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WORKING PAPER

Criminalisation and the Moral Responsibility for Sexual Transmission of HIV

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ABBREVIATIONS

ARV: Anti-retroviral
AIDS: Acquired Immune Deficiency Syndrome
HIV: Human immunodeficiency virus

The essay that follows is an effort to take on a narrow but important question in a serious, though limited, way. The question is whether there is a MORAL case for lifting primary responsibility for Human immunodeficiency virus (*HIV) prevention from the shoulders of those who know they are infected. The question is important because, for many people, it feels so obviously right to require those with HIV to accept this responsibility that punishing them as criminals if they fail to do so seems a natural, logical and entirely fair next step. As far as we can tell, objections to HIV exposure or transmission laws to date have rested on practical, rather than moral concerns. We will ask whether there is a good moral case to be made against criminalisation.*

There are two important things we will not do. We will not address the use of criminal law to deter or punish people who deliberately expose others to HIV with the aim of causing harm or with callous disregard of a significant risk of transmission. Like other commentators, we regard trying to harm others as wrongful and subject to prosecution regardless of the weapon used; our only concern in such a case, from the HIV perspective, is that a defendant not be punished more *harshly only because the chosen weapon was the virus*[3] *The second thing we will not do is attempt a moral analysis that is culturally comprehensive. The people of the world have developed many powerful systems of moral thought. We investigate our moral question within just one, the Western tradition of deontological ethics and liberal political philosophy. Our purpose is not, ultimately, to define for all people and all places a morality of HIV exposure, but to test whether the case for assigning primary moral responsibility for HIV to the person infected is as strong as it is assumed to be.*

> "[P]unishment involves hard treatment, inflicting harm that is often serious. Given that a state organization is justified only if it is largely to the advantage of the citizens, a punishment system and its design and contents must be justified by reference to convincing, rational (moral) reasons, including reasons that refer to some notion of the common good."
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> -- Nils Jareborg (Jareborg, 2004)

"Criminalisation of HIV" refers to the enactment of criminal statutes that penalise the exposure of or the transmission to another of HIV. It also encompasses the use of general penal laws in the same way. As a public health intervention, criminalisation of HIV is properly criticised. Most HIV infections are transmitted by people who do not know they are infected. Even where HIV status is known and disclosed, disclosure in itself does not prevent transmission. In both cases, transmission can only be avoided by safer sex, and safer sex does not require awareness of any partner's HIV infection. Criminalisation injects a punitive character into the prevention of HIV, causing distress to people who are infected and possibly discouraging safer behaviour by both the infected and the uninfected[4] Criminalisation has been discouraged as an HIV prevention strategy by both UN organisations and national governments[5].

But criminal law may express and even, some believe, transmit moral values. Laws that criminalise the failure by a person aware of his or her HIV infection to protect a sex partner from HIV by disclosure or the practice of safe sex are sometimes justified as expressing a straightforward moral belief that people aware that they pose a significant risk to another are responsible for either eliminating any significant risk, or at least giving the other the opportunity to fully and freely consent to the risk. Moral principles like beneficence and non-maleficence are certainly sufficient to create at least a qualified or *prima facie* duty to avoid harm[6].

There are many areas of reasonable debate about the application of this moral principle. For example, what constitutes a significant risk – i.e. at what level of danger does the obligation arise? Is infection with HIV always a trigger, or can someone with an undetectable viral load be deemed not to pose a risk? Are there circumstances in which it is reasonable to infer that a partner has consented to the risk of HIV – for example, where the sexual encounter occurs in a venue where people meet for anonymous sex, or if a partner refuses the suggestion that condoms be used? Does condom use always discharge the moral obligation of the person who knows he or she is infected, or is it also necessary to avoid sexual activity that would pose a significant risk of HIV transmission in the event of condom failure?

There are also consequentialist objections to the principle that the infected individual is responsible for protecting the uninfected, objections that are largely coextensive with the reasons that criminalisation is a poor public health measure. Some legal philosophers argue that merely expressing the belief that a behaviour is wrong is an insufficient justification for a criminal law that otherwise appears to do no good and may well cause unintended harms[7]. Even setting this objection aside, there is a very good argument that the moral case for criminalisation is polluted at its core by fear of HIV or disdain for those who are infected with it. We raise this not as an *ad hominem* attack on those who favor criminalisation, but to state an important reservation as to whether we really can treat criminalisation as embodying a consistent and coherent moral principle.

But neither disputes about how to apply the principle, nor objections to its consequences, nor even its malign embodiment in a particular criminal statute, challenge the principle itself as a deontological moral claim – that is, a claim whose truth or falsity is not judged by its real-life consequences. The idea that a person who has any sexually transmitted disease has a moral duty to avoid further transmission (or at least involuntary transmission) seems intuitively right, and can be readily justified as a proposition of moral philosophy.

We do not propose, then, to challenge that claim in this essay. Within its own terms, it is incontestable, and in fact is not generally challenged in the world. Even most people who have HIV agree with it. People accept this moral principle, and even try to live by it. And yet many ethical, thoughtful people are troubled by it as a justification for criminalisation. Moreover, their discomfort, we think, is with the moral claim, not with its consequences. They are not uncomfortable with placing moral responsibility on HIV-positive people because it is a poor public health strategy, because even in a strategy that encourages everyone to take responsibility for HIV prevention, we would still hope and expect that infected people would behave protectively towards others. The clue to our intentions here – and to the discomfort people feel with the moral principle – is in the phrase we used in the beginning of this paragraph – accepting the principle as incontestable "within its own terms." In its own terms, the moral question is what the person who knows s/he is infected should do. It does not address what people who do not know they are infected or people who reasonably believe they are not infected should do, let alone what moral obligations fall on members of the community to reduce the spread of HIV. The most important moral question HIV poses as to sexual behaviour is not what the ethical HIV infected individual should do in his or her sex life, but what we all, collectively, are morally obliged to do to create sexual communities that are both virally safe and socially just. No one can do this by herself, no matter how assiduously she monitors her HIV status and adheres to the rule of partner protection. The moral obligations of the infected can only sensibly be discussed within a broader conversation about the moral duties imposed on all of us by the presence of HIV in our lives.

