Toward a Critical Response to HIV Criminalization: Remarks on Advocacy and Social Justice

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In recent years, criminal laws have been increasingly applied in matters related to HIV nondisclosure, HIV exposure, and/or HIV transmission (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2008). In North America, there has been a dramatic increase in the number of people charged for allegedly failing to disclose their serologic status before engaging in sexual activities, exposing others to HIV (via bodily fluids), and/or sexually transmitting HIV infection (Bernard, 2010). In Canada, charges have been laid against persons living with HIV (PLWH) in numerous cases. As of February 2011, there have been a total of 115 prosecutions in which a PLWH was alleged to have transmitted HIV or exposed a sexual partner to the risk of infection without disclosing HIV-infection status (Canadian HIV/AIDS Legal Network, 2011). Of this number, more than 56% (65/115) were convicted of an offense under the Criminal Code of Canada (Canadian HIV/AIDS Legal Network, 2011). See Figure 1 for a review of some of these cases.

A similar situation has been documented in the United States, although at present, it remains difficult to determine exactly how many cases have been brought before the courts. As it currently stands, a growing number of PLWH are being prosecuted in North America, which is consistent with the fact that criminal laws are increasingly applied to punish certain conducts and prevent HIV transmission, although it has been clearly argued that criminalization hinders prevention efforts and may, in fact, dissuade some people from getting tested or accessing care (O'Byrne, 2011).

Given the widespread use of criminal laws against PLWH, a number of organizations such as UNAIDS have expressed concerns over the potential harmful consequences of such phenomena both from a public health and a human rights perspective. Lawyers, advocates, and policy analysts have also expressed criticism in response to the potential unfairness in the application of the law and clearly established that PLWH may be wrongfully convicted in the current context. It is important to understand criminalization as a phenomenon that does not exist in a social vacuum but rather in a context where PLWH are systematically disadvantaged.

In effect, not only are prosecutions disproportionately applied to this particular population (and its most vulnerable groups), they are also broadly applied to sanction conducts that are shaped by complex personal, social, cultural, and contextual factors. For example, criminal laws do not consider the various reasons why someone who is living with HIV infection might be unable to disclose at a particular time or what factors must be taken into account in order to understand why that same person might choose not to disclose within a particular context. Furthermore, criminal laws do not acknowledge the actions taken by a person to reduce the risk of exposure or the scientific evidence regarding transmission itself. And so, it is evident that PLWH are at significant risk of being prosecuted and found guilty of crimes for which they are not criminally liable.

As it stands, PLWH experience many challenges and barriers as they try to manage interpersonal

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Case 1. In July 2008, C. Mabior was convicted on six counts of aggravated sexual assault for not disclosing his HIV status to his sexual partners. He was sentenced to 14 years of imprisonment in a federal penitentiary. The decision was appealed before the Manitoba Court of Appeal, where he was acquitted on four of the counts in which he had carefully used a condom but did not have an undetectable viral load or had had an undetectable viral load but did not use a condom (Canadian HIV/AIDS Legal Network, 2010a). The case will be heard by the Supreme Court of Canada in 2012.

Case 2. In April 2009, a jury convicted J. Aziga of two counts of first-degree murder, 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault. J. Aziga is believed to be the first person in the world to be convicted of murder for the transmission of HIV infection. He was also convicted on aggravated (and attempted aggravated) assault charges for failing to disclose his serologic status to his sexual partners. Of the 11 complainants in the case, 7 tested positive for HIV at some point following their sexual encounters with Aziga. Two of the cases, which were the basis for the murder convictions, eventually died of cancer argued to be related to the progression of HIV infection (Canadian HIV/AIDS Legal Network, 2009). In August 2011, he was declared a dangerous offender and sentenced to be jailed indefinitely.

Case 3. In September 2009, Y. Mekonnen was convicted of aggravated sexual assault for failing to disclose his serologic status to a sexual partner with whom he had engaged in protected vaginal sex on three occasions and unprotected oral sex on one occasion. She did not test positive for HIV infection. He was sentenced to 9 months of imprisonment followed by 3 years of probation (Canadian HIV/AIDS Legal Network, 2010b). Similar cases have been widely reported across Canada.

Case 4. In February 2010, the Ontario Court of Justice sentenced J. Bruneau to 30 months of incarceration for assault and aggravated assault. He pleaded guilty to the charges after failing to disclose his serologic status to his ex-girlfriend prior to having unprotected sexual intercourse with her. She did not test positive for HIV infection (Canadian HIV/AIDS Legal Network, 2010b). Similar cases have also been widely reported across Canada.

