

Since the advent of highly active antiretroviral therapy (HAART) in the 1990s, people with HIV have begun living longer, healthier lives. This has accordingly afforded many of these men and women the opportunity to fulfil aspects of their lives that they previously could not have. From an HIV prevention perspective, though, these changes create new challenges: population-specific and population-sensitive initiatives are now needed to help HIV-positive people adopt, lead, and maintain healthy sex lives. Indeed, sexual expression is a vital aspect of human existence, regardless of one's HIV status, and thus constitutes an important topic for public health workers and researchers alike.

One strategy by which public health workers have attempted to assist HIV-positive people with the task of maintaining a healthy sex lifestyle has been by encouraging these men and women to disclose their HIV status to potential sexual and injection drug using partners. Recently, however, such disclosure has begun to be more frequently enforced via criminal law, even in cases where scientific evidence indicates that HIV transmission would not occur. For example, criminal convictions were levelled against an HIV-positive person who spit at another person. The court in this case ruled that the saliva of this HIV-positive constituted a deadly weapon. In other cases, HIV-positive people have been convicted for having performed oral sex without previously disclosing their HIV status. In these cases, the likelihood of HIV transmission is so low that scientific evidence refuted the criminal process; nevertheless, HIV-positive men and women have been convicted in these situations.

While such criminal prosecution might appear to be a sound approach for preventing HIV transmission, it has many problems. The most notable shortcoming is that these laws do not target the correct group. Research from the national public health agencies in Canada, the United Kingdom, the United States, and Australia (to name a few) indicates that people who are unaware that they are HIV-positive cause the majority of HIV transmission. Indeed, it is estimated that people who are unaware of their HIV-positive status (who only account for 25-30% of the foregoing country's national HIV prevalence) are responsible for upwards of 75% of the annual HIV incidence. Stated numerically, this means that, in Canada, 15,800 (i.e., the 26% who are unaware that they are HIV-positive) of all HIV-positive people (n=65,000) cause 1,750 (i.e., 75%) of the 2,500 annual cases of HIV. The remaining 49,200 people who are HIV-positive and aware of being are thus only responsible for 750 incident cases of HIV each year in Canada. Quite evidently, criminal laws which mandate HIV disclosure could only induce

a minimal reduction in HIV transmission because they have no effect on people who are HIV-positive, yet unaware of being so. In fact, ignorance of one's HIV status is immunity to these laws.

Of even greater concern, though, is that these laws seem to oppose other HIV prevention initiatives. On one hand, public health workers encourage HIV testing because awareness of one's HIV status correlates with decreased HIV transmission; people often forego practices that can easily transmit HIV once they become aware that they are HIV-positive. On the other hand, however, criminal laws might discourage testing. If one can be criminally charged even when one's practices cannot transmit HIV (such as in the case of spitting), why would an individual want to know his/her HIV status? Because the benefits of early treatment are highly contestable, and the legal repercussions of non-disclosure are not, the foregoing question is both valid and pressing. Public health professionals and researchers must begin to tackle this problem, particularly because the rates of prosecution for HIV non-disclosure are accelerating worldwide.

The implications of this criminalization trend are widespread. As it stands, the police in many countries can both obtain supposedly confidential documents and can use these documents as evidence against HIV-positive people. Health care professionals must therefore be aware of the HIV criminal laws in their respective jurisdictions. This is imperative; inaccurate assurances about confidentiality could be given to HIV-positive patients if clinicians do not know the state of their local HIV disclosure laws. Problematically, false guarantees of confidentiality could diminish the reputation and usability of HIV prevention services. As public perceptions about confidentiality strongly predict the usage of sexual health and HIV testing/treatment services, anything which undermines the privacy of these services is likely to deter people from using them. Likewise, researchers who gather data from HIV-positive people should also proceed with caution. Locked filing cabinets, ethics approval, and promises of confidentiality are not sufficient to prevent police interference.

The foregoing thus necessitates action. Health care professionals and researchers must determine if and how their work could compromise the wellbeing and the safety of patients/participants. This would include, at a minimum, a review of documentation techniques and an examination of the methods by which informed consent is obtained. The significance of the current situation is pressing, particularly when one considers that awareness about being HIV-positive often corresponds with decreased HIV transmission, and that the prosecution of

HIV-positive people may deter testing. The immediate moment (i.e., now) is thus an opportune time for exploring how charting practices can be modified to promote confidentiality, how HIV testing can be encouraged despite legal disincentives, and how the HIV criminalization trend can be reversed. While discussions currently exist about HIV disclosure laws from a legal, human rights, and population health perspective, little exists to guide clinical and research practices, and little focuses on how these laws may impede the development of therapeutic or caring relationships. This information is needed.

In closing, let us return to one of the founding principles of the helping/healing professions: first do no harm. In appreciating the significant nature of this statement, it is obvious that health care professionals and researchers (i.e., we) must protect HIV-positive patients and research participants from the strong arm of the law. This is required in an effort to help maintain the progress made in the field of HIV prevention over the last three decades. We should not return to the days when knowing one's HIV status was a social, economic, and personal liability, which outweighed the benefits of knowing one's HIV status. We should move forward, making knowledge, and not a lack thereof, powerful. If knowledge is power – as it is theorized – then let us ensure that it remains as such in the realm of HIV prevention. Let us challenge the current criminalization trend in HIV on ethical, legal, and public health grounds, and let us work toward decreasing HIV transmission without discouraging testing, without limiting confidentiality, and without creating further problems for people who are living with HIV.

Patrick O'Byrne  
Editor