

Criminalization of HIV Transmission: A Continuing Challenge in Health Law and Policy

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Introduction

Human immunodeficiency virus (HIV) infection is a leading world public health issue. Virtually no part of the globe is immune from the reach of this mortal microbe.¹ In the United States someone becomes infected with HIV every thirteen minutes.² Without effective and timely medical intervention HIV is a creeping condition that culminates in Acquired Immune Deficiency Syndrome (AIDS). No cure has yet been discovered for HIV/AIDS.³ Although relatively much is known clinically about HIV-AIDS today, the disease is still shrouded in mythology about its source and aetiology.⁴ Some commentaries about the disease in the United States embraced vilification and demonology.⁵ Disfavored communities have been castigated as incubators and purveyors of the HIV pathogen.⁶ This sentiment taps into the intense social and legal debate in the United States about the HIV epidemic.⁷

In the United States, an emergent approach to the HIV crisis was based on legislation and litigation.⁸ Reacting to public panic about HIV-AIDS, the political and legal system sought to criminalize HIV transmission.⁹ Criminal law in the United States is largely a state prerogative. Individual states enact their own criminal codes. Criminalization of HIV transmission, therefore, generated different approaches and interpretations in state criminal law.¹⁰ The impetus to criminalize HIV transmission also emanated from the federal level.¹¹

In response to federal initiative, (the Ryan White Comprehensive AIDS Resources Emergency (Care) Act of 1990) the states enacted HIV specific statutes that criminalized the intentional infection of HIV.¹² Whether the states were using traditional criminal laws or HIV-specific statutes, criminalization of HIV yielded disparate standards and approaches that have drawn skepticism in the legal community as to their propriety and utility.¹³

The thrust of this paper is about criminalization of HIV and the public health response. The paper has a two track approach. The first track maintains that criminalization is a wrong or dubious approach to the HIV epidemic in the United States because of (a) disparate standards between the states (b) problems of legal proof under traditional criminal law¹⁴, and (c) HIV-specific laws that were often overbroad, vague and ambiguously stated.

The thesis of this paper, therefore, is that criminalization of HIV transmission is a legally problematic approach to an epidemic that otherwise requires pragmatic initiatives in public health policy and jurisprudence. The second track identifies and analyzes those public health initiatives which include voluntary testing, mass education, prevention, counseling, treatment, and anti-discrimination laws.

The paper is organized into six sections. The first three sections cover the first track focusing on criminalization. The last three sections correspond to the second track dealing with public health law and policy analysis. The first section focuses on the biomedical and clinical anatomy of HIV transmission. This is necessary to explore the connection between legal and medical causation. Many of the HIV cases turn on the causation element. The criminal justice approach to HIV infection becomes tenuous when it is recognized that many of the acts that have drawn criminal charges and convictions may not be medically causative of HIV infection.¹⁵

The second section reviews the application of traditional criminal law to HIV infection and the legal problems posed by that approach. The third section discusses the emergence of HIV-specific statutes and the legal issues involved. The fourth section provides a broader analysis of public health law and policy on HIV. The fifth section examines the transnational dimensions of HIV, as a pathway to integrate the discussion into the comparative and international public health discourse. The final section outlines a cluster of recommendations to control HIV infection. As a matter of law and policy, a constructive approach to HIV transmission should be cognizant of the clinical and biomedical realities of HIV.

Ia. Clinical and Bio-Medical Anatomy of HIV

HIV is a highly contagious disease of white blood cells.¹⁶ Although HIV is referenced in tandem with AIDS, there are phases of infection that the HIV-AIDS patient experiences.¹⁷ HIV infection is contracted through one of two viruses-- HIV-1 or HIV-2 that invade white blood cells known as lymphocytes or CD4+ cells and continuously enfeeble them.¹⁸ There are many phases of infection that an AIDS victim experiences.¹⁹ In the initial stages after infection, a patient's CD4+ cell count may atrophy by fifty percent.²⁰ This early phase discloses symptoms often associated with mononucleosis. Upon recovery, the individual may feel well for many years.²¹

During the cycle of infection the HIV retrovirus attacks the host by imparting its genetic matter onto human DNA.²² Once it penetrates a host body, the virus never exits.²³ During the period of latency, the virus is detectable only through laboratory probe.²⁴ Another stage of escalation occurs through AIDS-related complex, which manifests itself in enlarged lymph nodes, night sweats, declining weight, and chills.²⁵ This stage of infection is not fatal until AIDS maturation occurs. AIDS is the end-stage of HIV infection. At this late stage, the virus decimates the body's T-helper or white blood cells that are the mainstay of the human immune system.²⁶

HIV infection is detectable through screening blood samples with a highly accurate blood test known as the enzyme-linked immunosorbent assay (ELISA) test.²⁷ If the ELISA test is positive, a repeat test is performed with the more accurate but costly western blot test.²⁸ During the screening, the tests reveal the presence of antibodies. However, those antibodies are not detectable by testing in all victims.²⁹

Due to this unclear window between infection and detection, criminal prosecution may fail for inability to prove causation against carriers who may have conveyed the virus during the dormant mode.³⁰ Full blown AIDS is diagnosed when an infected person's beneficent CD4+ cells plunge below 200 per micro liter of blood.³¹ HIV transmission occurs through contact and exchange of bodily fluids. Exposure does not always yield infection. There is no medical proof yet that HIV is transmitted through casual contact involving coughing, sneezing, mosquito bites, sweating, perspiration, handshaking, administering cardio pulmonary resuscitation, or spitting by an infected individual.³²

Because HIV is not casually transmitted, but has explicit blood infusion pathways of infection, any legal project to criminalize transmission may falter on scientific causation. Virtually all the earlier criminal prosecutions involved spitting and biting actions.³³ This problem of proof heavily afflicts the use of traditional criminal codes to trace transmission. To bypass this legal hurdle, prosecuting bodies embraced HIV-specific statutes³⁴. However, the HIV-specific statutes had several legal obstacles. They were either too broad or vague in terms of their scope, impact and coverage. Consequently, those specially enacted statutes were not entirely immune from the legal challenges discernible in traditional criminal law and its application to HIV as a serious public health issue. A leading issue about criminalization is whether HIV is an exceptional contagion that requires exceptional legal and policy consideration.

Ib. HIV-Exceptional or Traditional Public Health Issue

Contrary to the notion that public health response to HIV is inspired by HIV exceptionalism, HIV is not an exceptional epidemic.³⁵ Microbes have existed on earth for billion of years. In the Middle Ages, bubonic plague spread by rat fleas killed three out of four Europeans.³⁶

In the early twentieth century, a wave of influenza swept over Asia, Australia, Europe, and the United States killing over thirty million worldwide and one out of every ten Americans.³⁷ HIV has viral endowments that set it apart from other disease inducing microbes.³⁸ The unique epidemiology, microbiology or virology of HIV does not necessarily isolate it from other mass killers such as cardiac disease or malignancies.³⁹ Experts agree that all of these maladies represent different ways of dying that equally challenge public health to find effective curative therapies.⁴⁰

Yet, throughout history when confronted with an epidemic to which humanity has no known cure, societies have relapsed into hysteria and irrational psychosis.⁴¹ The human ability to control infectious diseases is recent. It was not until the twentieth century that science developed successful medicines for most bacterial and fungi infections, or effective vaccines for diphtheria, measles, polio, rubella, smallpox, tetanus, typhoid fever, yellow fever, and whooping cough.⁴² Miracle drugs such as penicillin, sulfanilamide, and streptomycin then became known.

