ADDRESSING HIV RISK BEHAVIOURS: A ROLE FOR PUBLIC HEALTH LEGISLATION AND POLICY

Background

According to international public health and human rights guidelines, when a person is given an HIV-positive test result that person should receive post-test counselling.[1] As part of that supportive counselling intervention the person should be informed about how HIV is transmitted and ways to prevent the transmission of HIV, be provided with access to tools to prevent the transmission of HIV (such as condoms to prevent the sexual transmission of HIV), and be encouraged to refer partners for HIV counselling and testing. The majority of people who are aware of their HIV status, and who have received counselling and who have access to HIV prevention tools, take measures to prevent the transmission of HIV to other people, including their sexual partners and drug injecting partners.

During the past decade, there has been a significant global increase in the use of criminal law to address cases of HIV exposure and transmission.[2] The Joint United Nations Programme on HIV/AIDS (UNAIDS), civil society and human rights organizations, people living with HIV, and eminent jurists have spoken out forcefully against the inappropriate over-extension of the criminal law in this area.[3] It has been suggested that public health legislation[4] should be considered as an alternative, or complement, to the use of the criminal law to prevent HIV transmission.[5] In many jurisdictions comprehensive public health programs **and** public health legislation are relied upon to reduce HIV transmission and protect public health, including the health of people living with HIV. [See the sidebar *Defining "public health" and "public health law"*.]

This info sheet explores the role of public health law, including coercive interventions, in addressing behaviours that carry a significant risk of transmitting HIV. *This document describes public health law in very general terms. The law that applies in a given jurisdiction may be different from the general description. If you want more details about the public health law that applies in a given jurisdiction, consult a lawyer in that jurisdiction.*

Defining the terms: "public health" and "public health law"

Public health practice is "what we, as a society, do collectively to assure the conditions for people to be healthy." – Institute of Medicine, *The Future of Public Health*, Washington, D.C.: National Academy Press, 1998.

Public health law is:

- "… the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g. to identify, prevent and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection and promotion of community health."

- The *five essential characteristics* of public health law:
  - *Government*: Public health activities are a special responsibility of government.
  - *Populations*: Public health focuses on the health of populations.
  - *Relationships*: Public health addresses the relationship between the state and the populations (or between the state and individuals who place themselves or the community at risk).
  - *Services*: Public health deals with the provision of population-based services grounded in the scientific methodologies of public health (e.g. biostatistics and epidemiology).
  - *Coercion*: Public health authorities possess the power to coerce individuals and businesses for the protection of the community, rather than relying on a near universal ethic of voluntarism.

- L.O. Gostin, Public Health Law: Power, Duty, Restraint. Berkeley, California: University of California Press, 2000.

Strengths of public health law

Public health law interventions based in human rights principles are better suited than the criminal law to encouraging sustained changes in HIV risk behaviour for the following reasons:

- Unlike criminal law, punishment is not a goal of public health law's approach to HIV prevention. There is no evidence that the threat of punishment in itself can cause people to change

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complex behaviours, such as sexual and drug using behaviours.

