

HIV-Specific Criminal Law: A Global Review

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Abstract

Although medical and societal advances have succeeded in greatly reducing the spread of the human immunodeficiency virus (HIV) in the three decades since HIV first confounded and crippled the globe, over two million people worldwide are still newly infected with the virus every year. HIV-specific criminal laws, present and often actively enforced in one-third of United Nations member countries, target people living with HIV (PLWH) for cases of exposure, non-disclosure, and transmission. The criminalization of acts specific to HIV is incompatible with current medical knowledge of HIV transmission, international human rights standards, and public health goals. These HIV-specific criminal laws do not reach the intended objective of reducing unsafe behavior that may spread HIV and in fact hamper HIV prevention efforts, reinforce hard-set societal stigma surrounding HIV and the associated acquired immune deficiency syndrome (AIDS), and perpetuate views of PLWH as dangerous criminals that hold sole responsibility for safeguarding the public from HIV infection. The public health and human rights concerns unveiled by the investigation of HIV-specific criminal laws around the world suggest a new course of action: to set aside attempts to use criminal law to govern the complex and nuanced nature of HIV infection and instead redirect limited resources to the continued expansion of historically successful, evidence-based, and rights-centered public health approaches to HIV prevention and treatment.

Introduction

More than three decades into the HIV/AIDS epidemic (Relf & Biederman, 2015), the combination of scientific research and political activism across the globe has paved the way for significant progress in controlling the spread and toll of HIV. The world has seen a drop of over one-third in the annual number of new HIV infections from 2001 to 2014 as well as in annual AIDS-related deaths since the highest recorded number of deaths in 2005. Antiretroviral therapy (ART) has added tens of millions of life-years since the beginning of the epidemic, and ART access for pregnant women has saved hundreds of thousands of children from HIV infection in the past few years alone. Still, over two million people across the globe become infected with the virus every year, with an estimated 2.1 million people newly infected with HIV in the year 2013 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014). A closer look at the numbers reveals that young women, men who have sex with men (MSM), and people who inject drugs (PWID)—groups often already afflicted with social and economic stigma and discrimination—hold a particular vulnerability to HIV infection (Patterson & London, 2002). This connection is of particular interest due to the fact that HIV infection introduces significant additional stigma of its own (Herek, 2002). The legal environment, comprised of laws, enforcement, and justice systems, has tremendous potential to stem discrimination, protect human rights, and provide equality of access to health care. HIV-specific criminal laws, however, turn this tremendous power against the citizens whom it ought—and often, is claimed—to protect. Instead of safeguarding people living with HIV (PLWH), HIV-specific criminal laws actually infringe upon their rights, foster discrimination, and restrict access to health services, including treatment and preventive measures (Global Commission on HIV and the Law, 2012). Such prominent international bodies as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Office of the United Nations High Commissioner for Human Rights (OHCHR), and the United Nations Development Programme’s Global Commission on HIV and the Law have repeatedly called for the elimination of all statutes defining HIV-specific offenses, citing international human rights obligations, misuse of HIV-specific criminal laws to target PLWH, and the sufficiency of general criminal statutes in exceptional cases involving malice (Global Commission on HIV and the Law, 2012; OHCHR, 2006; UNAIDS, 2013a). HIV-specific criminal laws, currently present in approximately one-third of countries worldwide (UNAIDS, 2014), are in need of thorough and proper review, not only to ensure that legislation remains up to date with the most current medical knowledge, but also to uphold the rights of PLWH and increase access to care for PLWH as well as preventive services for all vulnerable groups. By disentangling criminal law from HIV, countries will be able to set aside attempts to use criminal law to govern the complex and nuanced nature of HIV infection and instead turn their focus to the continued expansion of historically

successful, evidence-based, and rights-centered public health approaches to HIV prevention and treatment (UNAIDS, 2013a). Research suggests that this redirection of limited resources towards public health measures as opposed to cumbersome and harmful criminal prosecutions will provide a swifter end to the HIV/AIDS epidemic and a smoother course for those affected (Jürgens *et al.*, 2009). This review aims to provide a global look at criminalization of HIV exposure, non-disclosure, and transmission, evaluating effectiveness and equitability of these three types of criminal laws around the world and providing suggestions based on this analysis for future international directions for HIV-related law and policy.

