral depravity persists. This perception is not helped by the kind of messages that are being propagated on the electronic media. Thus, to the fear of certain death is added the stigma of immorality. This stigma aggravates the agony of the sufferer, and also increases the level of abhorrence of non-sufferers towards those who suffer it. No one escapes from the stigma of immorality. Even babies born with AIDS do not escape the stigma since the suggestion of an immoral ancestry serves to justify the rejection of them by the generality of 'decent' society.

The third and by far the most potent factor in the rise of AFRAIDS is the absence of a cure for AIDS. Unlike other diseases that cause death but which are curable, such as cholera, AIDS has to be avoided altogether if one is to escape its effects. Had a cure been already found, the sheer terror with which AIDS is perceived would be considerably lessened although people would not be the more anxious to contract it. As matters stand at the moment, the greater the distance between an individual and potential sources of infection, the higher the possibility of being spared the burden of the disease. All these factors have ensured that the strident calls for protection against sufferers have been induced by sheer panic, and often not very well-considered measures in those countries where some action has been taken.

Emergent issues

The preceding discussion has shown that there are several problems that must be confronted with some urgency. What then are the issues at stake? First, the spread of the diseases must be controlled; secondly the sufferers must be cared for; and thirdly, they must be protected by the law against abuses from those who would rather despatch them than suffer the possibility of their spreading the disease. These three objectives are linked, for the ability to control the disease depends upon identifying those capable of spreading it. This also would determine those in need of the arrangements for care that have to be put in place. These two objectives in turn would be attainable only if there were very little to be suffered legally, socially and economically, by a person so identified. Thus the policies to protect sufferers and provide for their care are directly linked to the success of any control measures that would be adopted.

Issues of control

The absence of a cure has ensured that the need to contain the spread of the disease has become paramount. This paramount need has in other countries, particularly in the industrialized West, spawned various public health measures as well as other pieces of legislation, such as immigration requirements, which are expected to assist in containing the spread. In the anxiety to respond to public calls for action, governments have lost sight of the purpose for such legislation, with disastrous results. Efforts to stem the spread of this disease have resulted in the adoption of measures that have driven carriers and other sufferers underground. It is now generally admitted that with increased inability to own up to infection comes an increased risk of transmission. People who know of the dangers to themselves

arising from characterization as AIDS sufferers are unlikely to assume that burden. Many countries now require compulsory testing of select groups only, such as prostitutes, drug addicts or immigrants, who are considered to be an obvious risk owing to their lifestyle or place of origin. Those countries which tried compulsory testing, have abandoned it because it is expensive. Further evidence has also shown that it was of doubtful utility anyway. Cuba is now the only country to maintain compulsory testing for all.

Among the control measures being adopted in some countries is the revision of quarantine regulations to include AIDS sufferers³, as well as a resort to the criminal law by the criminalization of certain activities, including conduct deemed risky as being conducive to the spread of the disease. In New South Wales, there is even criminal liability for failing to inform a sexual partner of one's infected state (Kirby 1993:361).

Although resorting to the criminal law as an instrument of disease control has dubious legal antecedents, this has not deterred those who wish to use it. Even for novel situations, old rules are being re-examined, stretched and re-interpreted to fit the new problems. For instance, traditionally in Anglo-American criminal jurisprudence, body parts have not been considered as 'weapons' for the purposes of considering whether an attack is a common assault⁴ or an aggravated assault resulting in grievous bodily harm⁵. The reason for this is to be found in the philosophical notion that a weapon is an implement external to the person of an individual, which is carried for the purpose of causing harm. Since the emergence of the disease AIDS, however, several courts in the United States have had occasion to pronounce on the issue. Some have restated the principle that teeth, even the teeth of an infected person which are used for the purpose of causing injury, cannot be regarded as an 'offensive weapon'⁶. Others are not sure, and believe that juries should, on a case-by-case basis, determine whether the body part is used as an offensive weapon (see Tomasevski et al. 1992).

There are compelling arguments on both sides. Those who choose to maintain the old rule have voted on the side of certainty, but are there not other considerations such as the deadly nature of the virus for which reason an infected person would attempt to use it in a fight against an opponent through a bite? This is not to say that the position of the other group is more defensible because there is also virtue in certainty in the administration of the criminal law. Their attitude indicates by implication that the intention with which the teeth are used is the determinant of whether or not they are an 'offensive weapon'. Surely this throws the law into some disarray? How do police officers figure out what charge to prefer when a particular part of the body has been used to cause injury? The big question here, however, is why well-worn norms are being suddenly questioned and re-defined. The answer is 'AFRAIDS'.