The essay proceeds as follows. First, we describe a sexual community, one that is composed of autonomous adults who are participating, or not, freely. We will try to describe a community that otherwise conforms as much as possible to real life, including a variety of relationships, imbalances in power and gaps in knowledge and the presence of stigmas and forms of discrimination, and varying levels of access to treatment for HIV. Next, we will enquire into what constitutes the Good in such a community. We will endeavour to define basic moral principles or goods, without at this point "balancing" or harmonising them. We will use a thought experiment (the "veil of ignorance" technique designed by the American philosopher John Rawls) to construct rules of justice for this community, rules that members would adopt if they were in a position of agreeing on basic principles of the good but shielded from knowing whether they would be male or female, gay or straight, HIV-positive or -negative, or indeed wishing to participate actively in the sexual life of the community at all. In this way, we aim to offer a more holistic account of the ethics of sexual behaviour in the presence of HIV, one that embraces as moral actors not just those who know they are HIV-positive and are engaging in sex, but everyone who has a stake in and a responsibility for a healthy sexual community. Finally, we will argue that this account of ethics and justice in a sexual community undermines a claim that criminalisation of HIV can advance a robust moral principle.

The Sexual Community

Sexual relationships, for many reasons, unfold in private. This privacy easily conceals the social element of sexual behaviour. We can easily forget that the mores and morals of sex, the expression of sexuality, preferences for various sexual acts or roles – everything about sex – is produced and reproduced collectively. Sexual relationships are social relationships, linking people in networks of affinity and responsibility. Sexual relationships have social status, endorsed through the medium of a "public" relationship like marriage or permanent partnership. Others, like the relationship of a sex worker and his client, may be stigmatised in the public character of a crime. The sex we have, its organisation, type, risks and "value" are all attributes of our societies as well as of our persons. Sexually transmitted diseases map sex as social, flowing like a diagnostic dye through the systems and subsystems of society, unveiling the private – and often the distribution of power and other resources in the society. Like it or not, all of us – even the celibate -- are members of the sexual community because it is the sum of all our attitudes and actions. The moral challenges we face as members of this community cannot be defined in a vacuum; they arise from the conditions we ourselves have created.

To ground our discussion of virtue and justice in a community, we must first describe it. The modern sexual community is complex. It can be intensely local, contained within a neighbourhood of a few streets, or it may be global, a constellation of venues where the voluntarily and involuntarily mobile meet. Relationships may be formed in person, or on the internet. They may be fleeting or held fast for decades. Values in these communities are often formed, reflected and transmitted not only through traditional institutions of moral influence but also popular culture and social media. Though we will for simplicity speak for the most part about a single community, there are nested within it manifold sub-communities defined by gender, sexuality, class, race, attractiveness, age, geography, religion and so on. The sexual community is an abstraction. It does not claim that we are all in fact members of a single, unified and consciously accepted group engaged in the common pursuit of our own forms of sexual satisfaction. It claims, rather, that this is the moral position from which we promulgate rules of sexual behaviour.

There is HIV in the community, but HIV is not the only serious sexually transmitted disease/ infection in the community. There are also people infected with syphilis, gonorrhea, HPV, chlamydia, herpes and hepatitis. Some people are infected and know it, other infected people do not. Some of those who do not know may suspect, just as some who are sure they are uninfected might be wrong. Some people reasonably believe they are negative based on sexual (in)experience and/or timely test. The proportion of each of these groups will vary with the prevalence in the community. People who are already infected with HIV can suffer further harm to health if infected with another strain. There may or may not be anti-retroviral (ARV) treatment available for some or all people living with HIV. Infected people vary in their infectiousness and some may be accurately aware that they are not particularly infectious because of the stage of their disease. Some infected people, receiving treatment or not, may have accurate and timely knowledge of their viral load to support a belief that they are not presently infectious.

There is a wide range of sexual options for people. Some sex acts are more risky than others. Condoms are more or less available, and are known to provide significant protection from HIV and other sexually transmitted diseases. People can make choices about risk and disclosure, but any one person's freedom is a matter of degree: the community exhibits power relationships of many kinds, including

gender, economic, emotional, physical, that may influence whether one partner can suggest or insist upon safer sex or disclosure or fidelity. Sex may be a person's road to economic survival or social acceptance. Sex may be the price a person pays to avoid gender-based violence. There is fear of HIV, stigma and discrimination based on HIV, though not all the uninfected are afraid or rejecting, and not all those who have HIV are equally vulnerable. HIV status intersects with other attributes to shape an individual's experience of HIV stigma and discrimination, or empowerment.

People in the community have varying expectations of honesty, fidelity, altruism or protection of their partners. These expectations often depend upon the duration and apparent nature of the relationship. Informed consent is not the norm of sexual relationships; this is a descriptive, not a normative statement, conveying merely that people do not normally expect or require of sex partners that they detail all possibly pertinent information and that explicit consent be given before sexual activity. At the same time, many people may expect that a partner will not withhold information they would think is important. For some people, choices about sexual practices and safer sex are a form of communication about trust and intimacy, so that love and avoidance of HIV sometimes may be in tension[8]. The community is made up of fallible people. Any given individual will vary at any given moment in capacity to behave in conformity with moral principles, influenced by mental health, social stigma, substance use, and other factors.