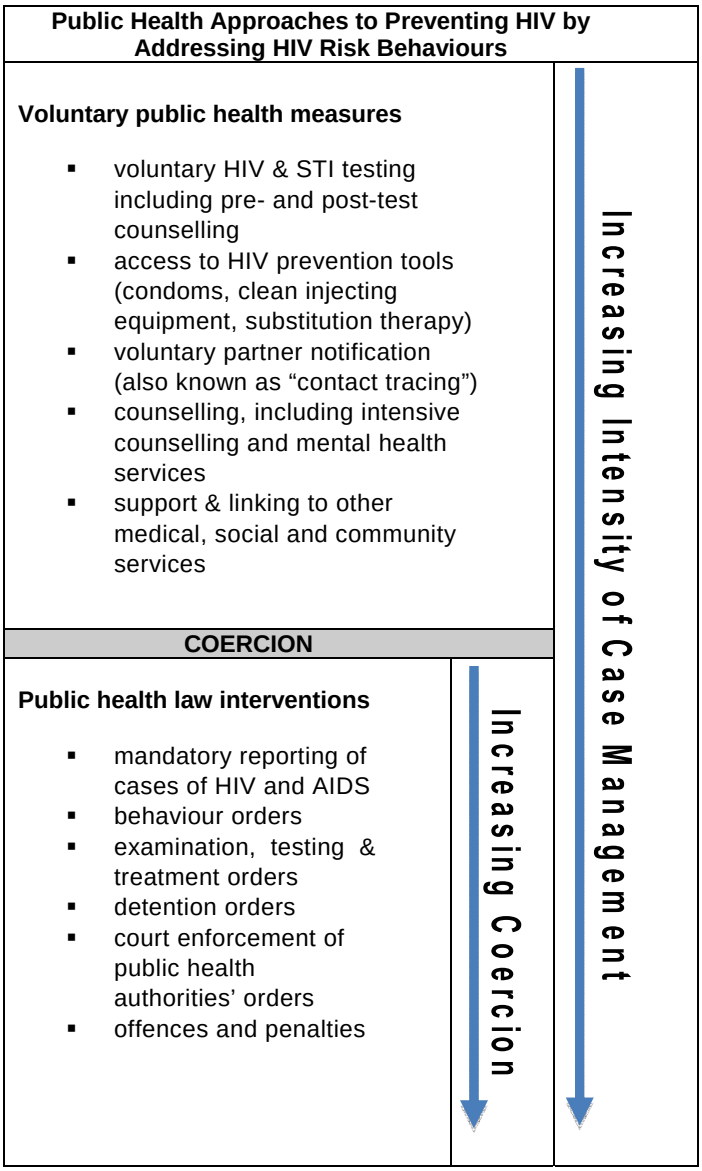
- In-person, supportive contact with public health staff seems more likely to result in ongoing reductions in risk behaviour than the remote threat of criminal prosecution and the possibility of police becoming involved in people's lives.
- Case management strategies can be tailored by public health staff to address the specific reasons and challenges that may be leading to HIV risk behaviours. For example, it makes sense to manage a situation where a person has limited ability to take precautions (e.g. for reasons of mental illness, addiction, or developmental disability, threats or actual partner violence, economic dependence) differently from a situation where a person wilfully, repeatedly and despite supportive interventions engages in behaviours that pose a significant risk of transmitting HIV.
- Increasingly coercive interventions to change or prevent certain behaviours can be adopted under public health legislation if less coercive measures fail. Criminal prosecution happens after the fact and is all-or-nothing; a person is either guilty or not guilty.
- Interventions can increase access to a range of health and social services, thereby promoting the human rights of people living with HIV and also promoting public health more broadly. Criminal prosecutions can impede access, by creating barriers to people disclosing information to health professionals and other support services workers out of fear of the repercussions, including having such information used as evidence against them.
- Public health legislation can include protections for the privacy and confidentiality of people living with HIV. Prosecutions under the criminal law are almost always open to the public and the media, which can increase the stigma against and social marginalization of people living with and affected by HIV, as well as contributing to misinformed perceptions of the risks of HIV transmission when criminal charges are laid for conduct that poses little or no risk of transmission.
- Even at their most coercive, public health law interventions can focus on the protection of the public based on the actual risk posed by the behaviours of the person living with HIV. Once the person living with HIV is determined to no longer pose a significant risk of HIV transmission, public health can discontinue a coercive intervention and continue to support the person through voluntary public health measures. Criminal prosecutions can result in long periods of incarceration, both before and after trial, even where a person poses no significant risk of transmitting HIV -- and incarceration can actually lead to greater risks of transmission, since risk activities like unsafe sex and drug injection continue inside prisons but often with less or no access to HIV prevention tools such as condoms

Policy options, scarce resources and the importance of context

The context must obviously be considered when looking at public health law as a policy alternative to criminal law to address behaviours that pose a significant risk of transmitting HIV. Many countries do not have an effective public health system, often because of a lack of financial and human resources. Many lack up-to-date public health legislation or the institutions required to support the effective implementation of public health legislation (e.g. public health professionals, an independent and well-trained civil service, independent courts and tribunals, access to legal services, effective human rights protections).

In light of these contextual factors, public health, legal and human rights experts and people living with HIV have noted:

> "In practice … relying on public health law as an alternative to criminal law is often not an option. Moreover, participants felt that it would be a mistake to devote scarce human and financial resources to increasing the capacity of public health authorities to deal with such cases [of potential HIV transmission] under public health law when such resources should be spent on programmes that would have broader public health impact, e.g. those that increase access to prevention, treatment, care and support." - UNAIDS & UNDP, *International Consultation on the Criminalization of HIV Transmission: Summary of main issues and conclusions, 2008*.



A continuum of public health measures and interventions

The public health approach to addressing HIV transmission risk behaviours **is a continuum of measures and interventions** intended to change behaviours. **Coercion is the dividing line** between voluntary public health measures and public health law interventions backed by the force of law. Coercion means the power to force someone to do something (or stop doing something), backed up by the threat of a penalty (e.g. a fine, detention or other restriction of a person's rights). Criminal law and some interventions under public health law rely on coercion.

