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Schuyler Frautschi  
*New York University School of Law*

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## Understanding HIV-Specific Laws in Central America \*\*

SCHUYLER FRAUTSCHI \*

### Abstract

This article explores HIV-specific laws in Central America: why they exist, where their terms come from, what choices have been made, and what the laws do. Part I outlines the influential work and standards of the U.N. and USAID. Part II presents contours of debate over AIDS law and policy in the United States. Part III reports on the HIV epidemics in Central America. Part IV compares the Central American laws, applying some of the lessons and theories presented in earlier Parts. The article concludes that HIV laws in the region do not function to provide the basis for claims of individual rights or impositions of responsibilities, the way U.S. laws often have. Rather, the Central American laws represent national aspirations toward a reasonable response to the epidemics. Central American aspirations toward safeguarding individual rights, while tracking heightening international standards, nonetheless are profoundly challenged as the epidemic is measured and expands: the law in Nicaragua, with its very low measured incidence of HIV infection, is very

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\*\* Parts of an early draft of this article were translated into Spanish and used by Central American AIDS activists at a meeting called “A favor de la Ley de VIH/SIDA” (*In favor of HIV and AIDS Laws*), which took place in Guatemala City from 7-9 May 2001. Special thanks for help in the preparation of this article go to Alexia Alvarado, Licida Bautista, Xiomara Bu, Manuel Burgos, Norma Garcia de Paredes, Victor Hugo Fernandez, Eugenia Monterroso, Cesar Antonio Nuñez, Joselina Paz, Carmen Reinoso, Howard Venable, and Benjamin Weil.

\* J.D. 2002 at NYU School of Law; United States Peace Corps Volunteer in Honduras, 1989-92, doing AIDS prevention; Masters degrees in Public Health and International Affairs, 1994, from Columbia University’s Schools of Public Health and International and Public Affairs (SIPA); Program Officer for the Latin America desk at the United Nations Development Program’s HIV and Development Program, 1994-95, and with both the Latin American and African Networks on Human Rights, Ethics, Law and HIV (the latter through 1996); Program Officer at the International Planned Parenthood Federation/Western Hemisphere Region, 1998-99, providing technical assistance to the Programa Acción SIDA Centro America (PASCA), a USAID-funded project based in Guatemala.

“rights” oriented, while the law in Honduras, where HIV incidence is relatively high, is very “duties” oriented.

This article explores HIV-specific laws in Central America, to understand why they exist, where their terms come from, what choices have been made, and what, if anything, the laws do. Part I outlines some of the work and standards of international organizations, such as the United Nations (U.N.), and bilateral aid, especially that provided by the United States Agency for International Development (USAID). Part II presents some of the main terms of the debate over AIDS law and policy in the United States. I take this route of inquiry, with a wary eye on cultural hegemony, because the United States has a very large epidemic, and has experimented on a massive scale in policy, with important state-level iterations. More data regarding policy and its outcomes is available in the U.S. than almost any other country, though it is still sorely lacking in several key areas. I will explore in very basic ways the relationship of U.S. policies to our Constitution, and the long history of Constitutional litigation.

Some have suggested that U.S.-based notions have “leaked” into the now global business of HIV legislation, and this leakage, insofar as it has occurred, may be keenly inappropriate in other countries, given their differing legal systems, Constitutions, and accessibility of newer treatments.<sup>1</sup> Part III will briefly report on the HIV epidemics in the six Spanish-speaking countries of Central America.<sup>2</sup> Finally, Part IV discusses the Central American laws in a comparative light, applying some of the lessons and theories presented in earlier Parts.

I conclude that HIV-specific laws in the region do not function, at least by way of formal litigation, to provide the basis for claims of individual rights or impositions of responsibilities, the way U.S. laws often have. This is because Central American constitutions, histories, political and social structures differ greatly from ours. Central American countries have civil law

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<sup>1</sup> See generally, e.g., John Linarelli, *Anglo-American Jurisprudence and Latin America*, 20 *FORDHAM INT’L L.J.* 50 (1996), *infra*. Linarelli’s argument does not mention HIV laws per se.