Another way in which the criminal law is being pressed into service is the introduction of specific legislation criminalizing certain kinds of conduct which were not criminal before. The view that the intentional spread of disease, or risky conduct that encourages the spread of dangerous diseases, ought to be criminalized, has found favour in some jurisdictions in the United States. This view has fairly respectable common-law antecedents, and is thus not a new phenomenon. In *R. v. Vantandillo*⁷, the court found criminal, the carrying of a child with

³ Cuba is reported to have isolated all known infected persons in a special camp with excellent facilities. This is just a euphemism for quarantine.

⁴ This is a misdemeanour and therefore makes one liable to a maximum term of imprisonment of three years. See section 296(4) of Criminal Procedure Code.

⁵ A first-degree felony carrying a maximum term of life imprisonment. See section 296(1) of Act 30.

⁶ *United States v. Moore* 846 F.2d 1163 (8th Cir.) (1989). See comment on this case in *State v. Gordon* (1989) 778 P.2d 1204, at 1206; Stansbury (1989); Martin (1991).

⁷ 4 M & S 73; 105 ER 762

smallpox along a public street, thus exposing other persons to the danger of infection. However, this view was discarded in *Queen v. Clarence* where the majority of judges did not consider it proper for the spread of an infection to be held criminal. This was a case in which a man who knew he had gonorrhoea had sexual intercourse with his wife and infected her. In the words of Judge Stephen, 'Not only is there no general principle which makes the communication of infection criminal, but such authority as exists is opposed to such a doctrine in relation to any disease'⁸ (p.39). One of the dissenting judges in that case indicated that he did not fully appreciate the difficulties raised by his colleagues because in appropriate cases there would be need for the law to respond to deliberate acts calculated to spread a disease. He indicated that he could conceive of 'a state of things in which a kiss or shake of the hand given by a diseased person maliciously with a view to communicate his disorder might well form the subject of criminal proceedings'⁹. The minority view in this case is now being resurrected and relied upon as the direction in which the criminal law must now move in the face of HIV/AIDS.

The attraction of this attitude at the present time is exemplified by the decisions of American Military Courts in two cases. In both these cases involving military personnel, the accused persons who were AIDS patients were convicted of aggravated assault. Their convictions were based on the fact that although they had been informed of their disease, its mode of spread, etc., they had gone ahead to engage in unprotected sexual intercourse without informing their partners of their condition¹⁰. For such risky behaviour, the court found them guilty of conduct likely to result in death or bodily harm. It is clear that the only reason their acts were considered worthy of punishment was the introduction of a new and fearful element: the spread of HIV.

Does Ghana want to take a like position?

Classification

There are other difficulties with the disease which, though medical in nature, carry serious legal implications. This is the problem of classification. AIDS is variously classified as 'contagious', 'sexually transmitted' and sometimes 'infectious' or 'communicable'. With the various classifications in the different countries, AIDS is transformed from one phenomenon into another as it moves from jurisdiction to jurisdiction. This is because all these classificatory words carry various connotations. For instance a sufferer from an infectious disease is subject to quarantine for the duration of the disease¹¹, but someone with a disease classified as 'a sexually transmitted disease' is not. The issue of classification thus has serious implications for any country's ability to adopt effective control measures to fight this disease.

The classification as an 'infectious' or 'contagious' disease carries its own problems. Such classification makes a person subject to quarantine regulations for the duration of the disease for purposes of treatment. The difficulty here is that the non-availability of a cure for AIDS renders difficult attempts to put any sufferer into quarantine, since this is likely to lead to a detention for the rest of the person's natural life. This is a serious consideration all on its own, but that is not the biggest of the problems with quarantine. The real issues are the following: what is the use in quarantining AIDS sufferers when there are other infected but healthy-

⁸ *Queen v. Clarence* (1888) 22 QBD 23.

⁹ *Queen v. Clarence* (1888: 52). See also (Bronitt 1994).

¹⁰ *United States v. Stewart* 29 MJ 92 (CMA 1989) and *United States v. Johnson* 30 MJ 53 (CMA 1990). Both these cases are discussed by Milhizer (1990).