The Good

We begin by recognising that the prevention of HIV is neither a moral principle nor an overriding social value. From a moral point of view, the avoidance of HIV is an end, a consequence. It is a very good and proper goal, but most of us do not see it as more important than every other goal. Specifically and significantly, we don't see avoiding HIV as so important a goal that achieving it requires or justifies giving up sex altogether, a fact demonstrated every time a person who knows the risks of HIV nevertheless initiates a new sexual relationship. HIV is a risk we balance with other risks and the benefits of sexual interaction: "relationship risk management in the time of AIDS is as much an effort to protect relationships as intimate, loving and secure, as it is an effort to ensure viral safety"[9]. The moral challenge, and the proper aim of the moral exercise, is constructing a just and virtuous sexual community encompassing but not defined by viral safety.

A deontological moral claim must begin with stating and defending some basic principle of the good, from which further guidance for ethical behaviour can be generated. In the classic Kantian approach, the principle is deliberately disconnected from consequences, but even within the Kantian tradition, modern philosophers have allowed that a moral actor can and indeed must take account of circumstances and outcomes. This may be accomplished through concepts of "prima facie" obligations, which may be altered depending upon circumstances[10] or the use of second-order principles for assessing conflicts among obligations[11]. John Rawls' theory of justice uses a thought experiment, the veil of ignorance, to investigate how fundamental principles can be fairly instantiated in moral rules[12].

In the present case, we can start with a principle common to many strands of moral thought (and skipping a few steps): every human being is, in principle, an autonomous agent with a right to express his individual nature in thought and action.[13] This individuality includes sexuality and its expression. Sexual activity is valuable human activity that serves many positive functions. Sexual

expression, sexual gratification, deepened feelings of intimacy, and the creation of life, are a few of the many benefits a sexually active individual can gain from sexual encounters[14].

In a world of more than one such human being, the exercise of one person's freedom may interfere with another's. It follows that the principle of individual freedom of thought and action must be subject to the qualification that its exercise does not deprive another of the same freedom. Thus (again skipping some philosophical steps) we come to the need to define the kinds of limits that may, consistent with first principles, be placed on individual freedom. In *The Right and The Good*, the modern British philosopher W.D. Ross posited a number of *prima facie* duties including fidelity, or a duty to keep one's promises; justice; beneficence to improve the conditions of others; and non-malfeasance[15]. These principles are also familiar as making up much of the foundations of bioethics (which includes autonomy rather than fidelity)[16]. They look a lot like the skeleton of love itself. They will serve for this analysis.

In a virtuous community, these basic principles and duties would produce a sexual ethic something like this. Every competent individual is entitled to express his or her sexual nature freely, with as much or as little sex as s/he likes, with whatever number and kind of consenting partner s/he likes. These rights are shared and enjoyed irrespective of gender. Beneficence would require every person to attend to the desires, needs and satisfaction of a partner just as non-maleficence would require a partner to avoid exposing his partner to a non-trivial harm of which he is aware. Fidelity would require that we stand by promises made to our partners, but when we take into consideration beneficence and non-maleficence this likely takes us farther than merely honoring explicit promises. For some, the act of sex itself may have attributes of a promise; the virtuous actor, attending to the well-being of the partner, has a duty not to ignore such feelings when he perceives them. He does not have to fulfill them, but he may need to act. For example, the man who knows his partner to believe that sex amounts to a proposal of marriage must, to act beneficently, respond. He must negate that belief in advance, forswear sex, or regard himself, post-coitus, as engaged.

The demands of justice run through these relationships and duties like a river, touching and nourishing every bank. Justice, to which we will return at greater length below, requires that the burdens and benefits of relationships be borne with some rough equality, demanding of each of us that we allocate the apples and oranges of our idiosyncratic pleasures so as to produce sufficient joy for all and an even burden of pain. Justice demands that personhood and autonomy – and not power, race, gender, wealth, or disease status – animate relationships.

These are general duties, applicable to all sexual relationships and all risks and benefits that might arise. HIV infection may trigger any of these duties, but not necessarily in every case. All of these ethical duties, though they assume and ultimately further the autonomy of the actor, are directed toward the other. They are universal duties, always applicable, but their application in specific cases requires ethical judgment by the actor, judgment that must grapple with the facts of a specific case and even more fundamentally be based on as thorough a *comprehension* of the needs and wishes of the other as the actor can achieve. None of these virtues are *passive.* It is not sufficient for an actor to rely solely on unambiguous statements of desire uttered by the other as if in a contract negotiation. Virtue requires the careful application of one's faculties to what is unsaid but communicated through action, expression and context. An act can be rape though the victim was still and silent; consent may and typically is expressed nonverbally. The moral actor is responsible for attending to non-verbal

communication, for understanding its meaning in the particular time and place, and for any errors s/he makes in so doing.

Among the other perquisites of autonomy, every individual is entitled to set his preferred level of risk for HIV, from highly averse to indifferent. A right to engage in risky behaviour seems to be logically required by a commitment to autonomy.[17]It follows that a simple rule about disclosure or safer sex does NOT follow from the principle of autonomy. Take, for example, the duty of non-maleficence as it applies to a person who knows he is HIV-positive but has an undetectable viral load due to effective ARV treatment. Objectively, he poses no risk of transmitting HIV to a partner, and so non-maleficence does not preclude unprotected sex without disclosure. But beneficence requires that he as much as possible understand and address the feelings of the partner. If the partner would be traumatised by even a trivial exposure to HIV, the actor has a duty to disclose; no form of safer sex would suffice to satisfy this obligation. With another partner, however, the obligation might play out differently. This partner might not be averse to a trivial risk of HIV but be quite unwilling to be reminded of it, an attitude that might offend a philosopher but come as no surprise to a psychologist. In such an instance, a beneficent HIV-positive actor with a zero viral load would keep his mouth shut.