<sup>2</sup> I have included Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama in this article. I have excluded Belize, otherwise a Central American country by geography, because it was once a British colony, and therefore does not have a civil law tradition like the rest of Central America. Belize is not usually included in regional political groupings, either, and in fact has closer affinities with Caribbean nations.

systems, are not nearly as litigious as the U.S., and have constitutions that were drafted within many of their citizens' lifetimes. At best, the Central American laws represent national aspirations toward a reasonable response to the epidemics. I conclude, albeit tentatively, that a nation's aspirations toward safeguarding individual rights, while tracking heightening international standards, nonetheless are profoundly challenged as the epidemic is measured and expands. This is a central reason why the law in Nicaragua, with its very low measured incidence of HIV infection, is so rights oriented, and why the law in Honduras, where HIV incidence is relatively high, is so duties oriented.

The initial impetus for writing this article came from Dr. Jonathan Mann,<sup>3</sup> and a short treatise on health and human rights that he wrote. Mann rose from being the New Mexico state epidemiologist, to leading the Global Programme on AIDS (GPA) at the World Health Organization (WHO). He came to see epidemiology and its methods as fundamentally flawed; after he quit the WHO post in frustration and moved to Harvard, he wrote: "Applying classical epidemiological methods to HIV/AIDS ensures, even pre-determines, that 'risk' will be defined in terms of individual determinants and individual behavior."<sup>4</sup> The science itself thus led to programs that focused on condom use or abstinence, or using clean needles. But Mann and others found that "[i]n each society, those people who, before HIV/AIDS arrived, were marginalized, stigmatized and discriminated against, became over time those at highest risk of infection."<sup>5</sup> Discrimination, considered as a vector, may lead in multiple ways to heightened infection rates: through poverty and its attendant barriers to safer sex (e.g., via sex work, or women's sexual disempowerment in household economic dependency<sup>6</sup>), or through low self-esteem and risk taking (e.g., via internalized racism and other psychological

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<sup>3</sup> On September 2, 1998, Dr. Jonathan Mann died in the crash of Swissair flight 111, on route to Geneva, where he was going to attend a meeting on AIDS at the World Health Organization. I met Mann only once, and shook his hand to receive my Masters degrees in Public Health and International Affairs. With his free hand, he gave me and my graduating cohort small scrolls that he and his team at the Francois-Xavier Bagnoud Center for Human Rights at Harvard had prepared, on health and human rights.

<sup>4</sup> Jonathan Mann, *Human Rights and AIDS: The Future of the Pandemic*, 30 J. MARSHALL L. REV. 195, 198 (1996).

<sup>5</sup> *Id.* at 201.

<sup>6</sup> For a provocative discussion of this topic, see María Antonieta Torres Arias and Ana Luisa Liguori, "La negociación para la prevención del SIDA: entre deseo y el poder," *Debate Feminista*, Vol. 9, March 1994, pp. 411-417.

mechanisms). This in turn suggested that society-wide, legally instituted anti-discrimination measures would be a useful approach in combating the epidemic, among an array of other human rights and programmatic approaches. These concepts, if sometimes inexact, have become increasingly central to the entire global response to AIDS; indeed, the theme of the XVIII International AIDS Conference in Vienna in 2010 is human rights.<sup>7</sup>

Mann also argued that fear of discrimination would undermine a public health system's ability to do individual prevention work. This kind of fear played itself out in one of the earliest policy battles in the AIDS epidemic, over the issue of HIV testing. Some thought that there should be prevention education for the entire population, and others thought it would be more efficient just to find out who was already infected, and work with them.<sup>8</sup> This debate has included people working from *a priori* sets of assumptions, and other empiricists scrambling for data sets. Mann's voice, for better or worse, came in from a third angle, that of expert authority: "Based on field experience, the [World Health] Organization declared that coercion and discrimination towards HIV-infected people and people with AIDS undermined and reduced the effectiveness of HIV prevention programs. For example, wherever rumors spread that HIV testing facilities were providing lists of HIV-infected people to governments, participation in HIV testing declined precipitously."<sup>9</sup> Neither here nor elsewhere<sup>10</sup> did Mann name what