¹¹ See Quarantine Ordinance, Cap. 95.

looking persons, in the nature of carriers, who are equally, or perhaps even more, dangerous to the uninfected? How can all infected persons be found out without compulsory testing of all the citizens? With what frequency would such mass testing be done in order to isolate those who might be infected after the mass testing? Can any country afford the expense of such testing with the frequency that would make the policy effective? These and other such questions render the prospect of quarantine an exercise in futility.

A classification as a sexually transmitted disease (STD) does not create an easier route for those charged with working out a solution since it implies that persons with whom the sufferer has had sexual contact must be traced. Such tracing is embarrassing to the infected as well as affecting the privacy of every person in that category. Persons so traced would, particularly those testing negative, be unlikely to keep their experiences to themselves. The classification of AIDS as an STD also affects the confidentiality of the medical personnel. If they are required by law to trace the sexual contacts of the sufferer, then they cannot guarantee confidentiality to the person now diagnosed to be infected. Without absolute confidentiality, persons having reason to suspect that they are infected would do their best to avoid consulting qualified medical personnel.

The Ghanaian situation

The Ghana legal system seems to have closed its eyes to many of the issues discussed earlier. Except in medical circles, the import of this new disease, which threatens the very fabric of society, is receiving no serious attention. Indeed, a look at the statute books would seem to indicate that either the public health regime established in colonial times for disease control still works perfectly, or else the prevention and control of diseases is not a matter of priority now in spite of the Primary Health Care program. It is unclear whether ignorance is the culprit, or whether denial or plain apathy is responsible for this state of affairs. Why would a legal system pretend that its guidance is not required on a major social issue such as this one? The exponential nature of the growth of this problem would be indicative of the problems that are being shored up for the future if no reaction is forthcoming from the legal system. Ghana's problems began in 1986 when the first two cases of HIV were recorded here. In under eight years, by September 1993, 11,872 cases had been reported. Judging by the number of people without access to hospitals, this figure is by no means an accurate indication of the size of the problem. Certainly those people who never reported to a health facility and have died in the villages, do not feature in these statistics. From these figures, it is clear that the attitude affecting the legal system has grave import for everyone in the country: the infected, the affected and non-infected people.

In 1990, the Secretary for Health of Ghana issued a policy statement on the testing of international travellers for the virus (Sarpong 1990). The statement was to the effect that the government wholly supported the WHO stand on the testing of international travellers because such testing was of doubtful utility, and very expensive.

The fact that an incoming traveller carries a certificate of freedom from HIV infection does not mean he is not carrying the virus. In the first place the certificate may be false. Secondly tests to determine HIV infection are not 100% specific and thus a negative result may be a false negative. Thirdly the timing of the test in relation to the date of travel is important in determining whether infected persons are detected or not. The longer the period between the test and the date of travel the greater the chance that the traveller might have become infected between test and travel (Sarpong 1990).

Although the reasons given were unconvincing, that represented the position of Ghana on the point. If this matter had been discussed by the generality of the population, it is

unlikely that they would have adopted such a light-hearted attitude to the value of testing on the sole ground of the presence already of the disease in the country. The question here is this: if the countries with better health-care systems and better facilities for the sick are still testing international travellers, why is a poor country like ours convinced that international travellers pose no risk to Ghanaians?

What public health laws exist at the current time, and how may they be pressed into service for the control of this new disease? The three most prominent statutes are the Mosquitoes Ordinance, Quarantine Ordinance and Infectious Diseases Ordinance. The Infectious Diseases ordinance lists as infectious the following diseases: 'plague, cholera, small-pox, yellow fever and any disease of an infectious or contagious nature which the Minister may declare in manner hereinafter provided' (Section 2, Cap. 78). It is those infected by these diseases who are subject to quarantine under the Quarantine Ordinance. Thus, where a disease cannot be classified as either infectious or contagious, it is not covered by the Ordinance at all. Regulations on quarantine are intended to prevent the spread of disease by isolating those who have contracted it. This is, however, done for the purposes of treatment. It is thus clear that neither of these pieces of legislation is any use in the current situation.

At the level of constitutional provisions, may recourse be had to the provisions of the general police power of the State?¹² This power includes the authority to regulate public health and welfare of the community for the purposes of protecting society from the harm any individual may cause, and preventing individuals from inflicting harm on themselves (Werdel 1990). The State can thus adopt measures that would achieve protection by compelling its citizens to conduct themselves in a prescribed manner. A consideration of the provisions on the police power of the State reveals that quarantine, and restriction of movement for reasons of public health are the measures mentioned for the purposes of the control of infectious diseases¹³. However, for the reasons already outlined above, the provision on quarantine cannot be usefully pressed into service, neither can the clause on restriction of movement¹⁴. The reason for this is obvious: restricting the movement of HIV and AIDS sufferers without more, would be pointless as the kind of activities that can spread the virus are not necessarily curbed by restriction of movement of particular individuals. Therefore new measures are required to deal with this problem.