The obligation to do good and limit harm informs conduct of the HIV-negative person, too. It takes little insight to imagine that a person with HIV may fear sexual and social rejection. If an uninfected person suspects a partner is infected but too afraid or confused to be responsible, beneficence would require her to facilitate safety or condom use. So would non-maleficence: the presently uninfected individual who intends to be sexually active with others in the future has a responsibility to avoid acquiring an infection she might later, inadvertently, pass on to another. While beneficence does not require the uninfected individual to expose himself to a significant risk of HIV infection, it may demand more than a kindly rejection. Behaviour in response to a partner's HIV status that enforces stigma is maleficent. The obligation to embrace the infected, even if not sexually, falls to everyone in the community. Beneficence and non-maleficence only really matter at the intersection of our autonomy and the other's vulnerability.

Fidelity with respect to HIV can make as many demands as there are explicit and implied promises. Any person who promises to be honest about his HIV status must be so. A promise "not to expose me to HIV" must be kept, even in the face of painfully changing circumstances. On the other side, a diagnosis of HIV is not enough by itself to justify breaking a promise to "love, honor and cherish." If our community has made a promise of care and equality for all its members, as most of our communities have, there is no moral basis for breaking it in the case of HIV.

And so, finally, to justice. None of our principles require that I sleep with all comers just to avoid inflicting pain or offence. When the comer has HIV, and is otherwise my heart's desire, justice nonetheless imposes a stern discipline. While beneficence and non-maleficence might allow me some room to gently parry an invitation, justice with any bottom to it demands I at least interrogate my fears. Justice requires that I treat HIV like any other similar condition. I ought not be more averse to the risk of HIV than another risk of similar magnitude; justice, arguably, demands that I be "rational" about risk. As we will discuss, it certainly demands that communities be rational about risk. Individually and collectively, sexually active or not, we are obliged to learn of and act on emerging knowledge about HIV.

The Just

It is pleasant to contemplate an ideal sexual community of virtuous (not to mention uniformly beautiful) actors. But the sexual community we have described is not a city of angels, or the omniscient, and so the challenge remains to construct rules of conduct that are calculated to advance justice under conditions of uncertainty and even mendacity. To do this, we undertake the thought-experiment of Rawls' veil of ignorance. [18]

Rawls' starting point is much like ours, a conception of society as a mutually benefitting cooperative venture. Rawlsian justice is rooted in avoiding unjustifiable inequalities in the distribution of essential goods – rights, power, material wealth, health and so on.[19] Inequalities are unjustifiable when they do not benefit all. Accidents of birth or biology are not justifications for a present inequality, but rather are themselves injustices that must be minimised in constructing a community and redressed if they occur anyway[20]. Although the duties Rawls derives from a principle of justice are not identical to the ones we have used above, for present purposes it is enough that we agree that people in a community are obligated to act virtuously to create a just society. As a means of eliminating bias in the framing of this community, Rawls proposes that basic decisions about the allocation of burdens and benefits in society be made from behind a veil of ignorance.[21] Behind it we know the details and conditions of the sexual community described above. What we do not know is our place within it: our gender, sexual preference, power, wealth, HIV status, psychological and emotional capacities. Our goal is to construct a set of rules of conduct that create a world in which the burdens and benefits of sex in the context of HIV are fairly distributed, allowing inequalities only when they benefit everyone in the community.

There are many burdens and goods at play in a sexual community. We will focus on those most directly connected to a just management of sex in the presence of HIV. The two primary goods to which all would want access (and which are, alas, in tension) are the opportunity to pursue one's desires for sexual relationships and sexual gratification, and to set one's own risk preferences as to HIV. Ethics limits our sexual opportunities to those that do not harm others, and reality (or here, our premises) precludes the possibility of choosing no risk of HIV if we also choose to engage in any behaviours that could transmit the virus. The challenge for justice is to allocate the good of sex and the burden of avoiding the harms of sex (and in this case the specific harm of HIV infection) in a way that benefits everyone in the community.

In devising rules to achieve this, we are constrained to treat HIV like any other similar risk. Here we must resort to reason, in spite of what we know about how humans actually assess risk[22] because otherwise fear of HIV becomes its own justification for discrimination. Though we all are aware of our own prejudices and predilections about risk, behind the veil, not knowing whether we are the object or the subject of risk assessment, we would want risk decisions to be made in the most objective manner humanly possible. Ultimately, a just world must be a rational world, no matter how important the capacity to appreciate subjectivity might be. (This point immediately implicates the rest of our discussion as itself unjust, because we will continue to talk about rules for avoiding HIV risk when justice as consistency and non-discrimination would require us to consider other sexually transmitted harms, from unwanted pregnancy through emotional distress to other significant sexually transmitted diseases.) Justice would also require us to recognise that people are by accident of birth or other circumstances not equally able to minimise risk to others or to themselves. This is not an excuse for their unethical behaviour, let alone an acceptable defence to a criminal charge. From a Rawlsian perspective

of justice, however, the individual's failing is not the individual's alone: to the extent that the individual's lapse is attributable to unfairness at the starting point, the community has an obligation to respond by providing as enabling an environment as possible for ethical behaviour.

If we cannot know whether we are going to be HIV-positive or HIV-negative in the new world, we will not create a rule that bars HIV-positive people from having sex altogether because there are less restrictive (and fairer) alternatives. Recognising that not everyone is equally averse to HIV risk, we would prefer a rule that lets people make their own choices. And because effective ARV treatment, condom use and safer sex are reasonably effective in preventing transmission, a categorical ban on sex would unfairly burden those with HIV, and even the most altruistic person behind a veil of ignorance would not be ethically required to risk that sacrifice. On the contrary, we would wish to use social resources to maximise the availability of testing, treatment and other services that reduce the risk of transmission and redress the inequalities that contribute to it. The now compelling evidence that early treatment can drastically reduce HIV transmission only adds weight to the claim that a just society would ensure that every HIV person had access to timely testing and treatment.