Reasoning Behind HIV-Specific Criminal Law

What and where

In 2014, 61 countries—just about one-third of all United Nations members—were reported to have in place legislation criminalizing HIV exposure (PLWH putting others at risk of contracting the virus), non-disclosure (PLWH not revealing positive HIV serostatus to those who may be at risk of contracting the virus from them), and/or transmission (PLWH engaging in actions that result in others contracting the virus from them) (UNAIDS, 2014). HIV-specific criminal laws take on a variety of forms, including free-standing statutes, specific provisions enhancing existing sexual offense or prostitution charges (for example, escalating a charge of rape to “aggravated rape” solely because of HIV infection), and specific inclusion under general public health-related crimes that punish disease propagation or infliction of “personal injury” or “grievous bodily harm” (Lambda Legal, 2010; World Health Organization [WHO], 2015). Prosecutions for these charges have been recorded in at least 49 countries (UNAIDS, 2014), indicating that the large majority of these laws are actively enforced. In fact, their use has even increased in recent years, with the 21st century seeing a dramatic rise in HIV criminal prosecutions, especially in North America and Europe (Bernard, 2010; Canadian HIV/AIDS Legal Network, 2014; Nyambe, 2005; Weait, 2007). What’s more, many countries have recently adopted new HIV-specific criminal laws (Csete *et al.*, 2009; Jürgens *et al.*, 2009). In the last four years alone, HIV-specific criminal laws have been newly enacted in Botswana, Uganda, Nigeria, the Dominican Republic, Nicaragua, and the United States (Bernard & Cameron, 2013; Civil Society Coalition on the HIV/AIDS Prevention and Control Act 2014, 2014; HIV Justice Network, 2015).

Why

The continued creation of HIV-specific criminal laws, particularly in Africa, Asia, Latin America, and the Caribbean, appears to be driven by the desire to curb the rapid spread of HIV compounded by the perceived failure of existing HIV prevention efforts (Jürgens *et al.*, 2009). Criminal theory suggests that HIV-specific criminal laws aim to accomplish the

goal of reducing HIV-transmitting behaviors in three ways: by using law to threaten punishment for PLWH who engage in risky behavior, to create a social norm that persuades PLWH that risky behavior is wrong, and to incapacitate via imprisonment PLWH who are most prone to risky behavior (Lazzarini *et al.*, 2002). Research shows, however, that support for HIV-specific criminal laws varies unmistakably based on HIV status, with most of those who believe they are HIV-negative backing laws that they believe will reduce their chance of contracting HIV (Horvath *et al.*, 2010), and providing rationales of retribution and punishment for PLWH as opposed to reduction of HIV transmission (Dodds, Weatherburn, *et al.*, 2009). Policymakers, too, most commonly justify HIV-specific criminalization with the argument that PLWH who engage in unsafe behavior ought to be punished for their morally wrong and harmful behavior (Jürgens *et al.*, 2009). In other words, fear of HIV, discrimination against PLWH, and ignorance about how HIV is transmitted are “almost palpable” beneath the even sometimes well-intentioned outer façade of public health enhancement (Bernard & Cameron, 2013).

HIV is a public health matter, not a criminal matter

Public health norms emphasize mutual responsibility in the endeavor to prevent HIV transmission (Cameron *et al.*, 2008), and the broader concept of social justice holds that burdens and responsibilities in a society should be equally shared among members, regardless of factors like serological status (Gagnon, 2012). Despite the fact that transmission of the virus by definition involves two people, HIV-specific criminal laws and prosecutions continually lay the blame solely on PLWH, reinforcing the societal idea that PLWH hold complete responsibility for HIV transmission (Cameron, 2009). As United Nations Secretary-General Ban Ki-moon remarked, in practice HIV-related criminalization has achieved the opposite of its intended public health goal and actually reduces effectiveness of HIV prevention by reinforcing stigma and broadcasting the message that PLWH are a danger to society (United Nations, 2009). The laws can even be seen to go so far as to criminalize sickness, as they only apply to PLWH and selectively restrict their civil liberties, punishing them for behavior that is undeniably normative for other members of society (Hoppe, 2014). PLWH are often prosecuted for cases in which HIV was not transmitted and for behaviors that present no significant epidemiological risk of infection (Hoppe, 2014), including spitting (UNAIDS, 2012a) and sexual activity using condoms (UNAIDS, 2012b). Prosecutions of this nature stand in direct opposition to the best scientific and medical evidence and are believed to in fact nurture an environment of injustice and ignorant fear (UNAIDS, 2013b). These criminal investigations, by far exceeding the original intent of legislation (Crown Prosecution Service, 2008; Power, 2009), also end up chipping away at public confidence in the criminal justice system (Dodds, Bourne, & Weait, 2009; Mykhalovskiy, 2011) and discouraging HIV testing, as lack of

knowledge of an HIV-positive status is potentially the best defense for someone targeted by an HIV-related lawsuit (Jürgens *et al.*, 2009). Because the principal purpose of the criminal justice system is to carry out justice and not to enhance public health (Burris *et al.*, 2007), the interjection of criminal law in the matter of HIV prevention erodes solid public health practice, discouraging openness, running contrary to current medical knowledge of transmission risk, and introducing unnecessary anxiety and confusion for PLWH as well as healthcare providers (Mykhalovskiy, 2011).