One of the most serious problems in this area is the problem of individual attitudes and how they threaten individual liberty. The reason for such an assertion is that in a study on attitudes to the disease, 87.5 per cent of the sample, who happened to be nurses, were of the opinion that HIV and AIDS sufferers should be quarantined (Walker 1990). This opinion was held despite evidence that the condition was known to be incurable. In other words, the people were advocating a detention for life for HIV carriers and AIDS sufferers. This attitude is not restricted to the nurses in the sample. In January 1992, a District Magistrate in Accra denied bail to prostitutes brought before him for soliciting (*West Africa Magazine* 27 January - 3 February 1992). According to the report, his reason for doing so was that he required them to submit to an AIDS test before granting bail. There are many interesting questions on this issue. What was the real purpose in such a requirement? Could the magistrate have ordered

¹² This is a reference to the ability of the State to compel its citizens to adopt certain modes of behaviour even against their will, e.g. citizens are compelled to stay alive, by the prohibition of suicide; women who get pregnant are compelled to carry the pregnancy to term, by the prohibition of abortion.

¹³ Article 14(1)(d) and Article 21(4)(c) of 1992 Constitution.

¹⁴ This omnibus exemption clause upholds the lawfulness of 'the imposition of restrictions that are reasonably required in the interest of defence, public safety, **public health** [emphasis mine] on the movement of residence within Ghana of any persons generally or any class of persons'

their detention indefinitely if the tests had revealed that they were HIV-positive? Is the absence of disease now a requirement for bail? Do the courts have a residual power to protect the public against persons with dangerous diseases? Such instances merely serve to illustrate the dangers in relying on knee-jerk reactions at a time when everybody in the society feels threatened.

Attitudes that are even more alarming were revealed in a recent study by Adjei, Owusu and Ablordey (1993). The study, which was based in the Ashanti and Northern regions, and which used the Focus Group Discussion method, showed that a large number of members of focus groups were of the opinion that persons diagnosed as infected should be surreptitiously injected with poison by the doctors so that they would not be able to spread the disease (Adjei et al. 1993:46). Some members opined that if a sibling contracted the disease, they would find a way of killing the person to save the family from disgrace (p.103). Is no one worried that the Ghanaian extended family whose virtues are much touted may now be the cover for murder as a result of this disease?

It is against this background that the absence of visible action on the legislative front gives cause for concern. In July 1993 amendments to the Criminal Code were debated in Parliament. These amendments related to sexual offences and the penalties attached. This was the most obvious occasion for some action to have been initiated on the issue of AIDS since the emergence of AIDS has increased the dangers to which victims of sexual assault are exposed. Unfortunately, AIDS did not feature in the discussion of these offences with the result that despite the alarming statistics of the increase in HIV-positives and AIDS, no consideration was given to these increased dangers. Was this again a classic act of denial, or mere ignorance of the pervasive nature of the disease?

Although Parliament has since this occasion requested, and received, a briefing from the Minister for Health on the disease, action is yet to come out of those sessions. This observation notwithstanding, it is of some moment that the Members of Parliament have exhibited a desire to be properly informed on the subject. It is certainly a welcome first step that would decrease the possibility of policies being adopted because of AFRAIDS. As has been pointed out, there is a danger that policies that may be adopted would not be even adequate responses to the problem. The danger is greatly increased when as a result of AFRAIDS, policies are adopted for the purpose of subjecting sufferers to oppressive measures, such as the confinement of the infected. A proper appreciation of the issues at stake is therefore the *sine qua non* of the formulation of proper policies. As Kirby (1989) pointed out, 'Good laws and policies arise out of good understanding of the relevant scientific data. They do not arise of guesswork, idiosyncratic decisions still less from prejudice, fear and loathing' (p.47). This observation still does not obviate the necessity that action must proceed beyond this first step, and quickly.