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<sup>7</sup> According to its website at [www.aids2010.org](http://www.aids2010.org), the theme of the XVIII International AIDS Conference is *Rights Here, Right Now*, which "emphasizes the central importance of protecting and promoting human rights as a prerequisite to a successful response to HIV. The right to dignity and self-determination for key affected populations, to equal access to health care and life-saving prevention and treatment programmes, and the right to interventions based on evidence rather than ideology, are all incorporated in this urgent demand for action. *Rights Here, Right Now* emphasizes that concrete human rights measures need to be in place to protect those most vulnerable to and affected by HIV, especially women and girls, people who use drugs, migrants, prisoners, sex workers, men who have sex with men, and transgender persons."

<sup>8</sup> Nan D. Hunter, Closing Address, Proceedings from the 1995 National Council for International Health HIV/AIDS Workshop: International Perspectives on Legal Issues and Human Rights, p. 47.

<sup>9</sup> Mann, *supra*, at 197.

<sup>10</sup> Mann et al edited the encyclopedic AIDS IN THE WORLD (1991). Tomasevski, Gruskin, Lazzarini and Hendriks submitted a chapter to the book, on "AIDS and Human Rights." They wrote, without further citation, that:

...it became clear that a discriminatory social environment was counterproductive for HIV information/education and prevention programs. Threats of coercion toward HIV-infected people had the effect of driving people with risk

countries he was talking about or what data was available,<sup>11</sup> but the notion that named reporting would frustrate a health system's ability to build trust with people at risk, in order to give them effective counseling, became a matter of faith in certain circles, and still often intersects with the business of lawmaking.

Mann's broad focus on anti-discrimination efforts, emphasizing generally that discrimination leads to new infections, has generally *not* trickled down into HIV-specific laws in Central America. Rather, significant attention is afforded in those laws to discrimination against people living with HIV, emphasizing the problems of discrimination *after* infection occurs, along the lines of the U.S. model, as discussed in Part II. However, U.S. approaches have not been copied outright; elements of the international response to the AIDS epidemics show up in national laws in the region, and provide a good starting place for understanding those laws.

### **Part I: The International Response**

In the early 1990s, several agencies at the United Nations tried to mount a global response to the AIDS epidemics. The Global Programme on AIDS, housed at WHO, was by far the largest of these efforts, and its approach was a bio-medical one, focusing on HIV, infected individuals, and modes of transmission. The United Nations Development Programme (UNDP) generally decried the exclusively bio-medical approach, and insisted on a so-called "inter-sectoral" response, involving as many governmental and non-governmental groups as possible. The United Nations Children's Fund (UNICEF) stressed children's issues, like the plight of AIDS orphans. The United Nations Population Fund (UNFPA) tried to focus activities through family planning clinics and programs. Some countries were targeted by each agency, but other countries seemed to slip through the cracks, unnoticed.

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behaviors away from the health and social services created to help prevent HIV transmission. Thus, from a practical viewpoint, discrimination was viewed as a danger to public health. (AIDS IN THE WORLD 540)

<sup>11</sup> One might give Mann the benefit of the doubt, given that the data, if such exists, belongs to the World Health Organization, which is a member agency of the United Nations. The U.N. has as its constituency not the people of the world, but the governments of the world. Although much of its work now tends towards NGOs, the U.N. to this day must be careful about protecting the interests of governments, and as such member agencies can be very cautious releasing information that would be critical of governments.

Donor fatigue, perhaps enhanced by the competing claims of the different agencies, led to diminishing resources for all the agencies.

To eliminate duplication of efforts and gaps in programming, and present a unified strategy to donors, the UN agencies co-sponsored the Joint United Nations Program on HIV/AIDS (UNAIDS). This agency, founded in 1994, has unfortunately failed to find much success in the area of fund-raising. It has, however, compiled a number of important studies, documented “best practices” as exhibited in different parts of the world, and even fielded regional representatives who try to bring together as many players, from generals to tourism officials, from legislators to people living with HIV, as will come to the meetings. As will become clear in many of the Central American HIV laws, the mandated inter-sectoral response is one of the central achievements, at least on paper, of UNAIDS’ activities.