In the second half of the twentieth century, optimism prevailed among microbe fighters, only to be pierced by a new plague-HIV/AIDS.⁴³

Once HIV surfaced, the public relapsed into its traditional response to epidemics by scapegoating and singling out those who are different.⁴⁴ HIV victims labored under the gaze of public displeasure.⁴⁵ In the history of communicable diseases, HIV has not been treated in a different or exceptional way when the response to it resembles the traditional public health panic.⁴⁶ As one commentary notes, AIDS makes people angry. However, in law, as in the public health milieu, one must be rational.⁴⁷ Yet over twenty states passed HIV specific criminal laws.⁴⁸ The preponderance of counterproductive policies and statutes, notably criminal statutes that have been enacted across the United States belie the notion of exceptional or even preferential treatment for HIV.⁴⁹ The unique properties of HIV do not make it exceptional. It is in the league of other major health threats that face the nation.⁵⁰ As a public health researcher explains, the passions that diseases can generally inspire, is what makes public health as much a political art as a bio-medical science.⁵¹ The political environment of public health became manifest when several states in reaction to public panic sought to deal with the HIV situation through traditional criminal law.

II. Criminalization under Traditional Criminal Law

Criminalization of HIV transmission is a controversial issue.⁵² Advocates of criminalization insist that criminal sanctions will curtail the intentional or reckless exposure of others to HIV.⁵³ Detractors of criminalization see it as counterproductive to an effective public health focus.⁵⁴ Nevertheless, sensational cases like that of Nushawn Williams who exposed over 100 women in New York to HIV inspired urgent calls to apply criminal laws to punish people for intentional HIV infection.⁵⁵ Criminalization of transmission became popular with state legislatures.⁵⁶ Criminal law is a state prerogative. Different states define offenses differently. However, most of the state criminal codes were inspired by the Model Penal Code. As such, some level of generalization of state practice is identifiable.⁵⁷

Depending on the activity at issue, criminal offenses such as murder, attempted murder, manslaughter, negligent homicide, assault or reckless endangerment have been used to prosecute those who expose others to HIV.⁵⁸ These offenses have proved difficult to establish under general criminal law. Under the Model Penal Code, three elements must be present for a murder conviction: conduct, state of mind, and causation.⁵⁹

According to the Model Penal Code, a homicide can either be murder -- a homicide committed purposely, knowingly, or with extreme recklessness; or negligent homicide - a homicide committed negligently, or manslaughter which may be reckless or negligent homicide.⁶⁰

Prosecuting an individual for homicide as a result of HIV transmission is problematic because homicide prosecution requires a *corpus delicti* and death of the victim.⁶¹ However, there is no immediate death upon HIV infection. The HIV transferor may be dead by the time the latent infection surfaces.

Using a homicide charge is also made difficult by the requirement in most states that a victim's death must occur within a year and a day of the criminal conduct.⁶²

Even so, often the first element of proof, conduct, is the easiest to establish.⁶³ It requires proof that the defendant engaged in the conduct that resulted in the HIV transmission. This might require a showing of sexual intimacy.⁶⁴ The more problematic barrier involves the mens rea and causation elements. The mens rea element requires that the perpetrator have an explicit or manifest intent based on circumstantial conduct to kill through HIV transmission. To establish first-degree murder, the actor must be aware of his HIV status and must exhibit a desire to spread it. This is difficult to prove absent an admission by the defendant.⁶⁵ Even if this element can be proved by shifting to lesser degrees of murder that requires a reckless state of mind, the causation barrier is formidable.⁶⁶ If the victim has multiple sexual partners, tracing the source of infection challenges judicial competence. The long gestation period between infection and detection is not helpful to this legal inquiry where the prosecution has to prove beyond a reasonable doubt that the defendant's conduct was the proximate cause of the victim's condition.⁶⁷

Ruling out all conceivable sources other than the accused is virtually impossible, especially if the victim is dead and not available to testify.⁶⁸ Clinical tests can be performed to identify the HIV strains involved, but the tests are expensive and not fail safe.⁶⁹

The causation element is equally problematic. Proving that the accused is a conduit is problematic without direct evidence of infection. The accused can always point to the victim's high risk behavior as defense.⁷⁰ The accused may argue that the victim's high risk contact prior to or following the alleged infection, occurred in a reasonable time before the onset of symptoms. This defense may handicap the prosecution because of the difficulty of proving beyond a reasonable doubt that the accused was the original contributor of the virus. Hence, successful prosecutions for homicide resulting from HIV transmission is rare.⁷¹

Prosecutors have shifted to prosecutions for attempted homicide.⁷² The crime of attempted homicide is relatively easier to prove than homicide because it does not require death of the victim or causation.⁷³ However, attempt is a specific intent crime. The prosecution has to prove beyond a reasonable doubt that the defendant acted with this requisite state of mind to commit homicide. This approach is legally problematic because it is difficult to prove to a trier of fact that a defendant intending to kill a victim chose this non-spontaneous instrumentality. The prosecution is at a disadvantage to prove specific intent to kill somebody absent an express statement by the defendant.⁷⁴

The intent requirement renders prosecution for attempted murder difficult. Many states seek to overcome this problem by enacting the impossibility doctrine, whereby a defendant cannot claim impossibility to a charge of attempted crime.⁷⁵ This means that even if it is medically impossible to transmit HIV through a particular defendant's conduct, if he/she believes that transmission is possible, the prosecution is allowed the inference that he intended to cause such transmission.⁷⁶

Legal problems abound also in the spitting cases where courts have found intent to murder based on the defendant's subjective belief that he could transmit HIV by biting, spitting, or scratching the victim regardless of the clinical and bio-medical integrity of that claim. In Weeks v. State, an HIV positive defendant was convicted of attempted murder and sentenced to life for spitting on a guard, causing saliva to land on the guard's glasses, lips, and nose.⁷⁷

A defense expert testified that HIV is present in saliva, but is inert.⁷⁸ The jury accepted a contra indication by a prosecution expert whose opinions were scientifically suspect.⁷⁹ Due to the legal problems of convicting defendants of attempted murder in the biting and spitting cases, some juries have acquitted HIV positive defendants of attempted murder and instead convicted them of assault as an alternative avenue of criminalization.⁸⁰