Problems with HIV-Specific Criminal Law: Prevention

The science behind HIV infection has long been understood, from the manner of transmission and how to best prevent it to the course of disease progression and how to slow it down in infected individuals (Patterson & London, 2002). But while transmission of the virus is easy enough to comprehend, criminal laws complicate matters by wielding their influence over many of the variables integral to HIV spread, including condom use, needle sharing, blood testing, and ART access (Lazzarini & Klitzman, 2002), often via additional factors of stigma, discrimination, social esteem, morality, and social responsibility (Gagnon, 2012; Hoppe, 2014; Kirkham & Browne, 2006). Though HIV-specific criminal laws began as structural interventions to reduce HIV-transmitting behaviors (Blankenship *et al.*, 2000), reduction of transmission relies heavily on the assumption that PLWH will refrain from engaging in risky behaviors as a result of these legal provisions (Burris *et al.*, 2007). Because sexual activity and drug use, which together account for most cases of HIV transmission (Jürgens *et al.*, 2009), are so tied down by societal influences, however, they become questionable targets for the blunt instrument of criminal penalties (Dodds, Bourne, & Weait, 2009; Gagnon, 2012). Indeed, historical examples of prohibition, drug, and sodomy laws have demonstrated the difficulty of enforcing laws criminalizing potentially pleasurable behavior along moral lines (Burris *et al.*, 2007). Criminalization of HIV exposure, non-disclosure, and transmission appears to only continue this time-tested trend.

EXPOSURE. The following is a small sample of current criminal HIV exposure laws around the world.

COLOMBIA: LAW NO. 599 OF 2000 - BY WHICH THE CRIMINAL CODE IS ENACTED

ARTICLE 370. SPREAD OF HUMAN IMMUNODEFICIENCY VIRUS OR HEPATITIS B (AMENDED BY LAW NO. 1220 OF 2008). ANYONE WHO, AFTER BEING INFORMED OF BEING INFECTED BY THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) OR HEPATITIS B, MAKES PRACTICES BY WHICH HE CAN CONTAMINATE ANOTHER PERSON, OR GIVES BLOOD, SEMEN, ORGANS OR GENERAL ANATOMICAL COMPONENTS, SHALL BE LIABLE FOR IMPRISONMENT OF SIX (3) TO TWELVE (8)

YEARS (Congress of Colombia, 2008; Global Network of People Living with HIV [GNP+], 2014).

KENYA: ACT NO. 3 OF 2006 - SEXUAL OFFENCES ACT

26. (1) ANY PERSON WHO, HAVING ACTUAL KNOWLEDGE THAT HE OR SHE IS INFECTED WITH HIV OR ANY OTHER LIFE THREATENING SEXUALLY TRANSMITTED DISEASE INTENTIONALLY, KNOWINGLY AND WILLFULLY DOES ANYTHING OR PERMITS THE DOING OF ANYTHING WHICH HE OR SHE KNOWS OR OUGHT TO REASONABLY KNOW -

(A) WILL INFECT ANOTHER PERSON WITH HIV OR ANY OTHER LIFE THREATENING SEXUALLY TRANSMITTED DISEASE;

(B) IS LIKELY TO LEAD TO ANOTHER PERSON BEING INFECTED WITH HIV OR ANY OTHER LIFE THREATENING SEXUALLY TRANSMITTED DISEASE;

(C) WILL INFECT ANOTHER PERSON WITH ANY OTHER SEXUALLY TRANSMITTED DISEASE, SHALL BE GUILTY OF AN OFFENCE, WHETHER OR NOT HE OR SHE IS MARRIED TO THAT OTHER PERSON, AND SHALL BE LIABLE UPON CONVICTION TO IMPRISONMENT FOR A TERM OF NOT LESS FIFTEEN YEARS BUT WHICH MAY BE FOR LIFE (National Empowerment Network of People Living With HIV and AIDS in Kenya, 2010).

ALASKA: STAT. §12.55.155(C)(33)

SENTENCE ENHANCEMENT FOR HIV EXPOSURE

THE SENTENCING COURT MAY IMPOSE A SENTENCE ABOVE THE PRESUMPTIVE RANGE IF THE OFFENSE WAS A FELONY SEXUAL OFFENSE SPECIFIED IN ALASKA STAT. §§11.41.410-11.41.455, THE DEFENDANT HAD BEEN PREVIOUSLY DIAGNOSED AS HAVING OR HAVING TESTED POSITIVE FOR HIV OR AIDS, AND THE OFFENSE EITHER (A) INVOLVED PENETRATION, OR (B) EXPOSED THE VICTIM TO A RISK OR A FEAR THAT THE OFFENSE COULD RESULT IN THE TRANSMISSION OF HIV OR AIDS (Center for HIV Law and Policy, 2015; GNP+, 2012).