Even with effective collective action to intervene for risk minimisation, HIV will remain at some level. This requires us to consider a fair distribution of the burdens of HIV prevention and risk-level selection. Would we, from behind the veil of ignorance, establish a rule that those who know they are infected should behave protectively and respect the risk preferences of their apparently uninfected partners by disclosure or safer sex?

As a standard of behaviour, this seems just and desirable for reasons already discussed. Yet this does not exhaust our inquiry. Looking at two people in a bedroom, one HIV-positive and one not, and not knowing which we will be, we would want both parties to take responsibility for prevention. If my partner is HIV-positive but does not know it, he cannot protect me – and if I am the one unknowingly infected, I would not know that my duty of protection had been triggered. There is no avoiding the fact that a system that depended solely on those who know they are infected would result in accidental HIV infections and onward transmissions in the community, even if all those who knew they were infected assumed the burden of protecting their partners. This would be undesirable to both the infected and the uninfected even without a veil of ignorance.

There are also good reasons that we might be concerned about this rule even in bedrooms where the infected partner knows her status. Whether we will be the HIV-negative or HIV-positive party, we have to consider that the HIV-positive partner may be too afraid, distracted, or selfish to follow a rule of protection; s/he may wish to respect the preferences of the HIV-negative partner but misconstrue them. If we were to be the HIV-positive partner, we have to assume we might be, at least on occasion, unable to discharge our moral duties; anticipating that possibility, we would want our HIV-negative friend to be clear and assertive about risk, and sensitive to the fears of an HIV-positive partner.

Because we cannot always know our HIV status, a rule of protecting the partner cannot apply just to the person who knows he is HIV-positive. Any person who has had sex, at least recently, and has not been tested or has other specific knowledge suggesting the high probability of being healthy, must also act protectively. It will be no comfort to us as an HIV-negative person behind the veil of ignorance to learn that the person who infected us did not know s/he was HIV-positive. Given uncertainty, we would have no choice but a "universal precautions" rule. Everyone should take responsibility for avoiding HIV, assuming transmission is possible and helping every sex partner make their own choices

about risk and pleasure. Indeed, self-protection is as much a right as an obligation. When we consider power relationships from behind the veil, we would insist upon a rule that people be entitled to safer sex (which, unlike disclosure, is a robust strategy for avoiding infection.) Universal precautions also benefit the HIV-positive person, who both avoids reinfection and is spared the burdens that may arise from disclosing her infection.

This is fine as far as it goes, but basically deals with initial or casual encounters. As relationships emerge, at whatever pace, do the rules change? How do we construct just rules that accommodate intimacy, trust, fidelity and other important elements of relationships as they grow over time (and sometimes over a very short time)? We would want everyone to be candid about their behaviour and status; we would want decisions about risk to be made together, freely. Not knowing who will be HIV-positive and who HIV-negative, though, we would see this in terms of reciprocal obligations within a relationship: both parties must be frank about preferences and risks, and the obligation of honesty about HIV status is matched by a reciprocal obligation to be beneficent and just in receiving the news. If it would be wrong to withhold knowledge of HIV infection when a partner fairly wants to know, it would be equally unjust to withdraw love from a partner who tells the truth. At this point, though, the problem of analysing a specific obligation with respect to HIV becomes clearly untenable. The obligations of people in relationships to which they have made a substantial commitment arise predominantly from the relationship itself. And just as clearly as these obligations exist, the issue with justice and HIV becomes whether a person behind the veil of ignorance would decide that criminal law should be used to selectively enforce general obligations of candor and protection selectively in the matter of HIV.

The growing evidence that treatment with ARV medicines significantly reduces the likelihood of transmission is likely to influence the ethical discussion in the future. We will not here address whether there is a moral obligation to get treatment as soon as possible in order to protect others, in spite of personal preferences and perhaps even at the cost of personal health. The efficacy of treatment does raise more questions about disclosure as a moral obligation. If a person living with HIV is, essentially, incapable of transmitting the virus because of treatment, the difference between this characteristic and other qualities of the actor become even more tenuous. In a committed relationship, there would remain important reasons to be candid about having a serious disease, but avoidance of HIV transmission would not be as compelling as in the past. From behind a veil of ignorance, we might say that a person living with HIV who has been treated so as to render himself non-infectious has discharged his primary moral obligations with respect to HIV.

To summarise, we suggest that rational people constructing a just sexual community from behind a veil of ignorance would stipulate general and reciprocal obligations of self- and partner-protection, and reject an obligation placed upon the infected person alone. The moral case for this view is at least as strong as the case for placing primary responsibility on those who know they are infected, and the practical effect on transmission is likely to be much better. The interests protected include viral safety, fulfillment of risk preferences, and avoidance of stigma or discrimination. The community as a whole would have the obligation to create an environment in which such mutual protection is maximally supported, including by ensuring that timely HIV testing and treatment are available and accessible to everyone at risk of or infected with HIV.

Can a Punitive Response to HIV Exposure and Transmission be Just?[23]

The discussion we have presented should, if nothing else, have indicated the complexity of the moral questions informing the legitimacy of criminalisation as an instrument of morality. In this section we seek finally to state a *moral* case against the use of criminal law in cases of alleged HIV exposure or transmission committed in the normal course of sexual events – i.e., not committed with an intention to harm another or the substantial certainty that harm would occur. Our analysis is informed by our view that responsibility must be understood socially and in the context of the relationships in which it is expressed. The argument rests on our belief that the character of both sexual intimacy and HIV risk cannot be realistically understood as posing moral questions merely for infected people. Its essence is that a just sexual community places moral obligations with respect to HIV upon everyone, and cannot accommodate their selective enforcement against people who are infected. We argue that criminalisation as it is now practiced is wrong because it unfairly places the burden of HIV prevention upon people who know they are infected with HIV, contrary to both justice as fair treatment and a robust moral vision of sexual responsibility in a community with HIV. Nor, we argue, would "equal criminalisation" of any risk behaviour by any person solve this problem; aside from its facetious quality, we suggest that criminalisation discriminates unjustly not merely in the people it targets, but in the way in which it treats similar acts and risks. The fear of HIV, and the stigmas assigned to the behaviour that spreads it, too readily cloud our judgment. Finally, we argue that criminalisation also fails the test of justice by failing to comprehend the many kinds of morally important differences in capacity and choice that define a sexual community realistically understood.