Usually a misdemeanor, assault is defined as attempting to cause or causing bodily injury to another.⁸¹ Generally, consent is a defense to assault. Yet in the assault cases, the prosecution contends that consent to sex does not include consent to HIV infection.⁸² Some observers contend that consent to engaging in behavior that presents a risk of exposure to HIV is not legally sufficient, there must be consent to the exposure per se.⁸³ Although the prosecution has to prove causation and intent in this crime, courts hold that the intent requirement is met where a defendant exhibits mere intent to engage in unprotected intercourse. Other courts hold to the contrary.⁸⁴ A study of multiple jurisdictions indicates that prosecutors have charged HIV infected people with assault and assault with a deadly weapon based on conduct believed to create risk of transmission.⁸⁵

The major proof problem under assault is that unless "likeliness" of transmission can be demonstrated, assault prosecutions flounder, falter, and fail.⁸⁶ Many states have instead used reckless endangerment statutes to prosecute HIV cases.⁸⁷ Under the statutes, one commits a misdemeanor if one "recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury."⁸⁸ This statute is arguably the most suitable criminal statute to apply if HIV transmission is to be sanctioned. It seems attractive because it does not require proof of purpose or intent to transmit HIV.⁸⁹ That is, no actual transmission needs to occur. The sole requirement is that the defendant consciously disregarded a substantial risk of transmission.⁹⁰

The proof problem or the disregard element in this crime requires a showing that the defendant was aware of the infection, and has been counseled about HIV and was aware of what behaviors could create unjustifiable risk of transmission.⁹¹ The issue is that prosecuting under this theory is minimally burdensome, but may be still potentially problematic because it could discourage people at high risk to seek testing and counseling which confers imputed knowledge to them.

Criminalization is also problematic when applied to prostitution.⁹² Laws that criminalize prostitution have minimal impact on fighting the spread of HIV.⁹³

Such laws drive prostitution underground, where unregulated, it thrives on behavior most likely to maximize infection.⁹⁴ Some states include HIV transmission in their communicable disease statutes, which are antecedent to the outbreak of HIV.⁹⁵ In other jurisdictions, HIV is not classified as a sexually transmitted disease.⁹⁶ Prosecuting individuals under those prior statutes is problematic because they implicate due process and fair notice claims.⁹⁷ Given the problematic issues involved in criminalizing HIV transmission under traditional common law, most states turned to HIV specific statutes.

IIIa. HIV Specific Statutes

The major impetus in the rise of HIV specific statutes was the passage of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990.⁹⁸ Under the Act, a state's emergency AIDS relief was contingent upon showing that the state's laws are adequate to prosecute individuals who inflict or expose others to HIV.⁹⁹ The HIV specific statutes also arose in part as a response to the legal challenges in using traditional criminal statutes to prosecute conduct that poses risks of transmission.¹⁰⁰

A recent study indicates that 23 states have adopted HIV specific statutes that create a crime of knowing HIV exposure.¹⁰¹ Unlike traditional penal laws, HIV specific statutes do not require proof of either injury, causation, or *mens rea*.¹⁰² The HIV specific statutes have recognizable advantages over traditional laws. First, they provide clearer warning about what amounts to a crime.

Second, they may focus on real risks of transmission and place the obligation to define the crime on the legislative body, not prosecutorial discretion.¹⁰³ Nevertheless, the HIV specific statutes are still legally problematic because many of them are underinclusive by reaching unsafe sex while leaving unsafe drugs unscathed.¹⁰⁴

Others are overinclusive because they fail to distinguish between sexual conduct likely to transmit HIV and conduct that poses little risk.¹⁰⁵

There is wide disparity among the states applying HIV specific statutes. Some provide for simple prohibitions against the intentional transfer of HIV to another person.¹⁰⁶ Others provide detailed statutes to specify prohibited acts.¹⁰⁷ Although the Congressional mandate in the CARE Act recommended criminalization only for those who act with specific intent to transmit HIV, only four states require specific intent.¹⁰⁸ The other states require mere knowledge, but some states do not define the knowledge element.¹⁰⁹ The new HIV statutes eliminated the burden of showing intent and causation. The statutes require knowledge of infection and committed acts that created some risk of transmission.¹¹⁰ Another advantage is that if the new statutes are narrowly crafted, they can give clear notice.¹¹¹ Another benefit is that those statutes that recognize the defense of informed consent can encourage disclosure to a partner.¹¹²

Three types of HIV statutes are identifiable.¹¹³ First, those that require disclosure of one's HIV status before exposing others to infection. Second, those with an informed consent element. Third, those that are so broad that they possibly criminalize all behavior that exposes others to HIV.¹¹⁴ These approaches are more or less problematic. The majority of the HIV specific statutes require disclosure to sexual partner(s).¹¹⁵ However, as one scholar notes, disclosure may be insufficient to protect those who may be powerless to decline intimacy.¹¹⁶ Even where informed consent is available, the states show disparity in enactment.¹¹⁷ In some states consent is an element of the crime that the prosecution has to negate. In other states, consent is an affirmative defense, which the defendant has to prove.¹¹⁸ Depending on the allocation of burden of proof, informed consent may be outcome determinative.¹¹⁹

A more problematic issue is that regardless of consent and disclosure, one may not legally consent to the transmission of HIV. Many of the HIV statutes are so seemingly broad that they appear to criminalize risky conduct regardless of consent or disclosure.¹²⁰ A major legal limitation for these statutes is that by their overbreadth, they can confuse individuals about what conduct is prohibited while criminalizing trifles and triviality through state enactments.¹²¹

III b. State Statutory Enactments

An overview of typical state HIV statutes reveals serious legal problems. The California HIV statute prohibits unprotected sexual activity by persons infected with HIV.¹²² The law requires that the infected person acts with knowledge and specific intent to transmit.¹²³ Yet, as in traditional criminal law, specific intent is problematic to prove.

Arguably, the most problematic statute has been enacted in Illinois. The statute states that criminalization of HIV occurs when a “person knowing they are infected with HIV engages in intimate contact with another.”¹²⁴ Intimate contact is defined as the “exposure of the body of one person to the bodily fluid of another person in a manner that could result in transmission of HIV.”¹²⁵ The statute has drawn constitutional challenges.¹²⁶ A major criticism is that the statute does not specify whether actual knowledge or constructive knowledge satisfies the knowing requirement.¹²⁷ For instance, the receipt of a confirmed positive test results is proof of actual knowledge of infection. Persistent symptoms of the disease may put an individual on notice and operate as constructive knowledge of infection. Such a distinction will be beneficial to the inquiry about a defendant’s knowledge. Yet, the statute provides no such clarity of definition. The statute is therefore constitutionally vulnerable for its overbreadth and amorphous scheme.

Invariably, proving intent is a transcending issue in state prosecutions. Even where intent is established by a subpoena of test results, problems abound because those results may be confidential or protected by a privilege.¹²⁸ The concern is that if the government coerces disclosure of confidential records, it could chill constitutional rights and deter future voluntary testing.