Ineffective prevention of unsafe behavior

Several empirical studies have concluded that criminal HIV exposure laws are “extremely unlikely” to reduce HIV transmission (Mykhalovskiy, 2011; O’Byrne, 2011). Few differences in frequency of unprotected sex have been observed between jurisdictions with and without HIV-specific criminal laws (Burriss *et al.*, 2007; Horvath *et al.*, 2010), and qualitative research on PLWH in England has found that almost half of homosexually active males report zero impact of HIV-specific criminal laws on the frequency of their unprotected sexual behavior. Even those with altered behaviors do not all report safer behavior, with some in fact increasing their anonymity during sexual relations because of fear of judgment and ostracism (Dodds, Bourne, & Weait, 2009). These criminal laws also tend not to encourage safer behavior because they foster a false sense of security in individuals who believe they are HIV-negative, thus uprooting the public health message that sexual relations necessitate responsible behavior from all involved (Jürgens *et al.*, 2009; Spencer, 2004). Furthermore, the fact that these criminal laws single out actions of PLWH renders them incapable of preventing HIV transmission in the first few months post-infection, when PLWH are generally unaware of their positive serostatus but also when the risk of HIV transmission is the highest (Jürgens *et al.*, 2009). Finally, the incarceration of PLWH as a

result of HIV-specific prosecutions may actually increase overall HIV transmission risk, as behaviors like unprotected sex and sharing of drug equipment are commonplace in prisons, and effective, evidence-based preventive measures like provision of condoms and sterile injecting equipment as well as programs for rehabilitation and rape or sexual violence reduction are not (Okie, 2007; WHO, 2007).

Vagueness regarding varying degrees of risk

The difficulty in using HIV-specific criminal law to prevent unsafe behavior is heightened by the fact that most of the laws do not account for degree of risk of HIV transmission, which can vary greatly depending on the nature of the behavior and any preventive measures that may have been taken (Francis & Mialon, 2008). As a result, PLWH and public health counselors run into difficulties reconciling the gradient of epidemiological HIV transmission risk with the stark black-and-white nature of law (Mykhalovskiy, 2011). The ambiguity of what constitutes a risk, or something that “can” or “is likely to” transmit HIV, as many of these statutes are worded, causes PLWH fear, anxiety, and frustration in their daily lives (Mykhalovskiy, 2011). Misconceptions are common even among those who understand the core elements of the law or have attended informational sessions on HIV-related criminal prosecutions, and can result in an underestimation of the risks of certain sexual behaviors (Dodds, Bourne, & Weait, 2009). Some laws are so broadly written that they could even be used to prosecute PLWH for an omission of action, such as becoming pregnant or not getting an HIV test, regardless of the availability of HIV testing or preventive services (Canadian HIV/AIDS Legal Network, 2007; Jürgens *et al.*, 2009). It is not surprising, then, that misunderstandings by police officers—of the laws, the nature of HIV transmission, or the meaning of scientific evidence—often result in improper application of HIV-specific criminal laws (Terrence Higgins Trust, 2009).

NON-DISCLOSURE. The following is a small sample of current criminal HIV non-disclosure laws around the world.

MICHIGAN: COMP. LAWS ANN. § 14.15 (5210)

(1) A PERSON WHO KNOWS THAT HE OR SHE HAS OR HAS BEEN DIAGNOSED AS HAVING ACQUIRED IMMUNODEFICIENCY SYNDROME OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX, OR WHO KNOWS THAT HE OR SHE IS HIV INFECTED, AND WHO ENGAGES IN SEXUAL PENETRATION WITH ANOTHER PERSON WITHOUT HAVING FIRST INFORMED THE OTHER PERSON THAT HE OR SHE HAS ACQUIRED IMMUNODEFICIENCY SYNDROME OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX OR IS HIV INFECTED, IS GUILTY OF A FELONY.

(2) AS USED IN THIS SECTION, “SEXUAL PENETRATION” MEANS SEXUAL INTERCOURSE, CUNNILINGUS, FELLATIO, ANAL INTERCOURSE, OR ANY OTHER INTRUSION, HOWEVER SLIGHT, OF ANY PART OF A PERSON’S BODY OR OF ANY

OBJECT INTO THE GENITAL OR ANAL OPENINGS OF ANOTHER PERSON’S BODY, BUT EMISSION OF SEMEN IS NOT REQUIRED. (Center for HIV Law and Policy, 2015).

BERMUDA: CRIMINAL CODE (SEXUAL OFFENCES) AMENDMENT ACT 1993

§ 324: SEXUAL ASSAULT BY PERSON WITH AIDS, ETC

(1) IT IS A SEXUAL ASSAULT IF A PERSON—

(A) KNOWING THAT HE HAS A SEXUAL DISEASE, DOES A SEXUAL ACT WHICH -

(I) INVOLVES CONTACT BETWEEN ANY PART OF HIS BODY AND ANY PART OF THE BODY OF ANOTHER PERSON (WHETHER OR NOT THAT OTHER PERSON IS HIS SPOUSE OR CONSENTS TO THE ACT); AND

(II) IS CAPABLE OF RESULTING IN THE TRANSFER OF BODY FLUIDS TO THAT OTHER PERSON; AND

(B) BEFORE HE DOES THE ACT DOES NOT INFORM THAT OTHER PERSON THAT HE HAS THE DISEASE, EITHER IDENTIFYING THE DISEASE OR MAKING CLEAR TO THAT OTHER PERSON THAT HE HAS A DISEASE TO WHICH SECTION 324 OF THE CRIMINAL CODE APPLIES.