Role of public health legislation & policy in HIV prevention

The legal duties imposed and powers granted under public health legislation in relation to HIV (and other communicable diseases, including sexually transmitted infections) may include:

- *Reporting of cases of HIV and/or AIDS*: Medical professionals (and other people, under some laws) are required to report known and suspected cases of HIV (and sometimes AIDS) to public health authorities. Public health authorities use this information for disease surveillance at a population level and for monitoring individual cases of infection.

- *Behaviour orders*: Where a public health official reasonably believes, on the basis of credible evidence, that a person living with HIV is engaging in behaviours that put someone else at a risk of acquiring HIV, the public health official can issue a written order against the person living with HIV. Such an order will usually set out how the person must behave—e.g. disclose HIV status before sex involving penetration; use condoms for sex involving penetration; provide public health with the names of sexual and injecting drug partners; participate in education and counselling sessions; enter into and remain under the care of a physician. Orders also routinely set out the behaviours the person living with HIV is prohibited from engaging in—e.g. do not share injecting equipment; do not donate blood, tissues or other organs. The power to issue orders is usually only given to senior public health officials.

- *Examination, testing & treatment orders*: A public health official can order a person who is suspected of having HIV to undergo medical examination and testing. Where a person has HIV, the public health official can order the person to undergo examination and treatment for the purposes of reducing or eliminating the risk of HIV transmission. The law may permit public health officials to enlist law enforcement

personnel to apprehend the person and take him or her for medical examination, testing or treatment. Sometimes legislation requires that the public health official receive approval from an independent administrative body or court before making this type of order.

- *Detention orders for the purpose of treatment*: A public health official can order a person living with HIV to be confined to a secure institution (e.g. a forensic hospital or other secure hospital setting) for a period of time. The purpose of this order is to thoroughly assess the person's mental and physical health, and provide the person with an opportunity to access treatment to address issues that contribute to HIV risk behaviour. Sometimes legislation requires that the public health official receive approval from an independent administrative body or court before making this type of order. Also, the public health official may be required to apply to an independent administrative body or court for approval to extend the order beyond the original period of time.

Some public health legislation requires that, **before issuing the types of orders set out above**, the public health authority (or a court) must reasonably believe that the order will be effective. In other words, public health (or the court) must reasonably believe that the order will make the person change his or her behaviour, thereby reducing or eliminating the risk of HIV transmission. Also, legislation may give the person living with HIV a right to appeal the order to an independent administrative tribunal or court.

- *Court enforcement*: Depending on the law in question, when a person has not complied with a public health order, a public health official can apply to have a court transform a public health order into an order of the court. Public health legislation may also grant a public health official the power to apply for a court order when a person has breached a standing legal duty set out in public health law, even if an order has not previously been issued. If the court issues an order, the public health official can then rely on the power of the court to enforce the order (e.g. requesting police assistance), and a person who disregards the court order may be prosecuted for being in contempt of court.

- *Offences and penalties*: Public health officials may be given the power to determine that someone has committed an offence under the public health law. Where a person is guilty of committing such an offence, they may be required to pay a fine.

In practice, public health legislation is frequently supplemented by **policy.** Policy provides overall direction as well as specific procedures to guide front-line and other staff responsible for implementing the legislation "in the real world."

Partner notification—one tool for breaking the chain of HIV transmission

Partner notification (also known as *partner counselling* or *contact tracing*) is a public health measure designed to prevent the spread of communicable disease by encouraging people who may have been exposed to such a disease to seek medical care, including testing and treatment if necessary. When someone (sometimes referred to as the "source person" or "index case") tests positive for a blood-borne or sexually transmitted infection, that person's sexual and drug injecting partners who may have been exposed to the infection are contacted and encouraged to seek medical care, including counselling and testing. International guidance on HIV recommends that partner notification should be voluntarily undertaken, with the co-operation of the source person, unless exceptional circumstances exist.[6] The source person, the source person's healthcare provider, or public health staff (or a combination of these people) contacts the source person's partners. If a healthcare provider or public health staff undertakes the partner notification, the identity and privacy of the source person should be protected to the greatest extent possible.