Second, the prosecution could prove the defendant’s knowledge through admission to family, friends, sexual partners, and other individuals.¹²⁹ The problem with this approach is that it invites the state to intrude into the personal lives of people close to HIV positive persons contrary to public policy.¹³⁰

The HIV specific statutes enacted by the other states involve the same or similar issues identified in the sample states. Whether a state is using traditional criminal law or HIV specific statute, criminalization generates other intractable problems that implicate the peri-natal or intra-partum setting.

The criminalization of transmission by HIV positive mothers presented intractable problems.¹³¹ The proliferation of HIV infected mothers and infants also generated drastic laws.¹³² At the beginning of the epidemic, suggested remedies included forced abortions, forced sterilization and criminalization of HIV transmission from mother to fetus.¹³³ The mandatory HIV testing of pregnant women advocated by some is legally problematic and undesirable in policy terms.¹³⁴ This is because criminalization of peri-natal HIV transmission through coercive state action undermines maternal privacy rights. As one analyst found, non-consensual disclosure of test results may place women at risk for abuse, discrimination, and heightened domestic violence.¹³⁵ Voluntary testing and counseling could be more effective in encouraging expectant mothers to submit to testing and desirable behavior.¹³⁶ Overall, criminalization of HIV transmission is a problematic approach in ethical, constitutional, and legal terms. Therefore, it should yield to more pragmatic policies in public health that are preferable to coercive criminal law policy in contrast.

IIIc. Policy Comparison: Criminal Law Policy vs. Public Health Policy Considerations

Invariably, public health initiatives should take precedence over criminal law policy on the basis on several considerations. Criminal sanctions usually serve four basic functions.¹³⁷ The first is to incapacitate the offender from injuring anyone else during the period of incarceration. This function may not significantly prevent HIV transmission. This is because imprisoning a person with HIV may not prevent them from spreading the virus, due to conjugal contacts and high-risk behavior with other inmates. Prisons are normally settings in which high-risk behavior is prevalent largely due to lack of access to means of prevention. In most cases, those in jail will ultimately be released into the general community. Risky behavior inside prisons may contribute to further transmission outside. Viewed in this light, it is apparent that prison health issues are not isolated from the protection and promotion of community health.¹³⁸

The second function of criminal law policy is to rehabilitate the offender, to enable him to modify his activities in order to avoid injuring others. It is doubtful whether criminal penalties will rejuvenate a person to the extent where they will avoid future fateful behaviors. Public health approaches are more versatile and can likely support longer-term behavioral changes than the crude instrument of criminal fines or imprisonment.¹³⁹

The third function of criminal law policy is to impose retribution for wrongdoing. This approach is inadequate when compared to public health goals, because imposing punishment for its own sake is unrelated to, and may well be antithetical to the primary public health interest to prevent the transmission of HIV. Furthermore, it appears that appealing to a desire for retribution in making policy runs the risk of appealing to prejudice and reinforcing discrimination.

Such discrimination occurs when policy makers do not hold steadfast to the reality that physically assaultive conduct is criminal per se, irrespective of whether it carries any risk of infection. This means that the HIV status of the offender is not essential in determining whether or not a crime has been committed.

In cases where the offender's sero status is considered as an "aggravating" factor, it must be based on bona fide evidence that a heightened risk exists. Without serious analysis and contemplation, any attempt to levy more serious charges and harsher sanctions on the accused based solely on his HIV-positive status could amount to unwarranted discrimination.

Such an approach is disfavored in public health policy, because singling out people living with HIV/AIDS as potential criminals, contributes to stigma and discrimination and undermines HIV prevention policy.¹⁴⁰

The final function of criminal law policy is to deter the offender and others from engaging in the forbidden conduct in the future. In cases where a moral concern for the welfare of others has not produced a change in behavior in the accused, it is dubious whether a legal edict will have much additional leverage. Risky behavior including drug use and sexual activity sometimes persist in the face of possible prosecution. When prosecutions materialize, those behaviors are temporarily suppressed and driven underground, thereby hindering efforts to promote HIV prevention, and facilitate access to appropriate care, treatment and support.¹⁴¹ Criminal law policy as such may have possible detrimental effects on public health initiatives by reinforcing HIV/AIDS-related stigma, creating a disincentive to HIV testing, hindering access to counseling and support, and creating a false sense of security that the virus may be at bay once an offender is jailed. To overcome such undesirable outcomes, criminalization should recede in favor of more pragmatic initiatives, strategies, and perspectives in public health.

IVa. Perspectives in Public Health

There are multiple perspectives about what constitutes a viable public health approach to the HIV epidemic. The status of HIV as a public health menace means that several traditional methods of disease control may be utilized. These methods include mandatory reporting, mandatory testing, quarantine, and contact tracing and education.¹⁴² Many of those techniques have been applied in the past by the medical community to combat communicable diseases.¹⁴³ But because infectious diseases are different, these instruments may not be equally suited to each epidemic including HIV. Most of the methods may well be counterproductive in the fight against HIV.

Advocates of mandatory reporting point to the fact that currently all fifty states require the reporting of confirmed cases of AIDS.¹⁴⁴ The suggestion then is to extend mandatory reporting to those who test positive for HIV.¹⁴⁵ The idea is that asymptomatic HIV carriers can unknowingly spread the infection and thus pose the greatest health risk. However, this approach is fraught with problems, not least of which is the potential breach of confidentiality that may not be easily cured by testing under a pseudonym.¹⁴⁶

Another controversial method is mandatory testing. Proponents of this method urge a broadening of testing to cover mandatory and universal HIV testing of all Americans on an annual basis.¹⁴⁷ The argument is that voluntary testing is not effective because most HIV positive individuals are oblivious of their sero status, and therefore pose greater risk to others.¹⁴⁸ In that sense the benefit of testing is early detection and access to life enhancing medications such as Zidovudine (AZT). Despite the perceived benefits, mandatory testing should include the cost of pre-and post-test counseling, absent that testing may be a hollow exercise.

Mandatory testing is akin to criminalization with its focus on compulsion and coercion. On the surface mandatory testing seems reasonable when it is linked to counseling and treatment. However, as one study found, it has been repudiated by the vast majority of the public health community.¹⁴⁹ While mandatory testing may be potentially attractive with safeguards for confidentiality, that trust can be breached through mismanagement or negligence that may eventually lead to the disclosure of test results.¹⁵⁰

Universal testing may not be a practical or prudent idea on several grounds. First, as one study notes, a negative test result does not necessarily mean that one is well and fit.¹⁵¹ There are several months of incubation following exposure before HIV antibodies develop. Hence, a recently infected person may receive a false negative. Similarly, a positive result does not always mean that a person will develop AIDS. Massive intensive testing is also costly.

Widespread involuntary testing is coercive, and not in line with the trust and confidences as well as the voluntary cooperation required to counsel people to alter their behavior.¹⁵² Involuntarily testing chills the cooperation that public health officials need to combat HIV infection. Mandatory testing is not a practical solution, and is likely counterproductive to the public health purpose to control HIV.