(2) “SEXUAL DISEASE” IN SUBSECTION (1) OF THIS SECTION AND IN SUBSECTION (2) OF SECTION 325 MEANS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR HEPATITIS B OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION (Government of Bermuda, 1993).

CANADA: SUPREME COURT RULING R. v. CUERRIER, (1998) 2 SCR 371

THERE IS A LEGAL DUTY TO DISCLOSE HIV-POSITIVE STATUS TO SEXUAL PARTNERS BEFORE HAVING SEX THAT POSES A “SIGNIFICANT RISK” OF HIV TRANSMISSION, INCLUDING ANAL OR VAGINAL SEX WITHOUT A CONDOM. UNPROTECTED SEX WITHOUT DISCLOSURE (AND CONSENT TO RISK OF HIV TRANSMISSION) IS FRAUD (R. v. Cuerrier, [1998] 2 SCR 371).

Unreliable link between disclosure and safer behavior

Criminal HIV non-disclosure laws do not necessarily bring about disclosure, and in turn, disclosure does not necessarily induce positive behavior change. Consistent disclosure of HIV status in all sexual contexts is widely viewed by PLWH as unrealistic, and interviews with PLWH reveal that what PLWH consider disclosure can often be as vague as statements like “You know we should use a condom” (Dodds, Bourne, & Weait, 2009). Even the most explicit disclosure does not rule out the possibility of unsafe behavior, as many HIV-negative individuals knowingly participate in unprotected sex with PLWH (Simoni & Pantalone, 2004). Moreover, PLWH have reported that the laws actually discourage HIV status disclosure by inspiring fear of the negative social consequences of being labeled morally reprehensible (Dodds, Bourne, & Weait, 2009).

Additional reasons for non-disclosure

Although there may be many potential reasons for non-disclosure, the stark nature of non-disclosure laws makes no distinction between being unwilling and unable to disclose (Ontario Advisory Committee on HIV/AIDS, 2002). Most PLWH who transmit HIV either are unaware they are infected or do not disclose their HIV status because of fear of violence, discrimination, rejection by family and friends, or other abuses based on their HIV status. A study of PLWH in China, for example, revealed that

100% of participants displayed high scores of disclosure concern related to the high prevalence of HIV-based public discrimination in China (UNAIDS, 2009; Wu *et al.*, 2015). While such fears do not free PLWH of all accountability, prosecution of these people under HIV-specific criminal laws does nothing to deter their behavior, address the underlying causes, or further justice (Jürgens *et al.*, 2009). Criminalization brews an atmosphere of fear and retribution around HIV transmission, instead of the safe and supportive social and legal environment that the United Nations and countless endorsing countries pledged to promote in 2006 (United Nations General Assembly, 2006). Even perceived stigma has been shown to prompt non-disclosure, lack of adherence to medications, low self-esteem, and poor quality of life (Charles *et al.*, 2012; Li *et al.*, 2011), and the combination of intensified stigmatization with the threat of criminal charges brought about by HIV-specific criminal laws only serves to make disclosure all the more difficult (Gagnon, 2012).

TRANSMISSION. The following is a small sample of current criminal HIV transmission laws around the world.

ROMANIA: LAW NO. 301 OF 2004: PENAL CODE

ART 384 - VENEREAL CONTAMINATION AND TRANSMISSION OF AIDS

(1) TRANSMISSION OF A VENEREAL DISEASE BY SEXUAL INTERCOURSE, BY SEX BETWEEN SAME-SEX PERSONS OR ACTS OF SEXUAL PERVERSION BY A PERSON WHO KNOWS THEY SUFFER FROM SUCH DISEASE SHALL BE PUNISHED WITH IMPRISONMENT FOR 1-5 YEARS.

(2) TRANSMISSION OF ACQUIRED IMMUNODEFICIENCY SYNDROME - AIDS - BY A PERSON WHO KNOWS THEY ARE SUFFERING FROM THIS DISEASE IS PUNISHABLE BY IMPRISONMENT FOR 5-15 YEARS (Parliament of Romania, 2004).

BURUNDI: LAW 1/018 OF 12 MAY 2005 ON THE LEGAL PROTECTION OF PEOPLE INFECTED WITH HIV AND OF PEOPLE SUFFERING FROM AIDS

ARTICLE 42. ANY PERSON WHO WILLFULLY TRANSMITS HIV BY ANY MEANS WILL BE PROSECUTED FOR ATTEMPTED MURDER AND IS PUNISHABLE ACCORDING TO THE PROVISIONS OF CRIMINAL LAW (National Assembly and Senate of Burundi, 2005).