Case 5. In August 2011, the Edmonton Police released the picture and full name of a 17-year-old girl who allegedly had unprotected sexual intercourse with two men without disclosing her serologic status. She is now facing two counts of aggravated sexual assault and has been in detention since her arrest 2 days after her personal information was released in the media. Other PLWH have seen their pictures and personal information released in the media by police departments who argue that this procedure is a matter of public safety warning. Most of them are now in prison, awaiting trial and have been denied bail.

Figure 1. Selected Canadian legal cases related to HIV transmission. (Canadian HIV/AIDS Legal Network, 2009; 2010a; 2010b).

relationships. The intensification of stigma and discrimination combined with the threat of one day facing criminal charges actually make disclosure more difficult. The overreaching application of criminal laws also creates a situation where it becomes impossible to comprehend the legal duties of PLWH. Furthermore, the inconsistent court decisions across states (United States) or provinces (Canada) make it impossible for nurses to know exactly what to tell their patients. Thus, it may not always be possible to give clear answers or guidance to patients. Finally, it may also be difficult to assess the best approaches when confronted by the widespread use of criminal laws and their impact on the lives of PLWH.

However, it is important to remember that criminal laws do not govern nursing practice. Nurses are not agents of the criminal judiciary system but rather agents of care who play an essential role in providing safe, compassionate, competent, and ethical nursing care to PLWH. Nurses also have an important role to play in addressing criminalization in the larger realm of political, legal, cultural, and social

complexities. In light of the current context, it is important to not only examine what can be done in clinical practice but what nurses, as a professional group, can do to build a critical response and engage in advocacy work against HIV criminalization.

Advocacy

Advocacy work should be conceptualized in ways that enable nurses, as a professional group, to forge a critical response to HIV criminalization. *Parrhesia*, as a conceptual metaphor for advocacy in nursing (Drought, 2007), can generate new possibilities for collective actions. This concept was first introduced in Greek literature and later reconceptualized by the late French philosopher Michel Foucault (1926–1984). In his lectures, Foucault defined parrhesia as:

> … a verbal activity in which the speaker expressed his personal relationship to truth, risks her/his life because he recognizes truth-telling as a duty to improve or help other people (as well as herself/himself). In *parrhesia*, the speaker uses his freedom and chooses frankness instead of persuasion, truth instead of falsehood or silence, the risk of death instead of life and security, criticism instead of flattery, and moral duty instead of self-interest and moral apathy. (Foucault, 2001, pp. 19–20)

The idea here is not that nurses put their lives at risk (as literally suggested in the quote) but rather that nurses engage in what Foucault described as fearless speech. In order to better understand what this task entails, an overview of the meaning of the word *parrhesia* is necessary.

Frankness refers to the type of relationship between the speaker, as a committed and audacious person, and what the speaker has to say to others (Foucault, 2001). Truth, as in telling the truth, is what the speaker does. As such, the speaker is known for sincerity and courage, which allows him or her to tell what he or she knows to be true. By making a voice heard and a position known, however, the speaker is required to take risks or engage in an activity that may attract critique. In this sense, criticism is to be expected because fearless speech threatens the status quo and what ought to be the majority. Duty is the last characteristic of parrhesia. Here, parrhesia is seen as a duty and is not forced upon the one who speaks the truth. As Foucault (2001) explains, "No one forces him to speak, but he feels that it is his duty to do so" (p. 19). The speaker thus feels obligated to engage in fearless speech and risks his or her privilege in order to voice a truth in spite of some danger (Foucault, 2001), for in parrhesia the danger always comes from truth telling.

Foucault's framework is important because, first, it articulated the notion of advocacy work in an unforeseen way and, second, because it offered a detailed account of what could be expected of *parrhesiastes*—those who speak the truth. These expectations could very well be applied to nurses who have the professional obligation to advocate for persons in their care, even more so when they believe that these persons are systematically disadvantaged in the current legal context. It is therefore important from a moral and ethical standpoint that nurses, as one group of health care professionals who have regular contact with PLWH, speak the truth and raise concerns about how criminal laws exacerbate the burden experienced by this population. Nurses also need to examine the impact of criminalization on their practices and their ability to preserve a climate of trust in which PLWH can share their concerns, ask questions, and interact with nurses without the fear of being prosecuted.

For nurses working in the field of HIV, there is a need to mobilize collectively so that criminalization does not impede on the care provided to PLWH or the way care is provided in clinical settings. This, of course, requires nurses to take risks and engage in a critical analysis of current practices that require nurses to reinforce the legal duties of PLWH and intervene when these duties are not fulfilled.