The other problematic approach is public health quarantine. Initial calls for tattoo on HIV infected persons never took effect. Quarantine is a method of disease control that is applied to highly contagious diseases. Historically, quarantine has proved ineffective in controlling the spread of diseases.¹⁵³ The public usually yearn for quarantine under two or more conditions. First, the disease was dreadful with no immediate cure. Second, those most impacted by the disease were socially disfavored. Third, the public was fearful of the disease.¹⁵⁴ HIV fit all these attributes. It has no confirmed cure, yet. It afflicts minorities disproportionately, and it terrifies the public.

Quarantine is neither efficacious nor practical. It is inappropriate and problematic in relation to HIV because quarantine is generally used to combat highly infectious diseases. HIV is infectious but it is not spread through casual contact. HIV-positive individuals may remain asymptomatic for many years. Quarantine is impractical in that context. Using quarantine is also problematic because that step implicates constitutional rights.¹⁵⁵ Extending a quarantine to those who are infected with HIV means they may be denied their fundamental liberties due to what they may or may not do in the future.¹⁵⁶ Unless an HIV positive person can be pronounced completely cured, a quarantine of such a person will be in perpetuity and would amount to a life sentence.¹⁵⁷ Such a disproportionate approach is problematic, counterproductive and undesirable in public health terms.

Another public health approach is contact tracing. It is a traditional method of disease control designed to disrupt the nexus of disease transmission spread through person-to-person contact.¹⁵⁸ Although some commentators allude to the efficacy of contact tracing in helping to stop the spread of communicable diseases, that approach is impractical and problematic for three reasons.¹⁵⁹ First, contact tracing is cumbersome. Second, it exposes the infected person to breach of confidentiality, stigmatization and discrimination. Third, it may discourage people from seeking testing.¹⁶⁰ One possible way to enhance contact tracing is to promote the confidentiality and anonymity of those tested.

A related public health approach is mandatory partner notification and name reporting. Partner notification involves tracing past partners of an HIV infected person and notifying them of their exposure. People in the AIDS community embrace voluntary partner notification than a state mandated program.¹⁶¹ Name reporting involves collecting personal data about patients who test positive for HIV, and reporting the information including the patient's name to the state health department. The practice of name reporting is already in use for HIV positive individuals who have AIDS. The issue then is whether to report new HIV infection by the patient's name or by a unique identifier.¹⁶² This has to be handled delicately. AIDS is a unique condition that stigmatizes its victims in a way that requires sensitivity by public health actors. AIDS still evokes powerful emotions and irrational fears of transmission including latent or overt hostility to AIDS patients.¹⁶³ Disclosure of a person's HIV positive status or diagnosis may entail serious repercussions for that patient. Discrimination against those living with HIV/AIDS is commonplace. Such patients are often denied access to medical care, deprived of housing and squeezed out of jobs. These actions are legally redressable, but often go unresolved due to the resource imbalance between the HIV patient and the purveyor of discrimination.¹⁶⁴

Disclosure may also lead to subtle behaviors by others that can harm the HIV positive person's interests. Credit may dry up, friends and community may keep their distance and impute promiscuous lifestyle and related innuendos. The more individuals dread this likely rejection, the less willing they are to seek testing. Hence, public health measures that appear to compromise confidentiality is not a practical idea because it discourages high risk individuals from getting tested. These intrusive policies may also fall unevenly on minority communities where the disease is growing the fastest.

As one study found, it then become psychologically comforting to feel that AIDS belongs to a group of which one is not happily a member.¹⁶⁵

The distrust of healthcare providers by minority communities is not new. The distrust may emanate from skepticism about the government's sincerity in keeping records private. The distrust may also stem from a general reluctance to place one's self in the hands of the public health care system due to abuses at Tuskegee and elsewhere, coupled with the stereotypical belief that Africa is the harbinger of HIV/AIDS.¹⁶⁶

The belief that AIDS originated in Africa feeds a perception that people of African descent are presumptive virus carriers.¹⁶⁷ Earlier in the evolution of the epidemic, there were contra-suspicions in the minority community that the disease was manufactured in a conspiracy to decimate the minority.¹⁶⁸ AIDS mythology is a powerful subject in itself that refuses to disappear in the face of contrary signs.¹⁶⁹

Trust and social attitudes have an impact on HIV policy. The ability of HIV patients to trust the public health service is essential to efforts to promote prevention. Although awareness and public attitudes about HIV/AIDS have improved over the past two decades, the persistence of social stigma and discrimination should galvanize public health efforts to protect individual rights as a matter of legal policy.¹⁷⁰

IVb. Public Health Policy and Jurisprudence

In terms of practical public health policy, the consensus is that the best way to eradicate AIDS is through education and pragmatic public health policy, not through impractical projects like mandatory testing. Most of the jurisdictions in the United States have therefore made voluntary testing the centerpiece of their HIV prevention laws.¹⁷¹ By law several states prohibit involuntary testing.¹⁷² In Kentucky, the General Assembly noted that the public health will be better served by facilitating informed, voluntary and confidential use of tests designed to detect HIV.¹⁷³ In Pennsylvania, the General Assembly has declared its intent to promote confidential testing on an informed and voluntary basis in order to encourage those most in need to obtain testing and counseling.¹⁷⁴

One transcending theme in AIDS prevention statutes are provisions that forbid involuntary HIV testing and guaranteeing the confidentiality of results. As one study found throughout the 1990's, prohibiting involuntary testing became a cottage industry for legislatures.¹⁷⁵ Thus, every jurisdiction in the nation has a statute that requires consent before an HIV test can be administered, or a statute that implies that the test must be voluntary.¹⁷⁶

The United States Congress has embraced the notion of prohibiting involuntary HIV testing by making written informed consent a requirement for receiving grants under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.¹⁷⁷ Most states now require that a subject be informed that the test is voluntary. Most of the state statutes also require actual consent, informed consent or written consent.¹⁷⁸ Voluntary testing is now the norm.

To achieve policy balance, voluntary testing where necessary is accompanied by limited purpose exceptions. These exceptions are closely limited in scope. As a study indicates, most of the exceptions deal with medical necessity.¹⁷⁹ First, testing is usually permitted on body fluids or parts earmarked for medical research, transfusion or transplantation.¹⁸⁰

In those cases the HIV status of the specimen is essential. Second, under the medical necessity exception, healthcare workers exposed to possible contaminated body parts are allowed to demand an HIV test. Third, truly blind medical testing is allowed because it poses no privacy problems, and has great potential for medical advancement.¹⁸¹ Fourth, testing is allowed as a matter of necessity in an emergency situation where an individual is unable to give consent. Fifth, testing performed as part of autopsy is permitted where the breach of privacy is moot.¹⁸²

Another cohort of exceptions involve the criminal justice system.¹⁸³ Many states require convicts or suspects in sexual offense cases to be tested.¹⁸⁴ This exception is to enable victims in those cases to learn about their HIV status. Another arena in the criminal justice system where involuntary testing has become an issue is the prison system.¹⁸⁵ Even though advocates of mandatory testing argue that it is necessary to halt the spread of AIDS in prisons, public health officials advocate voluntary testing and education in the prison system.¹⁸⁶ Despite the lack of consensus about how to deal with AIDS in the criminal justice arena, the overwhelming consensus on the civil side favors voluntary testing.¹⁸⁷

Another exception outside the realm of medical necessity and criminal law is for life insurance companies.¹⁸⁸ In that enterprise, the exception was granted as an underwriting necessity. Another area of exception is that many states have provisions in their voluntary testing statutes which allow involuntary testing when required by state or federal law. As a matter of appropriate medical federalism, an effective HIV policy also requires a concerted approach at the national level.