If everyone in the community has obligations to reduce infection with HIV, and those who are infected cannot in fact do it alone, placing the burden of criminal liability solely on those who know they are infected is unjust by definition. We have set out the arguments supporting this conclusion above. Of course, this problem might be addressed by *more* criminalisation. The law might impose a positive obligation to assist a prospective sexual partner to disclose relevant information (e.g. HIV status), and punish those who failed to disclose negative status or failed to assist a partner to disclose. It might impose a positive obligation to protect oneself against exposure to viral infection, and punish those who failed to protect themselves. It is possible to even conceive of a legal system in which allowing oneself to become infected with HIV would be a crime. Leaving aside whether such a criminal law would be consistent with social values or human rights – or even capable of consistent enforcement – it is hard to imagine that individuals behind a veil of ignorance would, aside from its consistency, find such a legal system desirable. The burdens would be enormous, and fall unevenly on those who preferred more sex or tolerated higher risk without offering a strong promise of freeing the community of HIV. Yet even if those objections could all be dismissed, there would still be a fundamental injustice at the core: we would no longer be discriminating among actors, but the law would still be discriminating among risks.

We can illustrate this concern with two examples of the way criminalisation treats actions involving HIV in a way that is inconsistent with the usual practices of criminal law. The first has to do with the significance of knowledge in determining the existence of consent. In typical liberal legal systems, the offence of rape is established when it is proved that the complainant did not consent to the penetration, and the defendant was either aware of the absence of consent or did not give any thought to whether or not the complainant was consenting. Consent is central to the offence because its absence converts an expression of autonomy into a violation of autonomy. And in order for consent to be meaningful it can only exist where the person giving it is in possession of all material information (i.e.

the information that makes a difference to, or significantly impacts on, his or her decision). It follows that withholding relevant information, or lying, renders consent meaningless.

With this in mind, consider the following hypothetical situation: Tom knows, because he has been told on good authority, that Gina will not have sex with married men. Tom is married. Tom meets Gina at a party, and they are sexually attracted to each other. Gina asks Tom if he is married and he says no. They have sex. On these facts, and in light of the principles set out above, Tom has behaved in an immoral way. Legally, it may be thought that Tom has raped Gina. He knew that his marital status was significant and material, and he lied about it. From Gina's perspective, she has engaged in sex that she would have refused had she known the truth. However, in most legal systems these facts do not establish rape. Why? Because despite the moral opprobrium that may be attached to Tom's deceit, Gina has in fact consented to the intercourse itself: she knew what she was doing. The "quality" of the intercourse (i.e. the fact that it is intercourse with a married man) is insufficient to render it a crime.

Comparison of this situation with criminalisation of non-disclosure of, or deceit, as to, HIV status is instructive. First, where HIV is not transmitted, lying about HIV is being treated differently from lying about other matters relevant to a sexual decision; and risking the harm of HIV infection is being treated differently from other risks of harm arising in sex. The argument that the difference is justified because infection with HIV is different – i.e., worse – than the consequences of rape (an interesting claim in and of itself) just makes the problem worse. To see how, consider a case where HIV in such a situation is transmitted. Since deceit has happened in both cases, it can only be the transmission of HIV that justifies criminalisation. If the principles underpinning most western legal systems preclude the "quality" of sexual intercourse from establishing the offence of rape, then deceit or non-disclosure about HIV status ought to of themselves be insufficient to establish the requisite criminal fault. If this is so, then it necessarily follows that it is the fact of HIV infection that is making the difference and justifying punishment. But if this were the case, then all proven cases of transmission – even where there had been consent to the risk of transmission – ought, in principle, to be prosecuted and infectors punished. And this is not the case in most legal systems, which allow the defence of consent, thus preventing the punishment of – for example – Roman Catholic husbands living with HIV whose wives have consented to the risk of HIV transmission rather than offend against religious proscriptions concerning non-procreative sex.

The fact is that the moral core of transmission liability is itself infected with a discriminatory notion of HIV. We tell ourselves that criminalisation is justified by moral notions of deceit and disclosure, but at the same time treat this as irrelevant in some other categories of case, such as rape.[24] We tell ourselves that it is about the harm that HIV infection necessarily represents, while at the same time allowing the defence of consent to the risk of transmission. We think HIV is somehow worse, and so we treat it more harshly than like phenomena. The moral lapse is our own: HIV is different in the law because HIV is associated in the public mind with sexual deviance and drugs. The immorality here is that the harshest form of law is being trotted out mostly because people with HIV are not the people we like in our societies, because those people's only identity to society is as vectors of unacceptable behaviour.

Allocating responsibility for harm in sex provides a second illustration of this different treatment of HIV. Criminal liability depends on determining responsibility for the proscribed act, conduct or consequence. Unless the defendant is the author of what is forbidden, he may not legitimately be punished. Now consider the following example. Tom knows he is HIV-positive. He has sex with Gina,

during which HIV is transmitted and she is infected. If we were to ask a random and representative sample of people – a jury, say – "who is responsible for Gina's infection?" (a necessary precursor to determining criminal liability), the answer will typically be "Tom." Tom has made a difference. Tom has caused the change. Ignoring for the moment questions of deceit and non-disclosure, we will typically allocate blame (the moral content of responsibility) to the behaviour that resulted in the change – despite the fact that the behaviour itself (sex) has no necessary moral significance or content. Because the change (HIV infection) is understood as a harm, and because we elide moral fault (blame) and agential responsibility (having unprotected sex when you are HIV-positive), it is easy to see why Tom is seen as responsible (and therefore legitimately punished) for Gina's HIV infection.