What are some of the questions to which the legislature ought to address itself? These fall into different categories. Some are regulatory in nature, and others are in respect of protection for the infected. For the criminal law, some of the issues are the following: ought there to be criminal liability for the intentional spread of the disease through indiscriminate sexual activity? What about intentionally donating blood knowing one's HIV-positive status? These questions are not idle queries. In a recent incident, a man who had been diagnosed HIV-positive at Cape Coast travelled to Saltpond to donate blood. He was found out only because one doctor's suspicions were aroused as to why a voluntary blood donor would move away to donate blood. How many such incidents have occurred without detection? If it has happened once, it can happen again. Should there be increased penalties for infected persons who commit sexual offences? What should be the criminal liability of third parties who intentionally or negligently pass on contaminated blood to patients in a hospital or other health facility? This is not a far-fetched possibility. In a study carried out in Berekum-Jaman

District on the HIV seroprevalence among certain groups of the population, as many as nine per cent were found among 261 blood donors in 1990 (Sardick 1992). In 1993, the average for such donors in the Western Region was a frightening 28.9 per cent (Baka 1993). Other questions are: should there be criminal liability for persons who engage in reckless conduct likely to spread the disease, such as by the use of unsterilized instruments in the course of their occupations, for example herbalists, traditional birth attendants, *wanzams* and barbers? Should 'soliciting for immoral purposes' remain a crime when the AIDS Control Programme is targeting prostitutes as a means of reducing the spread of the disease? Should a seropositive status be a defence for euthanasia, or attempted suicide?

Even health-care workers cannot be trusted to look out for the welfare of the public. The recent case in France involving doctors in the blood transfusion service is instructive on this score. Those doctors were found to have knowingly kept hundreds of litres of contaminated blood in hospital stocks, and given them out for transfusion. Therefore the possibility of health-care workers intentionally or negligently allowing such a situation to occur, is a real one. Similarly, there are people who would rather avoid the expense of procuring sterilized equipment for their occupations by re-using syringes or other equipment, than operate in the manner that would protect the public. The dangers posed by AIDS are such that the criminal sanction should be invoked to the end that it might deter potential violators.

Apart from the criminal law, there is need for the development of a regulatory framework to tackle the issues arising from this epidemic. One of the more pressing issues is the ethics of curative measures. Every so often, the media feature a herbalist who claims to have treated and cured a number of people with AIDS. No one considers this to be human testing of drugs, but are the people involved not being used as guinea pigs for the testing of all manner of herbal preparations? Why should the efficacy of a drug be proved only by its effect on human beings? Is that not the role of guinea pigs and other laboratory animals? Could any pharmaceutical company adopt such methods without a hue and cry from national and international organizations? Yet we suffer this exploitation of the desperate by the opportunists to continue.

Other regulatory measures are also required to resolve the issues such as the following: should hospitals and other health facilities not have a statutory duty to ensure that the appropriate safety regulations are followed by their staff, as well as the correct reporting procedures? Ought there not to be anti-discrimination measures for the protection of the infected? In a number of studies, between 74 per cent and 80 per cent of the sample of respondents indicated that they would not eat with an AIDS patient (Walker 1990; Amofa 1992). Indeed the higher figure is from a sample of nurses. Would such people as represented by the sample attend to a medical emergency involving a known AIDS sufferer? Would they willingly rent out accommodation to such people, or keep them as tenants if they were landlords? What about the 70.7 per cent of the sample who indicated that they would not like to work next to someone with AIDS? Would such people employ people with AIDS? Would they calmly accept a decision by their common employer to continue to employ such a person? Would they tolerate such a person as the teacher of their children? Or a doctor to whom they must go for treatment? If they were lawyers would they represent such a client? What about their families? In Kenya, a female teacher who refused to divorce her infected husband was dismissed because parents would not let her teach their children when this fact became known (Muriithi 1993). People cannot be compelled to relate to the infected in the privacy of their homes, but should such attitudes be encouraged where facilities provided by the State with public funds are concerned? We may vigorously deny that there are such problems in this country, but merely pretending that there would be no such problems in the immediate future will not make the issues disappear. On the contrary, such an attitude is

likely to cause untold hardship to the sufferers who do not need any external force to increase their misery, and who need all the protection that any country can offer to its citizens.

There are other issues pertaining to individual lifestyles; this is because certain lifestyles are known to be risky. The issues then are: should there not be legislation aimed at backing the educational measures being adopted, in order to enforce the observance of some preventive measures? In colonial days, the Mosquitoes Ordinance, 1911 (Cap. 75) was enacted to enforce sanitation measures that would assist in the eradication of malaria. In the same manner that the this ordinance made it an offence to create conditions that would promote the growth of mosquito larvae, ought certain lifestyles to be controlled by legislation? Would such an intrusion into our bedrooms be acceptable to the citizens of this country? The answers to these questions involve choices which have to be made at one time or the other. Why can we not start discussions now?