IVc. Trends and Policy at the National Level

The oldest field of public health regulation is the control of communicable diseases.¹⁸⁹ Traditionally, states have police powers to regulate the public health of their citizens. Periodically, the federal government involves itself in disease control. In previous generations, the federal government became heavily involved in efforts to stop the spread of sexually transmitted diseases.¹⁹⁰ That involves preventing the spread of such diseases and efforts to control other epidemics which occur. The federal government offers guidelines for the states in areas of disease control through the federal grants-in-aid programs. Generally, public health matters are legislated by the separate state governments rather than the federal government. Within each state, the legislature sets the overall limits on the reach of its state or local department of health.¹⁹¹

A more effective and practical policy about HIV requires a robust federal focus. Yet, as one analyst notes the federal government's efforts to shape a national response to the crisis has been at best ad hoc and piecemeal.¹⁹² Parallel to the national program, each state adopted its own approach to the epidemic. The spread of HIV is a national public health threat. Separate state actions may be ineffective in coping with the threat. There is a need for a sustained national public health policy focus.

Typically most of the funding provided by the federal government is for HIV/AIDS prevention and treatment.¹⁹³ Restrictions imposed on the use of that funding influences public health policy at virtually every level. As one study found, while federal agencies such as the Centers for Disease Control and the Health Resources and Services Administration offer guidelines for the array of HIV prevention, care and research throughout the nation, the enactment of public health law occurs primarily at the state and local level.¹⁹⁴ This enables states and counties to tailor HIV services to the specific needs of their population. Yet, as the study found, this approach also results in diffused and inconsistent HIV treatment and prevention policies across the country.¹⁹⁵ This situation is challenging given the finding that public health agencies in the United States tend to be underfunded, overworked, and are often struggling to gain political support for their agendas, legal mission, and regulatory reach.¹⁹⁶

IVd. Public Health Laws and Regulations

As a regulatory matter, some states combine public health laws with HIV-specific criminal statutes.¹⁹⁷ The benefit of using public health law instead of criminal sanctions is that an individual's quarantine or isolation will only last as long as that individual refuses to modify his/her behavior.¹⁹⁸ In that sense, alternative public health methods are preferable to criminal approaches. If the legislatures embrace public health laws, community programs and mass education, and de-emphasize criminal prosecutions that suspend confidentiality of HIV results, then more HIV carriers may undergo testing and crucial counseling and receive life preserving aid.¹⁹⁹

Although state legislatures have a compelling interest in preventing the spread of HIV, overzealously attacking the crisis from every angle, presents conflicting interests which may impede or detract from any effective progress.²⁰⁰

One area of progress is education. This essential component in disease control constitutes the government's primary weapon in its efforts to combat the spread of HIV.²⁰¹ The educational strategy has had a positive effect in slowing the spread of HIV in most communities. However, to the extent that the disease continues to spread, there is a need to couple education with other pragmatic initiatives and regulations.

Hence, some states seek to control HIV through regulatory rather than criminal provisions.²⁰² Due to the problematic nature of criminalization, the outright preference for public health alternatives over coercive and mandatory measures is openly displayed in many legal systems in both the developing and developed nations.

V. HIV Policy in Comparative /International Perspective

HIV/AIDS is a global threat of the first magnitude. It has affected much more than the social and legal communities in the United States. It has severely impacted Africa and other regions over the last two decades.²⁰³ Its effects have been so severe that it has caught the attention and attracted the involvement of the United Nations. One nation that epitomizes this crisis in Africa, and one whose approach has been recently compared to that of the United States is South Africa.²⁰⁴ Several factors led to the spread of HIV in South Africa. The nation maintains an efficient transportation infrastructure that allows for high mobility and thus facilitate the rapid spread of HIV. There is lack of objective information and services for the South African youth regarding the virus. The nation also has increased high poverty and low educational levels which lead to risk taking behavior.²⁰⁵

Cultural norms also make it difficult to halt the spread of the disease as well. Adolescents are targeted because of the belief that sex with a virgin can cure HIV.²⁰⁶ Traditionally, women have low status in society, making it difficult for them to protect themselves in sexual relationships.²⁰⁷

By all accounts, HIV/AIDS is a devastating social and medical epidemic in South Africa. Yet unlike the United States, the South African government did not single out HIV victims by enacting legislations that criminalize HIV related behavior.²⁰⁸ Analysts recount several reasons why the government did not choose criminalization. The primary objective of South African criminal laws are the same as American jurisprudence: incapacitation, deterrence, retribution and rehabilitation.²⁰⁹ The South African Law Commission did not believe that criminalization of HIV transmission will serve these purposes.²¹⁰ Instead, it believed that criminalization of HIV transmission would have an isolating effect on the afflicted. The legal establishment saw criminalization as neither the ideal nor the only way to cope with the epidemic.²¹¹

Many other nations do not favor the criminalization of HIV transmission. The United Nations and Amnesty International reject criminalization, and in African countries where HIV is widespread, there is no appetite to adopt anti-HIV laws prevalent in the United States.²¹² In South Africa and elsewhere in Africa, the consensus is that criminalizing or stigmatizing sufferers of HIV will not solve the epidemic.

The belief is that it is necessary to combat the ways the disease is transmitted without condemnation, shame or guilt.²¹³ The suggestion is to craft policy that focuses on education and sustained medical funding. The belief is that HIV prevention, care, treatment and support will emanate from effective public health policy, and not from criminal legislation.²¹⁴

The idea is that public health policies can better address the underlying causes of vulnerability to HIV infection and risk taking. A related point is that concentrating on a cure rather than punishment is the most effective means of halting the spread of HIV.

There is also a recognition that the moral panic, such as fear or prejudice that accompanies the HIV epidemic does not prevent the disease. Instead, it merely impedes public health education and funding. Observers note that syphilis was defeated by penicillin, and not by the Contagious Diseases Act.²¹⁵ In the United States as in Africa, HIV/AIDS will be defeated by education, funding, research and curative therapies rather than criminal edicts per se.