In September 1996, UNAIDS and the Office of the UN High Commissioner for Human Rights convened the Second International Consultation on HIV/AIDS and Human Rights. The Consultation drafted the International Guidelines on HIV/AIDS and Human Rights, which were approved in 1997 by resolutions of the Commission on Human Rights and the Sub-Commission on the Prevention of Discrimination and Protection of Minorities. The Guidelines were published in Spanish and several other languages in 1998, and were updated (to restate for revisions to Guideline 6 adopted in 2002) in 2006.<sup>12</sup>

Expanding on the original 1998 Guidelines, in 1999 UNAIDS published, in conjunction with the Inter-Parliamentary Union, a Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact.<sup>13</sup>

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<sup>12</sup> UNAIDS *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version*, U.N. Sales No. E.06.XIV.4 (2006) (hereinafter Guidelines).

<sup>13</sup> UNAIDS *Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact* at 25, U.N. Doc. UNAIDS/99.48E (1999) (hereinafter UNAIDS Handbook for Legislators), available over the Internet. It is interesting to note that Zury Rios Montt, a drafter of some of the Guatemalan legislation discussed in this article, was consulted in the drafting of the Handbook. Acknowledgments at 4. There are other such tools for parliamentarians, such as the Spanish-language “Modulo Legislativo sobre VIH y SIDA,” published in 2000 by the Grupo Parlamentario Interamericano Sobre Población y Desarrollo (GPI) and the Programa Acción SIDA Centro America (PASCA). This Module contains a booklet of conceptual tools, which few will find useful, and a booklet which contains tabulated versions, in Spanish, some of the most

The handbook states, without further explanation, that it “does not provide model laws at this time owing to the wide variety of legal systems in different countries.”<sup>14</sup> Nonetheless, the handbook outlines legal responses in a nearly encyclopedic range of areas.<sup>15</sup> In a section entitled Law Review, Reform and Support Services, the authors offer that “Legislative checklists requiring affirmative or negative responses are included to assist with implementation of this technical area.”<sup>16</sup> The checklists themselves were not developed in a vacuum, but were tested in a variety of settings, in countries such as Nicaragua.<sup>17</sup>

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recent laws presented in this article. The module is available by writing to the Interamerican Parliamentary Group on Population and Development, 120 Wall Street, 9<sup>th</sup> Floor, New York, NY 10005-3902.

<sup>14</sup> *Id.* at 18.

<sup>15</sup> *See id.* Of note (for the purposes of this article) in the Table of Contents are sections on: interministerial committees; Parliamentary committees on HIV/AIDS; multisectoral advisory bodies; national examples of reform; voluntary testing and informed consent; notification of coded information; partner notification; detention or isolation/quarantine; blood safety; infection control; transmission/exposure offences; needle and syringe exchanges; sexual acts; sex work or prostitution; prisons; antidiscrimination legislation; discriminatory impact of laws affecting vulnerable populations; privacy; employment law; ethical research; rights of education and information; et cetera.

<sup>16</sup> *Id.* at 36.

<sup>17</sup> In March 1996, UNDP sponsored a seminar on HIV and human rights, held in the open session of the Nicaraguan Parliament. The UNDP HIV and Development Programme invited its partners, such as members of the Network on Human Rights, Ethics, Law and HIV, the Latin American and Caribbean Council of AIDS Service Organizations (LACCASO), the Pan-American Health Organization (PAHO), the Nicaraguan National AIDS Program, and others. (See UNAIDS Handbook for Legislators, *supra*, at 37.) The seminar was centered on a bill drafted by the Fundación Nimehuatzin and the Center for Constitutional Rights, two Nicaraguan NGOs. Rita Arauz from the Fundación Nimehuatzin would later write to the authors of the UN Handbook for Legislators that “The success of the seminar was demonstrated by the later enactment of Law No. 238 (Promotion, Protection and Defense of Human Rights in the face of AIDS.” (See UNAIDS Handbook for Legislators, *supra*, at 23.)