MARSHALL ISLANDS: TITLE 7 - PUBLIC HEALTH SAFETY AND WELFARE

§1511. OFFENSE FOR TRANSMISSION OF AIDS OR HIV

ANY PERSON KNOWINGLY INFECTED WITH AIDS OR HIV, WHO PURPOSEFULLY OR THROUGH GROSS NEGLIGENCE TRANSMITS SUCH DISEASE TO ANOTHER PERSON, SHALL BE GUILTY OF A CRIMINAL OFFENSE, AND SHALL UPON CONVICTION BE LIABLE TO A FINE NOT EXCEEDING \$100,000 OR TO A LIFE OF ISOLATED CONFINEMENT UNDER THE CARE OF THE MINISTRY OF HEALTH SERVICES, OR BOTH. IN ADDITION, ANY SUCH OFFENDER SHALL BE LIABLE TO CIVIL DAMAGES AND ANY OTHER RIGHTS AND REMEDIES WHICH A VICTIM MAY HAVE AT LAW OR EQUITY (Nitijela of the Republic of the Marshall Islands, 2004).

Punishing knowledge or lack of knowledge of HIV status

Criminal HIV transmission laws may better account for the range of risks associated with various sexual behaviors than exposure and non-disclosure laws, as behaviors carrying lower risks are less likely to result in the

transmission that the laws target. To assess the effectiveness of HIV-specific criminal laws in the United States, Francis and Mialon (2008) developed a model of HIV testing and sexual behavior decisions that ultimately points to the superiority of criminal transmission laws in reducing HIV transmission. The model indicated that most of the United States' HIV-specific criminal laws do not sustain the socially optimal outcome of potential PLWH choosing to get tested for HIV. Since most criminal HIV exposure and transmission laws only penalize exposure or transmission when individuals are aware of their positive HIV serostatus, these laws may discourage PLWH from getting tested, thus jeopardizing individual as well as public health. According to Francis and Mialon's model, the socially optimal law is a criminal transmission law with a single penalty of one to two years in prison for knowingly or unknowingly transmitting the virus, and no penalty for exposing someone to the virus without transmitting it. While this proposed socially optimal law would indeed no longer punish knowledge of HIV status as many current HIV-specific criminal laws do, it would now actually punish lack of knowledge of HIV status, which while theoretically capable of increasing HIV testing, in practice presents significant ethical dilemmas, as availability of testing is limited in many parts of the world (UNAIDS Reference Group on HIV and Human Rights, 2015) and even where testing is available, access may be obstructed by factors like stigma and social inequalities (Global Commission on HIV and the Law, 2012).

Human rights violations

Human rights emphasize the dignity of all people and provide conditions including freedom from violence, sexual coercion, arbitrary arrest, and discrimination, allowing individuals to make healthy, safe, and responsible choices regarding their health and their lives (Jürgens *et al.*, 2009). Reviews of HIV-related legislation and circumstances facing PLWH repeatedly lay out human rights violations not only limiting access to HIV services but also negatively impacting the ability of PLWH to live full and dignified lives, through such diverse avenues as employment, housing, education, social security, and insurance. Worldwide, approximately one in eight people with HIV is denied health services and one in nine is denied employment due to HIV-positive status (UNAIDS, 2014). All PLWH interviewed in Iran had experienced denial of care by healthcare providers (Karamouzian *et al.*, 2015), and half of the HIV-negative interviewees in India reported they would not accept treatment at a clinic serving PLWH (Ekstrand *et al.*, 2012). In China, 42% of the thousands of PLWH studied had experienced HIV-related discrimination (UNAIDS, 2009), and in the United States, the Centers for Disease Control and Prevention (2014) reported that in 2014, almost one in eight American PLWH were unaware of their positive serostatus, largely due to stigma (Relf *et al.*, 2015).

Problems with HIV-Specific Criminal Law: Treatment and Care Criminalization of HIV exposure, non-disclosure, and transmission not only stands in the way of efforts to prevent unsafe behavior, but also dissuades individuals who may be HIV-infected from getting tested or accessing care (O’Byrne, 2011). Though transmission by default involves two parties, criminalization and criminal prosecutions of PLWH reinforce the idea that PLWH hold sole responsibility for HIV transmission, escalating preexisting stigma and discrimination in all sectors of life (Cameron, 2009). Stigma and discrimination in the realm of health care in particular deserve special attention because they effectively bar not only human rights but also personal health of PLWH (UNAIDS, 2013b).