In Africa for instance, while most governments were ignoring or denying HIV/AIDS, the Ugandan government acknowledged the crisis and took steps to contain it.²¹⁶ First, well publicized education campaigns were organized. Second, prevention campaigns were initiated. Third, there was an encouragement of religious groups and community organizations to reach out to vulnerable people, especially the young.²¹⁷ With safe sex drives, Uganda witnessed a significant reduction in teenage pregnancies, decline in risky sexual behavior and lower rates of infection.²¹⁸ Yet, in many countries there is still denial because the outbreak of a dreaded disease can harm national prestige, commerce and tourism.²¹⁹ Many African governments took initial steps that were counterproductive and reminiscent of the coercive approach discernible in criminalization.²²⁰

Initially, in Kenya, journalists were threatened with deportation for reporting about HIV/AIDS.²²¹ In Zimbabwe, the Minister of Health forbade all references to AIDS on death certificates.²²² Even in Uganda, one doctor was expelled for discovering and reporting that more than thirty percent of women in pre-natal condition had the virus.²²³ In the region, HIV/AIDS cases tend to be eighty to ninety percent underreported.²²⁴

Professor Gostin has argued that the real challenge of the HIV epidemic is for the international community to replace the culture of tradition with a new and more flexible culture of basic rights, in the arena of public policy.²²⁵ This is because, it is in such a climate that a disease like HIV can genuinely be controlled.²²⁶ He postulates that repressive measures used to fight the spread of the disease have had the exact opposite result.²²⁷ He notes that the best health policies are those that actually limit or lessen the spread of disease.²²⁸ He counsels that it is time for people and nations to recognize that people discriminate, diseases do not.²²⁹ He concludes that when societies use disease as an opportunity to punish, they may ultimately punish themselves by losing control of the disease.²³⁰ The point is that in today's world, a truly sound public health policy especially about HIV should not be based on coercion but on cooperation. Public health policies are to be well targeted, which means that governments should neither favor nor disfavor particular groups for no legitimate purpose.

This is because discriminating among groups based on who they are could create a permanent reservoir of “blameworthy” infected persons who would perpetuate the epidemic.²³¹

Battling the HIV epidemic requires more than the efforts of a single nation. The United Nations reports that by 2020 HIV could potentially claim up to 65 million victims.²³² This will be three times the number of victims lost to the disease in the twenty years since the epidemic began. It was also reported that with education and condom distribution programs, over 29 million new infections could be prevented by 2010.²³³ Faced with this worldwide threat, debate about criminal prosecution is a dangerous distraction. In the developed world, nations such as Canada, the United Kingdom and Sweden have not enacted any specific criminal codes to deal with HIV cases.²³⁴

A United Nations report emphatically disfavors criminalization. It encourages the use of public health law as a more flexible alternative.²³⁵ The report warns that apart from the risk of stigmatization and discrimination, there can be a negative public health message conveyed by criminalization to the effect that one is in some measure protected from contracting the virus, because of the potential prosecution of an infected partner or person.²³⁶ Fighting the disease effectively requires more commitment. The admonition is for politicians to channel their energy on fighting the virus through greater resource endowments to cope with the ongoing need for a prospective public health/biomedical breakthrough.²³⁷

Advances in HIV research have been phenomenal. Due to practical public health achievements, during the past several years, the face of the HIV/AIDS epidemic has dramatically changed. In the last decade researchers announced the development of new combination therapies with the potential to delay or suppress the onset of symptoms.²³⁸ In many ways, AIDS has come to be seen as invincible. The effect of the new treatment was miraculous. As experts noted, people who seemed to be in the final stages of the illness began to suddenly recover.²³⁹ Friends and families of these patients who had prepared themselves for the worst were amazed and relieved at the immediate improvements. Apparently, patients who had exhausted their resources, who had lost everything and declared bankruptcy in anticipation of death now found themselves planning for futures they thought would never materialize.²⁴⁰ Those revived patients now attended seminars on how to rebuild credit and cover gaps on resumes. Testing positive for HIV was no longer an imminent death sentence.²⁴¹ Although HIV remains a potent pathogen, the epidemic is not immune from relentless and pragmatic initiatives in public health.

VI a. Toward a Pragmatic Public Health Policy and Jurisprudence

Public health authorities have resisted political and public pressure to use coercive powers to combat the spread of HIV. Instead, public health officials emphasize the efficacy of education and counseling to encourage behavioral modification.²⁴² Analysts note that public health experience with venereal diseases show that coercive measures are largely ineffective in curtailing epidemics.²⁴³

The problematic nature of criminalization points to the inadequacy of applying criminal law theory to an infectious disease. It is doubtful whether criminalization advances the public health mission to eradicate it.²⁴⁴ The skepticism is that it may be psychologically reassuring to identify bad actors who intentionally and recklessly spread a dreaded disease.²⁴⁵ Society may even isolate or quarantine them. But such “purification rituals” rarely leave the public any safer.²⁴⁶ As one analyst observes, HIV is too widespread to be so easily contained.²⁴⁷ Demonology in that sense is apparently wrongheaded and downright dangerous from a public health perspective if it lulls the public into a false sense of complacency that the virus “is contained once the bad guys are all locked up.”²⁴⁸ The public health community should hold steadfast that HIV will be defeated by education and appropriate resources for medical treatment and curative therapies, not by criminal codes and exposure laws to combat public health crimes.²⁴⁹

HIV is a unique challenge to be confronted socially, politically, medically, and legally in a way that does not discourage but encourages desirable choices.²⁵⁰ Because HIV specific criminal statutes have become so counterproductive and legally problematic, as a matter of public health policy, they should be shunned. Some states with higher rates of HIV infection refrain from enacting HIV specific statutes that criminalize sexual activity. These states include New York, New Jersey and Texas.²⁵¹ To the extent that criminalization undercuts public health education, it should be avoided.

To every rule, there may be an exception. An engaging suggestion now is that only the most egregious cases involving a real risk of transmission should be addressed under regular criminal statutes, preferably reckless endangerment than under the more problematic traditional criminal law and HIV specific statutes.²⁵²

This very limited option is the least problematic, and also assures that the difficulties of criminalization does not mean that any individual may deliberately disseminate a potentially deadly virus with virtual impunity.

A counter argument could be proffered that proceeding under reckless endangerment could be equally counterproductive to public health goals, that is the rampant fear of sanctions could discourage people at high risk of HIV infection from being tested and receiving counseling.²⁵³ The counter argument is untenable because considering reckless endangerment is advocated for the most egregious cases that may still elude liability because of intractable proof problems that plague the other criminal causes of action.²⁵⁴

The counter argument is also dubious and disingenuous because it fails to recognize the various dimensions of the public health mission. Public health involves multiple approaches.²⁵⁵ The priority in public health policy absolutely should be non coercive measures. Criminalization where warranted should be a very last resort, and should be reserved for the truly atrocious cases, such as AIDS rape. Criminalization reflects the traditional posture of public health with its emphasis on coercion.²⁵⁶ The more contemporary view of public health which is the preferred and most favored approach adopted in this paper relies increasingly on voluntary co-operation and non intimidating posture and strategies.