Consider, though, the following analogous hypothetical. Tom has sex with Gina as the result of which Gina falls pregnant. Now ask the same group "who is responsible for the pregnancy?" The response will typically be "they both are" or (from those who wish to preclude biological fathers from decision-making as regards pregnancy and termination etc.) "Gina is". The reason for this difference has nothing to do with the activity (it is the same), or the fact that a consequence has occurred from the activity (both HIV infection and pregnancy are consequences of the same activity). It has to do with the fact that pregnancy is treated as a normal consequence of sexual intercourse and HIV infection as abnormal. A developing foetus is a to-be-expected outcome and a replicating retrovirus is not. Pregnancy is not considered harmful (though for some women it may be) and HIV infection is considered harmful (though for people with access to treatment it may not be, and for many people it is as acceptable a risk of sex as is conception). The point is that identification of the person responsible for the consequence depends on our characterisation of that consequence as good or bad, expected or unexpected, deserved or undeserved.

Thus we see that the criminalisation (a) treats HIV infection as *necessarily* a harm, (b) views risk-taking as *necessarily* unjustifiable (c) considers non-disclosure as *necessarily* reprehensible, and (d) constructs the person to whom HIV is transmitted as *necessarily* a victim. The imperative for criminalisation lies not in the punishment of immoral behaviour – there is much that is immoral that is not criminalised – but in the social meaning of HIV and acquired immunodeficiency syndrome (AIDS), and in the way we understand responsibility for onward transmission and risk-taking as individual rather than as social. Nor does the desirability of avoiding HIV transmission provide a warrant: morally and practically, HIV prevention is a task for all. Precisely because judgments about HIV are so bound up with fear of death and, for many, disdain for the behaviour that brings transmission, the communal voice that speaks through the law cannot be uncritically heeded. It was one of the United States' greatest jurists, a man known for his defence of constitutional rights, who accepted uncritically the eugenic ideas in vogue in his time and dismissed a woman's challenge to involuntary sterilisation with the infamous explanation that "[t]hree generations of imbeciles are enough"[25].

We have argued that criminalisation is inherently unjust because it treats HIV, or people living with HIV, differently without thereby benefiting everyone. Criminalisation also fails for the converse reason: it treats as the same things that are different, in ways that are meaningful if not fundamental to a coherent account of a just community with HIV. Members of the sexual community, we posited (and which we believe to mirror reality), do not have identical capacities, resources, wishes, or levels of tolerance for risk. Criminal law by its nature creates and imposes a standard of responsibility that largely ignores facts and distinctions that drive moral reasoning and behaviour in the sexual community,

particularly when understood as being composed of many sexual sub-communities. Criminal law denies – or at the very least marginalises – the relevance of gender, class, sexuality, colour, ethnicity and history. It assumes that the individual human being on trial is the only, or at least the primary, responsible party. The richness, variety and complexity of what it is to live as a human being in society and in relationships with others is reduced to the defendant's knowledge and motive as those attributes are defined by the law. The moral measure of the defendant's behaviour is taken by the judge or jury, by reference to their own values and experience, and the ascribed to the accused.

This is, of course, what criminal law is designed to do: impose a clear and uniform standard of behaviour. The uniformity and majestic equality of the criminal law is its strength – when it is applied to acts that are harmful committed with intentions that are culpable. Criminal law is law in its most violent form. In defining individuals as criminals, it wields symbolic violence. In depriving them of liberty and property, it wields the iron fist of violent coercion in the velvet glove of due process.[26] Where the moral and practical case for criminal sanctions is strong, its use can be worth the price. But when it is used with improper motives, to punish behaviour the immortality of which is not clear, it can, as it does in the case of HIV, do violence to the moral essence of a just sexual community.

Conclusion

HIV transmission occurs between human beings. Those human beings may be male or female masculine or feminine, hetero-, homo- or bisexual. They may be young or old. They may be mothers, fathers or carers. They may be orphans. They may belong to any ethnic, religious, or national group. They may be in marital, casual, committed or commercial sexual relationships with others. They may be HIV-negative or HIV-positive. They may know their HIV status, have unconfirmed beliefs or be ignorant about it, or not have given it a moment's thought. They may consider themselves to be "at risk", or immune. They may believe, rightly or wrongly, their sexual partner(s) to be HIV-positive, or HIV-negative. They may understand the way in which HIV is transmitted, be unsure, or ignorant. Those who have contracted HIV may have been infected decades ago and be asymptomatic, or they may have been infected last year and have been diagnosed as suffering from an AIDS-related illness. They may have contracted HIV through maternal-foetal or perinatal transmission, a blood transfusion, needle sharing in the course of injecting drug use, consensual sexual intercourse or rape. They may have taken no precautions against transmission, or attempted unsuccessfully to protect themselves. They may have a high or undetectable viral load. They may have access to care, treatment, advice and support, fail to take advantage of these where they are available, or be denied such services. They may know the identity of the person who infected them, or neither know nor care. They may feel ashamed, empowered, stupid or unlucky (or all of these things). They may voluntarily disclose their HIV-positive status to those with whom they have sex of a kind that poses a risk of transmission, or stay silent. They may tell the truth if asked, or they may lie. They may not care about infecting others, or they may take every precaution against doing so. They may feel responsible for their infection, or that someone else is responsible for infecting them.

HIV affects everyone, whether they are HIV-positive or HIV-negative, and whether they know this or not. It affects them in different ways, in different contexts and for different reasons. Those who are HIV-negative may, unless they take precautions against transmission in situations where that is a risk, become infected; those who are HIV-positive may, unless they take precautions, infect others.