Some common elements of public health policy

Some jurisdictions have published policy to guide public health staff responsible for HIV risk reduction case management. A review of policy from three jurisdictions — the state of New South Wales in Australia[7]; the Calgary Health Region in Alberta, Canada[8]; and the state of Texas, USA[9]—reveals a number of features are common among all three jurisdictions' policy:

1. An individualized, case-by-case approach.
2. Graduated (step-by-step) management of individual cases based on the "least intrusive, most effective" principle, setting out clear criteria and considerations for moving from one step to the next.
3. Comprehensive assessment that focuses on the person's mental capacity and mental health and the social determinants of health when examining the reasons underlying ongoing HIV risk behaviours.
4. A central role assigned to supportive counselling as a tool to promote behaviour change—beginning with counselling and education after HIV testing, followed by intensive counselling throughout the management of the case by public health staff.
5. A role for case conferencing and regional advice and expertise, involving individual experts or expert panels.
6. Collaboration by public health staff with other supports and services (e.g. healthcare, mental health and social work, community-based organizations and peer-led programs) to address the range of determinants of health.
7. Clear procedures for the use of coercive public health law interventions.

Incorporating human rights protections

Coercive public health law interventions inherently involve a balancing of individual and collective interests—they give public health authorities the power to restrict the human rights of a person living with HIV in the interest of protecting public health and public safety. Further, relying on coercive public health laws to address HIV risk behaviours raises, in practice, some of the same human rights concerns as criminalization of HIV exposure/transmission.[10] There is a danger that public health laws themselves, and actions of public health authorities, may breach rights guaranteed under international human rights law,[11] including the rights:

- to non-discrimination and equality;
- to liberty and security of the person;
- to respect for private and family life;
- not to be subject to arbitrary arrest or detention; and
- to a full, fair and public hearing by and independent and impartial tribunal.

A human rights-based approach can help respond to the inherent limitation of individual rights under public health law, and the potential for human rights infringements arising from the misuse of public health law. There is widespread agreement among experts that behaviours that carry a significant risk of transmitting HIV should be addressed using a graduated response on a case-by-case basis.[12] A graduated response is consistent with a human rights-based approach to reducing HIV risk behaviour; interventions should be proportional to the level of risk posed by the behaviour in question, be tailored to the person's particular circumstances, and limit the person's rights only to the extent required to reduce or eliminate the significant risk to public health or public safety.[13]

The *International Guidelines on HIV/AIDS and Human Rights* call on legislators and authorities responsible for public health law to adopt a principled approach. Guideline 3 recommends that:

> States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

The *International Guidelines* further include recommendations for implementation of this Guideline by states, including with respect to coercive public health laws:

> Public health legislation should ensure that people not be subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status. Where the liberty of persons living with HIV is restricted, due process protection (e.g. notice, rights of review/appeal, fixed rather than indeterminate periods of orders and rights of representation) should be guaranteed.

In rare instances where public health officials issue coercive orders, people living with HIV will likely need access to legal services. Guideline 7 of the *International Guidelines* recommends that:

> States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

UNAIDS has called on states to ensure that the human rights of people living with HIV are respected when drafting public health legislation, developing policy guidance, and relying on coercive public health law interventions.[14]

Conclusion

How should we, as societies, respond when a person living with HIV who has received counselling and who has access to the tools needed to prevent HIV transmission engages in behaviours that pose a significant risk of transmitting HIV? Evidence-informed and effective public health programs that increase access to care, treatment and support for people living with HIV are part of the answer. Creating enabling legal and policy environments based on a human rights approach to HIV is also part of the answer. These are core, priority responses in all jurisdictions.

Depending on the context and the human and financial resources available, public health legislation—including coercive public health interventions—may also be part of the answer. Public health law interventions that respect human rights principles are better suited than the criminal law to encouraging sustained changes in HIV risk behaviour. Many jurisdictions rely on comprehensive public health programs **and** public health legislation to reduce HIV transmission and protect public health, including the health of people living with HIV—this info sheet highlights three examples.

However, there has been little systematic evaluation of the use of interventions under public health laws to deal with cases of conduct posing a significant risk of HIV transmission. Further research, including human rights impact assessment, is needed to better understand and exploit the full potential of public health law interventions to reduce HIV risk behaviours of people living with HIV.[15] International organizations and domestic governments and public health authorities at the national, provincial/state, regional and/or municipal levels, can play a leading role in building public health law capacity[16] by:

- contributing to expertise and infrastructure;
- facilitating collaboration among governments, non-governmental experts, civil society organizations and people living with and affected by HIV;
- promoting research and evaluation of the use of public health law interventions;
- disseminating existing legislation and policy guidance; and
- developing model laws and best practice guidance.

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Notes and references

[1] WHO, *Guidance on provider-initiated testing and counselling in Health Facilities, 2007*; Office of the United Nations High Commissioner for Human Rights & UNAIDS, 2006 consolidated version, *International Guidelines on HIV/AIDS and Human Rights*.