Patient-provider relationship

The intrusion of criminal law into health care diverts valuable attention in patient-provider relationships away from public health and feeds further confusion through contradictions between legal advice and medical knowledge of risk. The existence of HIV-specific criminal laws also makes it markedly more challenging for healthcare providers to establish strong counseling relationships in which PLWH can be open and honest about their sexual activities and difficulties with disclosure (Mykhalovskiy, 2011), as PLWH commonly fear that information shared with healthcare providers will be used against them in the criminal justice system (Jürgens *et al.*, 2009). In both industrialized and developing countries, HIV-related stigma has been observed to have a negative impact on the patient-provider relationship, provision of care, health and wellbeing of PLWH, and ability or willingness to access health care (Nyblade *et al.*, 2009). Stigma expressed by healthcare providers, through judgmental language, blame, humiliation, mockery, moral disapproval, assumptions, physical distance, and unnecessary precautions, as well as discriminatory practices like delayed, withheld, or differential treatment, breaches in confidentiality, intrusive questioning, and isolation from other patients (Naughton & Vanable, 2013), cause fear and reluctance to seek care (Rahangdale *et al.*, 2010; Turan *et al.*, 2008), lack of disclosure of HIV status to healthcare providers (Agne *et al.*, 2000; Mill *et al.*, 2009; Mill *et al.*, 2010) and even termination of healthcare relationships (Dawson-Rose *et al.*, 2005). Despite strong evidence that with standard safety measures, the risk of healthcare providers contracting HIV is low (Duffy, 2005; Genberg *et al.*, 2009; Holzemer *et al.*, 2009; Lekganyane & du Plessis, 2012), providers continue to display unnecessary and discriminatory precautionary behavior around PLWH. Because physicians are traditionally seen as confidants for private personal information (Karamouzian *et al.*, 2015), discriminatory behavior by healthcare providers puts PLWH in the uniquely challenging situation of attempting to seek proper health care while avoiding stigmatization from the very people they are expected to be most vulnerable to.

Public stereotypes

Though HIV-related stigma in the healthcare setting has traditionally been studied in terms of the direct interaction between the healthcare provider as the perpetrator of stigma and the patient as the target of stigma, researchers are becoming increasingly aware of the need to examine HIV-related stigma at a more structural level, with the added forces of social motivations, institutions, laws, and policies (Gagnon, 2015). Prosecutions of PLWH for low- to nonexistent-risk actions such as spitting, biting, and scratching contribute to a misinformed public and reinforce the stereotype of PLWH as immoral and dangerous criminals. In addition, the inflammatory and ill-informed media coverage that comes with criminalization causes the same reluctance to seek health care and talk openly with healthcare providers as direct discrimination from providers (Gagnon, 2015; Jürgens *et al.*, 2009). Interviews with PLWH reveal that they are made aware of negative social perceptions of HIV through such disparate routes as hearing others express ignorant thoughts, seeing bias in the media, and being rejected by partners, family, or friends (Mazanderani & Papparini, 2015). In many societies, HIV infection is commonly given an across-the-board attribution to immoral and socially unacceptable acts such as drug injection and prostitution, regardless of whether individual PLWH actually partook in such activities (Wu *et al.*, 2015). Because these activities are considered voluntary, avoidable, and risky, infection is then regarded as a personal responsibility, resulting in much greater stigma than would come from any other infection deemed beyond an individual's control (Ntoh Yuh *et al.*, 2014). The fact that HIV and other sexually transmitted infections attract particular legal intervention demonstrates how criminalization is used to bolster existing societal concepts of right and wrong and forge the moral link between sickness and badness (Hoppe, 2014).

Personal influences

The effects of HIV-related stigma extend from broad public swaths into even the closest of personal circles. Quality of life of PLWH is highly dependent on social support (Bajunirwe *et al.*, 2009; Gielen *et al.*, 2001; Yadav, 2010). In China, internalized stigma was reported to have a greater impact on quality of life of PLWH than any other factor, and decreased family stigma was also associated with increased quality of life (Wu *et al.*, 2015). Similarly, PLWH in Colombia with strong family support reported better mental health, a vital component of an individual's total health (Cardona-Arias *et al.*, 2011). Families that withdraw support may practice extreme avoidance of PLWH, display anger and rejection, demand that PLWH eat and sleep separately, or evade casual contact, among other isolating behaviors. The effects of losing family support can be devastating: in a qualitative study on PLWH in Iran, 100% of participants expressed misery about their HIV status, often based on assumptions that they were completely alone, with no loved ones willing to care for them

anymore. Many spoke of lost hope and wished to die rather than endure their seemingly pointless current circumstances (Karamouzian *et al.*, 2015).

Recommended Action

Due to the broad and far-reaching effects of HIV-related stigma and discrimination on all aspects of the health and wellbeing of PLWH, the Global Commission on HIV and the Law, Joint United Nations Programme on HIV/AIDS (UNAIDS), and other international organizations dedicated to ending the HIV/AIDS epidemic repeatedly urge countries to take immediate action to repeal HIV-specific criminal laws and prohibit discrimination based on HIV status (Global Commission on HIV and the Law, 2012; UNAIDS, 2013a; UNAIDS Reference Group on HIV and Human Rights, 2015). The extreme and rare cases of truly intentional HIV transmission are best addressed by general criminal laws against harm to others, rather than targeted, easily misappropriated, and empirically detrimental criminal laws punishing PLWH (Global Commission on HIV and the Law, 2012). According to UNAIDS (2013b), 60% of all countries report the presence of laws, regulations, or policies that impede effective HIV prevention, treatment, care, and support for PLWH and vulnerable groups. When used in the right way, however, the legal system does harbor the potential to empower PLWH and better guarantee access to needed care. It is time to turn the legal impact of HIV from something completely negative—punishing PLWH, increasing vulnerability, and driving them further from HIV services—to something markedly more constructive—prohibiting discrimination, providing retribution for violence, and guaranteeing equal access to HIV services (Jürgens *et al.*, 2009). More than 100 countries already have legislation outlawing discrimination based on HIV status, but the reality that anti-discrimination laws are often ignored, barely or not at all enforced, or deliberately flouted (Global Commission on HIV and the Law, 2012; UNAIDS, 2014) suggests that laws alone are not enough to fight the deeply ingrained societal conceptions of HIV/AIDS around the world.