In Canada, for example, nurses are increasingly being asked to document that their patients have been made aware of their legal duties (regarding disclosure of HIV status for instance) and request that patients sign release forms to ensure lawsuit protection for health agencies. In some institutions, nurses are also expected to record their interactions with patients, the data they collect during assessments (i.e., disclosure to sexual partners), and the "legal" counselling they provide to their patients, all of which can be used to protect the institution (and its staff)

from reprisal. The same information, however, can be used to prosecute a patient. The tensions that arise in this situation require more attention and, evidently, a courageous response. In order to engage in fearless speech, nurses need to expose the negative repercussions of HIV criminalization on the lives of PLWH and on nursing practice itself. While this type of response may attract critique, nurses have an obligation to speak the truth as opposed to remaining silent.

Social Justice

Building on a call for greater involvement and advocacy, it is important to address HIV criminalization in a larger realm of political, legal, cultural, and social complexities. As such, it draws our attention to the application of criminal laws to social groups who are unjustly burdened and systematically disadvantaged in the process. Again, it is important to understand HIV criminalization as a phenomenon that does not exist in a social vacuum but rather in a context where PLWH continue to experience many injustices. Here, the concept of social justice is particularly important to consider because it brings into focus how these injustices are sustained by the discourse on criminalization and its neoliberal underpinnings. The framework proposed by Kirkham and Browne (2006) is of utmost importance in understanding the significance of social justice as one concept that binds redistribution, recognition, and parity of participation.

This framework is highly relevant because it acknowledges that social justice requires redistribution of burdens and responsibilities among members of a society, recognition that members of certain social groups are denied status in the context of social interactions and within social institutions, and parity of participation in order for all members of a society to interact with one another as equals (Kirkham & Browne, 2006). It also challenges the liberal interpretation of social justice and calls for new ways to engage with this concept within the nursing discipline. As such, the idea that society is comprised of freely choosing individuals who exist in an environment of equal opportunities and prospects is strongly criticized by Kirkham and Browne (2006), who have engaged in a critical reading of social justice. Nurses working from this perspective are thus required to challenge the impact of social conditions on the lives of their patients and examine how injustices are sustained, rather than support patients as they learn to cope with these social conditions and make better choices for themselves (Kirkham & Browne, 2006). To this extent, it is important for nurses to see that injustices are produced within a particular context and kept in place by various social structures.

Applied to the present context, the concept of social justice suggests that burdens and responsibilities should be equally distributed among the members of a society. However, at present, criminal courts continue to place burdens on PLWH and charge them based on the most severe offenses. Perhaps this explains why court judgments come in direct contradiction with the notion that HIV prevention and related matters are a shared responsibility among members of a society, regardless of serological status. This notion has guided the development of public health campaigns for the past 30 years and has become a central tenet of prevention efforts worldwide. Yet, it has not been taken into consideration in criminal courts where PLWH are typically represented as assailants and their counterparts as victims who bear no responsibility. From this particular standpoint, PLWH are entirely responsible—and inherently guilty—for any undesirable outcome of sexual contact that may or may not have resulted in HIV transmission.

Nurses should reinforce that HIV prevention and related matters are a shared responsibility and call for a greater recognition of complex personal, social, cultural, and contextual factors that mediate sexual behaviors. However, nurses also need to move beyond distributive justice and recognize that the construction of PLWH as criminals has intensified stigmatization and discrimination. The social response to criminal prosecutions, as portrayed by the media, attests of a predisposition to blame PLWH and perceive them as perpetrators. It is therefore important that nurses, as one group of health care professionals who have regular contact with PLWH, intervene at a broader level to expose the social repercussions of HIV criminalization. The injustices that arise from this situation require more attention because they reduce the opportunities for PLWH to achieve social esteem (as explained by Kirkham and Browne, 2006) and to participate as equal members of society. As such, it is important for

nurses to focus on the root causes of these injustices and address HIV criminalization in the broader social context. The framework proposed by Kirkham and Browne (2006) may prove to be useful in this respect.

Final Remarks

In conclusion, we must understand that health care providers, particularly nurses, have an important role to play in addressing HIV criminalization in their practices and understanding its impact on PLWH. Furthermore, it is argued that nurses should be at the forefront of this initiative because they have the professional responsibility to act as advocates and, therefore, engage in parrhesia amid the rise in criminal prosecutions.

Building on a call for greater involvement and advocacy, this commentary has highlighted the importance of addressing HIV criminalization more broadly to identify new possibilities for collective actions and shape how to respond to injustices such as those produced by the application of criminal laws in matters related to HIV nondisclosure, HIV exposure, and HIV transmission. It is important to recognize that nurses, as the largest group of health care professionals in North America, have a key role to play in advocating for changes in institutional policies and the application of laws that are inappropriate to respond to the HIV epidemic. As suggested here, it is important for nurses to forge a critical response to criminalization and take advocacy to another level.

Disclosures

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