In general, non punitive public health law rather than criminal law and policy should be much more in evidence in the fight against HIV as a leading public health issue.²⁵⁷ In that context, several recommendations are discernible

VI b. Public Health Policy Recommendations

Public health policy should be informed by the recommendations in the final Report of the Presidential Commission on AIDS.²⁵⁸ The following findings by the commission are pertinent to public policy analysis on HIV. The first is that there is a need to provide accessible, confidential, voluntary testing accompanied by appropriate counseling. Secondly, practitioners need to treat HIV as a disability whose victims deserve strong legal anti-discrimination protection. Third, it is important to formulate stronger confidentiality standards at both the federal and state levels to protect those persons infected with HIV. Fourth, make prevention and treatment a priority. Fifth, make public health law reforms a priority.²⁵⁹ Lastly, provide health care operatives with complete information about HIV, adequate protective materials as well as a safe and model work environment.²⁶⁰

A Model Public Health Policy

In addition to such policy recommendations, public health law and policy should encompass the ensuing guidelines as a framework for an HIV abatement regime:

- (1) The use of criminal or coercive public health laws must be the very last resort. Otherwise, the rampant operation of criminal law policy may trivialize the use of criminal sanctions themselves.²⁶¹ Such an approach may also impose harsh penalties that are disproportionate to any possible offense. It may also discriminate against the accused on the basis of his HIV status, contrary to the tenets of public health and international humanitarian law.²⁶²
- (2) Set parameters on the use of criminal law to avoid its over-extension. There must be clear policies and protocols about the conduct of legal proceedings, where they may be absolutely necessary, to avoid adverse publicity about HIV/AIDS. Such a precaution can remove bias towards people living with HIV/AIDS and ensure their rights and dignity. Whether in criminal or public health proceedings, HIV-positive defendants should be handled in the same manner as other defendants. Unusual safety or security precautions such as gloves, masks or restraints or permitting counsel or law enforcement agents to stand back from HIV-positive defendants is inflammatory, prejudicial and discriminatory toward HIV-positive individuals in a way that is contrary to public health policy.²⁶³
- (3) Establish prosecutorial guidelines to avoid misuse of criminal law. To preserve the public health effort to encourage access to counseling and support service, the contents of an HIV patient's communications to a health care professional or medical provider should be legally excluded in a proceeding relating to a criminal or public health offense.²⁶⁴
- (4) Prevention of HIV must be the primary objective of the policy of criminalization.
- (5) Repeal or amend laws that impede HIV prevention, care, treatment and support.
- (6) Ensure access to good-quality HIV testing, counseling and support for risk reduction.

- (7) Guard against the proliferation of what is termed “a new virus-HUL- for highly useless laws”. Transnational human rights policy indicates that people living with HIV/AIDS should not be subjected to coercive policies solely on the basis of their sero status.²⁶⁵ The World Health Organization has counseled that there is no public health rationale to isolate, quarantine or discriminate against HIV patients.²⁶⁶ Furthermore, applying coercive discriminatory policies toward people on the basis of their HIV status violates their legal and human rights.²⁶⁷
- (8) Protect against discrimination and protect privacy.
- (9) Address the underlying causes of vulnerability to HIV infection and risk-related activities.
- (10) Best available evidence should be the basis of law and policy in the end.²⁶⁸

Conclusion

Human Immunodeficiency Virus (HIV) infection, the precursor to Acquired Immune Deficiency Syndrome (AIDS) is a global epidemic. In the United States, HIV afflicts approximately one million people. At the onset of the epidemic in the US there was widespread apprehension and misconception about how the virus was transmitted. The aetiology of HIV was often obscured by mythology. In the US an incipient approach to the HIV infection was based on legislation and litigation. Reacting to public panic, several states resorted to criminal codes to control HIV transmission. The application of traditional criminal law to prosecute HIV cases proved insufficient. To overcome this deficiency, many states enacted HIV specific statutes. Those statutes similarly proved to be inadequate because they were either too broad, over-inclusive, vague or ambiguous, and as such potentially vulnerable on constitutional grounds. Either in traditional criminal law or HIV-specific statutes, criminalization was beset with ‘proof problems’.

The theme of this article, therefore, is that criminalization of HIV transmission is a legally problematic approach that should yield to more pragmatic initiatives in public health law and policy. The preferred strategy in HIV control delves on practical public health policies. Those policies involve mass education, prevention, voluntary testing, counseling, treatment, and anti-discrimination laws. HIV is a communicable, transnational pathogen. Hence, the centrality of public health response to HIV infection in the national and international setting informs the legal analysis and policy recommendations.

A very useful suggestion is that four particular functions of public health law will be most effective in preventing the spread of HIV.

1. Classify transmissible diseases
2. Specify which legal provisions apply to which diseases.
3. Impose legal duties on certain individuals, such as physicians to identify, report and treat diseases.
4. Grant powers to state public health officials to be exercised in the prevention and treatment of diseases.

Criminalization is problematic and counterproductive in legal and policy terms. This article advocates for a more pragmatic initiative based on public law and policy. The containment of HIV as a global malaise requires practical policy and legal strategies as well as progressive perspectives in the international public health domain.

Over the past fifteen years, a number of cases have been reported in which people living with HIV have been criminally charged for a variety of acts that result in HIV transmission or carry the risk of transmission.²⁶⁹ Prosecuting those cases became problematic because of serious problems of legal proof. The HIV specific statutes enacted to overcome those problems suffered from vagueness and overbreadth problems, thereby calling into question their constitutional integrity. It is desirable, therefore, to move away from criminalization except in extreme and outrageous cases such as AIDS rape.²⁷⁰

Admittedly, states have a genuine public health interest in curtailing the spread of HIV-AIDS.²⁷¹ However; it is widely acknowledged that rampant criminalization is unlikely to advance that interest.²⁷² Criminalization compromises public health efforts to curb the spread of the virus by inducing people to avoid contact with the public health service. Criminalization tends to create more legal problems than it resolves. By diverting limited resources away from testing, treatment and educational projects to pay for court costs and prison expenses, criminalization is a counterproductive approach.²⁷³ The containment of HIV as a creeping epidemic requires more practical policy and legal strategies in the national and international domain. Ultimately, the universal demise of HIV will also require a cure and effective prevention. Such a preferred outcome in the effort to overcome the multinational menace of HIV remains a continuing challenge in contemporary public health and bio-medicine.

Notes

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⁷⁰ Id; see supra note 56.

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⁷³ Id.

⁷⁴ Id.

⁷⁵ See supra note 24.

⁷⁶ Id.

⁷⁷ See supra note 65.

⁷⁸ Id.

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⁸⁵ See supra note 71.

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¹⁰⁰ Id.

¹⁰¹ See supra note 55.

¹⁰² See supra note 5.

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¹⁰⁴ Id.
¹⁰⁵ Id.
¹⁰⁶ See supra note 95.
¹⁰⁷ Id.
¹⁰⁸ Id.
¹⁰⁹ Id.
¹¹⁰ See supra note 98.
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¹¹⁷ Id.
¹¹⁸ Id.
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¹³⁸ See supra note 47.
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¹⁴¹ Id.
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¹⁴⁵ Id.
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¹⁶⁸ See supra note 165.
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