Legal frameworks to counter discrimination must be complemented by appropriate enforcement to ensure that law enforcement officials are up to date on current HIV medical knowledge and avoid “knee-jerk” reactions harming PLWH (Bernard & Cameron, 2013). Enforcement of anti-discrimination also includes legal support for PLWH and education for PLWH on their rights, as well as anti-stigma programming to establish sustainable social norms of inclusion, tolerance, and non-discrimination. In 2013, 103 of 109 countries conducting mid-term reviews of national progress in the effort to reverse the HIV/AIDS epidemic identified elimination of stigma and discrimination as a national priority. But 62% of countries in Eastern and Southern Africa and 50% of countries in Asia and the Pacific disclosed that they were not on track to eliminate stigma and discrimination, and more than half of the 133 countries with reported HIV

spending had not invested at all in human rights programs (UNAIDS, 2013b). As resources are limited, efforts are likely best directed towards public health measures with known impact on HIV transmission, such as HIV/AIDS and sexual education for young people, integration of HIV preventive services into routine reproductive and sexual health care, provision of multiple HIV testing settings and modalities, and linkage of testing with prevention and treatment services (Jürgens *et al.*, 2009; UNAIDS Reference Group on HIV and Human Rights, 2015). Addressing underlying causes of gender-based violence and gender inequalities has also been shown to reduce HIV transmission (Jürgens *et al.*, 2009). A study of adolescent boys in South Africa, for example, found that boys who believe condom use symbolizes love and respect for a partner are more likely to use condoms, demonstrating a need for shifts in gender beliefs and condom attitudes (Harrison *et al.*, 2012).

In addition to efforts to reduce social discrimination on the large scale, HIV counseling and specialized interventions addressing internalized and family stigma can be used to improve perceptions of HIV for PLWH and family members, reevaluate feelings of guilt and shame, and empower PLWH to take charge of their personal health (Wu *et al.*, 2015). Good counseling and access to preventive measures like condoms as well as medicine to reduce mother-to-child transmission of HIV make PLWH more likely to take steps to protect others from infection (Jürgens *et al.*, 2009). Finally, sharing experiences, a key component of counseling, anonymous phone lines, and support groups, has been shown to fortify sense of self in PLWH. In more unstable, economically poor countries, sharing stories in the right way with the right people can not only empower PLWH but can also even provide a precious gateway to scarce lifesaving antiretroviral treatments (Nguyen, 2010).

Conclusion

The criminalization of HIV exposure, non-disclosure, and transmission in one-third of United Nations member countries worldwide is incompatible with current medical knowledge of HIV transmission as well as international human rights standards and public health goals. HIV-specific criminal laws do not accomplish the intended objective of reducing unsafe behavior that may spread HIV. In fact, they undermine the effectiveness of HIV prevention by reinforcing existing societal stigma and hampering open and honest communication with sexual partners and healthcare providers. Because the laws do not effectively prevent HIV transmission, in essence they simply serve to punish PLWH, sustaining the misguided thought that PLWH are dangerous criminals holding sole responsibility for protecting the HIV-negative from infection. Seeing as HIV-specific criminal laws raise such public health and human rights concerns, these laws require prompt and thorough review worldwide. HIV prevention necessitates a public health and not a criminal law perspective, emphasizing mutual responsibility for safe sexual relations and increased

access to health care and preventive services for all. Criminal law should be reserved for cases of truly intentional transmission, which are rare and already covered by general criminal laws against harm to others. Laws and policies to curb discrimination, social and gender inequalities, and sexual violence must be properly enforced, and legislation must be coupled with public health measures incorporating HIV services into routine care, educating young people on HIV transmission, and linking testing to preventive services in order to best combat HIV. Finally, HIV counseling and personal and family interventions are needed to address specific obstacles and empower PLWH to take care of their own health. In sum, redirecting limited resources from demanding and caustic criminal prosecutions to the more comprehensive, evidence-informed, and rights-based combination of societal anti-discrimination measures, HIV prevention and treatment services, and individual support will enable us to uphold the best interests of PLWH and public health at large as we continue to endeavor to put an end to the three-decade-long struggle that is the HIV/AIDS epidemic.

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