Reinforcing ethical rules on confidentiality would also require examination. The issue of confidentiality is directly related to the effectiveness of the control measures. Without adequate assurance of confidentiality, few would seek medical assistance in recognized health facilities. Yet there are grave challenges to these time-honoured principles. What is the real substance of this duty of confidentiality that doctors owe to their patients? When has it been broken? Where an infected person refuses to share that information with the spouse or spouses, what should be the doctor's duty? Should the person's spouse be informed anyway? Are the parents and other close relatives of an infected person entitled to be informed of the condition? What about employers who are contemplating investment in training for an employee? Must school authorities be told of a child's condition? In a country where the extended family system ensures that many people feel an affinity towards very many others, keeping professional confidences about a disease of this nature requires almost superhuman effort. Should that effort be required of all health personnel? These are questions not admitting of easy answers. Yet, it may be that in giving attention to them lies the possibility that solutions adopted would bring sufferers out of hiding and into official statistics. The contrary position would only exacerbate the situation and frustrate attempts at increasing protection. Can the legal system continue to maintain a stoic silence on these issues?

Which way forward?

As a matter of urgency, the problem of AIDS should cease being treated as a medical emergency. At the very least, it must be recognized that a multidisciplinary approach is the only hope for the future. Establishing public health agencies to monitor the spread and educate the public are useful starting points, but they risk being ineffective if action does not proceed beyond those points. The aid of the law must be sought in establishing a regime and adopting mechanisms for control. Legislation can be of assistance, but only if formulated from an informed base.

In order to do so effectively, the government must set up a committee to produce a Working Document for legislative action on AIDS. Such a starting point would have two advantages: it would provide a scientific approach to the issue and thus lower the emotional temperature of the discussions that would follow; secondly, it would put together a team of multidisciplinary professionals whose interaction would serve to adequately cater for the interests of the various disciplines. Currently, the medical personnel are setting up systems aimed at monitoring and controlling the epidemic; these include home-based care. Whilst they are so engaged, sociologists note that the extended family that may be expected to take care of a sick member, is not what it used to be. Therefore it may not be a good idea to design a health system based upon the participation of the extended family. Lawyers are likely to worry more about the rights of their clients and other human rights issues. Other social scientists are interested in the effect of this new phenomenon on the social scene and want to

be a part of the solution. Putting such disparate elements together would produce a response which would be a more efficacious assault on the disease.

Recommendations on legislation should approach the issue from the standpoint of protection for the sufferer. At the present time, the stigma of infection is a potent ally to the spread of the disease. The uninfected can take care of themselves by rejecting and isolating the infected. These methods however only serve to provide incentives for going underground so as not to increase the burden of one's infected status. It is for this reason that solutions should aim at reducing the social burden of the disease so as to encourage people to seek medical assistance. Once afflicted, there is no hope of cure. Therefore for those already afflicted, there is no incentive to make public their condition since they stand to gain no personal benefit. If they are being called upon to assist the society by protecting the health of others, then at a minimum, there must be legal guarantees that would assure them of the protective arm of the law. As matters stand at the moment, we require a *kamikaze* mentality in all infected people. Thus, our success in controlling the disease is bound to be limited by the human instinct for self-preservation.

Conclusion

In this paper, an effort has been made to demonstrate the fact that the absence of AIDS-related activity on the legal front is itself a disease. The extent of the problem is such that neither ignorance, feigned or genuine, nor denial that there is a problem requiring action, is of any use in the battle against the disease AIDS. Public health has ceased to be of legislative interest for too long a time and this does not augur well for the health of the country. The AIDS issue goes beyond a public health problem and that fact must be appreciated by all. The nature of the disease, its mode of spread, and the age-groups most at risk compel the conclusion that we continue at our peril to treat HIV/AIDS issues as a mere problem of public health. Indeed, uncontrolled, it would strike at the very heart of the Economic Recovery Programme. Where will be the able-bodied of the society if within the next decade, effective measures are not adopted to stem the tide of HIV infection? How effective can the control measures be if the legal system continues to manifest the symptoms of the Absolute Ignorance or Denial Syndrome? This is a matter that should concern all of us. As John Donne wrote, 'Any man's death diminishes me, because I am involved in Mankind; and therefore never send to know for whom the bell tolls; it tolls for thee'.

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