There is, therefore, for those in each category a responsibility, both to themselves and to others, to minimise the risk of onward transmission. This simple truth of prevention, central to safer sex and health promotion initiatives in the field of HIV and AIDS, nevertheless fails to capture – as the variety of experience, attitudes, emotions and statuses described above demonstrate – what being responsible means and entails, both for people living with HIV or AIDS and those at risk of infection. Nor does it give any indication of how people, individually or in their relations with others, are able to put, or are prevented from putting, their understanding of what being responsible means into practice. Being sexually responsible in the time of AIDS is both critically important and challenging; and it is something that criminalisation fails to address.

This sense of the *actual* complexity of responsibility for HIV has inspired many critiques of criminalisation.[27] In this essay, we have considered this complexity from a moral standpoint. We reject the moral principle that individuals who know they are infected must protect their partners – but only in so far as it is supposed to stand alone. By posing a different moral question – what must all of us do in a sexual community with HIV – we come to an answer that starts with, rather than denies, the real complexity of responsibility. No one of us can make the community safe; every one of us is compelled to try; no one's obligation is more compelling than any other's. Criminalisation fails from a moral point of view not because it has no moral principles, but because the principles are incomplete and, in their partiality, unjust.

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[3] Cameron, E., Burris, S., & Clayton, M. (2008). *HIV is a virus, not a crime*. HIV/AIDS Policy & Law Review / Canadian HIV/AIDS Legal Network, 13(2-3), 64-68. See also Jurgens, R., Cohen, J., Cameron, E.,

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[12] Rawls, J. (2005). *A theory of justice* (Original ed.). Cambridge, Mass.: Belknap Press.

[13] We recognise that many ethicists, not least those concerned with a more globalised ethical framework, question foundational individualism. For present purposes, it is enough to note that we are explicitly placing our agent, whatever his actual autonomy, within and dependent upon a community, in an analysis devoted to exploring how agency and contingency can justly be managed in a social context. Cf. Van Niekerk, A.A. (2006), *Principles of Global and Distributive Justice and the HIV/AIDS Pandemic: Moving Beyond Rawls and Buchanan*. In *Ethics & AIDS in Africa: the challenge to our thinking*, edited by A.A. Van Niekerk and L.M. Kopelman, 84-110, Walnut Creek, Calif.: Left Coast ("It is therefore our dependence upon and our commitment to society that…. constitute our moral sense.").

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[18] We use Rawls as a philosophical flag of convenience. Our aim here is to illustrate in a plausible, if preliminary, way, that there are entirely respectable moral arguments to be made for allocating responsibility for HIV to all members of the community. We do not hereby adopt a liberal, let alone Western, mode of analysis as the only right and true approach.

[19] Rawls actually distinguishes "primary goods" like wealth from "natural goods" like health, which he supposes are equally important to well-being but not so much under social control. In this, we differ, since we believe as an empirical matter that the level and distribution of health generally is strongly influenced by social factors, and that

our particular concern, HIV, is likewise shaped in its spread by social ideas and policies. See Commission on Social Determinants of Health (2008), *Closing the gap in a generation: Health equity through action on the social determinants of health*, Geneva: World Health Organisation.

[20] Rawls, J. (2005). *A theory of justice* (Original ed.). Cambridge, Mass.: Belknap Press.

[21] The veil we will use is perhaps a thinner one than applies in Rawlsian analysis writ large. Daniels uses this sort of "thinner" veil of ignorance in his classic application of Rawls's ideas to health care. Daniels, N (2008), *Just health: meeting health needs fairly*, Cambridge; New York: Cambridge University Press.

[22] Finkel, A. M. (2008). *Perceiving others' perceptions of risk: still a task for Sisyphus.* Ann N Y Acad Sci, 1128, 121-137.

[23] This final section is adapted from Weait, M (2007), *Intimacy and Responsibility – The Criminalisation of HIV Transmission*. Abingdon: Routledge-Cavendish.

[24] Commentators on criminalisation generally exempt from their criticism criminalisation of deliberate transmission of HIV, on the grounds that this nothing more than an instance of (attempted) murder, a crime that is generally punished and in which the HIV element is merely a random detail. They also have tended to leave open the possibility of criminalisation of fraud, or what we would in this analysis call failures of fidelity. See, e.g., Burris, S, and Cameron, E (2008), *The Case Against Criminalisation of HIV Transmission*, JAMA 300: 578-81; Jurgens, R, Cohen J, Cameron, E, Burris, S, Clayton, M, Elliott, R, Pearshouse, R, Gathumbi, R, and Cupido D, (2009), *Ten reasons to oppose the criminalisation of HIV exposure or transmission*, Reprod Health Matters 17: 163-72. Our analysis does not challenge the view as to murder, but as to fraud the case is perhaps harder. We agree there is a strong moral obligation of fidelity. It is wrong for a partner to lie about his HIV status. The question, as we have laid it out in this part of the paper, is whether we can properly treat breaches of fidelity with respect to HIV differently than other significant lies in relationships. If our criminal law of relationship fraud is general and generally enforced as with the case of murder, then it would seem consistent with justice to include fraud as to HIV among the types of lie that is punished. Otherwise, obviously, not.

[25] *Buck v. Bell*, 274 US 200 (United States Supreme Court 1927).

[26] Cover, R. (1986). *Violence and the Word*. Yale L.J., *95*, 1601-1628.

[27] Burris, S., & Cameron, E. (2008). *The Case Against Criminalization of HIV Transmission*. JAMA, 300(5), 578-581. See also Csete, J., & Dube, S. (2010). *An inappropriate tool: criminal law and HIV in Asia*. AIDS, 24 Suppl 3, S80-85. See also Jurgens, R., Cohen, J., Cameron, E., Burris, S., Clayton, M., Elliott, R., et al. (2009). *Ten reasons to oppose the criminalization of HIV exposure or transmission.* Reprod Health Matters*, 17*(34), 163-172. See also UNAIDS (2008). Criminalization of HIV Transmission. Geneva: UNAIDS.