[2] See for example, Cameron E, "Criminalization of HIV transmission: poor public health policy, *HIV Policy & Law Review* 14:2, 2009; Global Network of People Living with HIV (GNP+), *Global Criminalisation Scan*, available at www.gnpplus.net/criminalisation.

[3] Despite the strong, principled arguments against the criminal law, UNAIDS among other organizations and experts accept that general criminal law offences may have a role to play in the very small number of situations involving intentional HIV transmission—in other words, where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and transmits HIV.

[4] In this document, "legislation" refers to Acts passed by the legislative branch of government and subordinate legislation passed by the executive branch of government. The term "law" is used interchangeably with legislation.

[5] UNAIDS & UNDP, *International Consultation on the Criminalization of HIV Transmission: Summary of main issues and conclusions, 2008*; Inter-Parliamentary Union, UNAIDS & UNDP, *Taking Action Against HIV: Handbook for Parliamentarians (No. 15), 2007*; AIDS and Rights Alliance for South Africa (ARASA) & Open Society Initiative for Southern Africa (OSISA), *Report of the ARASA/OSISA Civil Society Consultative Meeting on the Criminalisation of the Willful Transmission of HIV (11 & 12 June 2007), 2007*; Office of the United Nations High Commissioner for Human Rights & UNAIDS, 2006 consolidated version, *International Guidelines on HIV/AIDS and Human Rights*; UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*; *R v. Cuerrier*, [1998] 2 SCR 371 (Supreme Court of Canada), 2002. However, the National AIDS Trust in the United Kingdom is "strongly opposed to any application of coercive public health powers to sexually transmitted infections," as explained in National AIDS Trust, 30 September 2009, *DH Consultation on Health Promotion Regulations: Submission of National AIDS Trust*.

[6] WHO, Guidance on provider-initiated testing and counselling in Health Facilities, 2007; UNAIDS & WHO, Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting, 2000.

[7] Department of Health, NSW, HIV – Management of People with HIV Infection Who Risk Infecting Others (PD2009_023), 28 April 2009.

[8] Calgary Health Region, Alberta Health Services, Management of Unwilling or Unable Persons with HIV, January 2003.

[9] Bureau of HIV and STD Prevention, Texas Department of Health, Accelerated HIV Intervention Program, Addressing the Potential for Recalcitrant Transmission of HIV in Texas (HIV/STD Policy No. 410.003), 23 January 2003.

[10] For example, in Southern Africa, civil society organizations have pointed to the danger that as national responses to HIV/AIDS gain momentum, human rights principles are forfeited in the name of public health: AIDS and Rights Alliance for South Africa (ARASA) & Open Society Initiative for Southern Africa (OSISA), *Report of the ARASA/OSISA Civil Society Consultative Meeting on the Criminalisation of the Willful Transmission of HIV (11 & 12 June 2007), 2007.*

[11] See, for example, *Universal Declaration of Human Rights*, UN General Assembly Resolutions 217 A (III), UN Doc. A/810 (adopted 10 December 1948); *International Covenant on Civil and Political Rights*, 999 UNTS 171 (1966); *African [Banjul] Charter on Human and Peoples' Rights*, OAU Doc. CAB/LEG/67/3 (adopted June 27, 1981), as amended; [European] *Convention for the Protection of Human Rights and Fundamental Freedoms*, 213 UNTS 222 (1953), as amended.

[12] See, for example, Australian Health Ministers' Conference, *National Guidelines for the Management of People with HIV Who Place Others at Risk, 2008*; "Persons Who Fail to Disclose Their HIV/AIDS Status: Conclusions of an Expert Working Group," *Canada Communicable Disease Report*, 31:5, 2005; UNAIDS *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* (2002); L.O. Gostin, *Public Health Law: Power, Duty, Restraint*. Berkeley, California: University of California Press, 2000.

[13] This approach conforms to international human rights law applicable where states enact legislation or pursue interventions that limit individual rights to protect public health or safety. See, for example, United Nations, Economic and Social Council, Siracusa Principles on the

Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4, Annex (1985).

[14] UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper, 2002*.

[15] Reports calling for further research into public health law interventions include, ARASA, *An evaluation of the steps taken by countries within the South African Development region to implement the HIV/AIDS and Human Rights International Guidelines, 2006*; UNAIDS, Criminal Law, Public Health and HIV Transmission: A Policy Options Paper, 2002; Elliott R, After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status. Montreal, Canada: Canadian HIV/AIDS Legal Network, 1999.

[16] International Development Law Organisation, *International Expert Consultation on Public Health Law: Report of the Rapporteur (26-28 April 2009), 2009*.

Links and Resources

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