The Inter-American Parliamentary Group on Population and Development held a regional conference in March 1997 of Parliamentarians and the heads of national programmes on HIV/AIDS in Managua, Nicaragua. Nicaraguan Law Number 238 was promoted to other countries in the region as a model for human rights concerns. (See UNAIDS Handbook for Legislators, *supra*, at 23.)

The handbook points out that:

As members of the United Nations, States are obliged to promote and encourage respect for human rights without discrimination under the U.N. Charter. Although the Universal Declaration is not a treaty as is the U.N. Charter, it is widely considered to be binding under customary international law<sup>18</sup>...It is important to note that the U.N. Commission on Human Rights resolved that the term “or other status” used in several human rights instruments should be interpreted to include health status, including HIV/AIDS, and that discrimination on the basis of actual or presumed HIV/AIDS status is prohibited.<sup>19</sup>

The non-discrimination aspects of the Handbook, accordingly, have the legal authority of the U.N. Commission on Human Rights behind them.

The UN is not the only player active in HIV legislation, at least in Central America. USAID began funding the Central American HIV/AIDS Prevention Project, called by its Spanish acronym “PASCA,” in 1995. PASCA was conceived to operate along several fronts, to strengthen Central America’s capacity to respond to the HIV epidemic by strengthening NGOs in the region, and stimulating policy dialogue. An early PASCA document described the problems it faced:

Owing to the cultural context in Central America, characterized by a conservative ideology, with authoritarian traditions and based in strong religious beliefs, and seeing as AIDS touches on extremely sensitive topics such as sexual behavior, the epidemic has provoked a series of reactions, not all of which are favorable. These include incidents of discrimination, ostracism and stigmatization, directed at people affected by the disease. The press is filled with stories of people who, once identified as HIV carriers or suffering from AIDS, have been obliged to leave work or home, and are turned away by

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<sup>18</sup> Citing to LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 4 (1997).

<sup>19</sup> Citing to U.N. Commission on Human Rights Res. 1996/44 and Sub-Commission on the Prevention of Discrimination and Protection of Minorities Res. 1995/21. This whole quotation appears in the Handbook, at 26. U.N. Commission on Human Rights Res. 49/1999 reaffirmed that “Discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term, ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”

health care facilities, just as occurred in the middle ages with the plague. Anecdotal reports tell of at least one person who committed suicide to escape social isolation. In this light, when there are violations of the right to privacy, work, or even life, it is necessary that the society formulate a judicial-legislative response that prevents such consequences. On the other hand, given the weakness of bureaucratic and community structures in responding to the epidemic, as witnessed in health services, education, and social support, it is necessary to strengthen these through commitments which achieve political support and the necessary resources to respond appropriately to the epidemic. Therefore, there is a need to revise and develop a legal framework that facilitates an integral and effective approach to HIV/AIDS in Central America.<sup>20</sup>

By 2000, PASCA personnel participated in the development of national strategic plans on HIV/AIDS in five project countries, and provided technical assistance in the drafting of the HIV laws in Honduras, Panama, and Guatemala, as well as in the process of executive branch operationalization, called *reglamentación*, of the Nicaraguan law.<sup>21</sup> While PASCA personnel were mostly from the countries where they were working, the conceptual germ of the project was drawn up at USAID, where U.S. citizens perceived the AIDS epidemics in Central America to involve a weak legal response.

This focus on an indigenous legal response can now be questioned in light of the fact that there has been very little litigation in sovereign national courts in the region on HIV-specific issues. This article discusses just three cases, in Costa Rica, El Salvador and Guatemala, in which classes of people living with HIV sought court orders to receive antiretroviral medications. The El Salvadoran case reached the Inter-American Commission on Human Rights in Washington, D.C. While the cases were eventually resolved in favor of the petitioning patients in the Supreme Courts of Costa Rica and El Salvador, it should be noted that important international standards come to bear: all the Central American national constitutions, with the exception of that of Nicaragua, explicitly recognize the legal power of the human rights

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<sup>20</sup> PASCA, Proposal for Legislative Action to Fight the HIV/AIDS Epidemic in Central America (unpublished, undated manuscript, on file with author).

<sup>21</sup> Correspondence with Carmen Reinoso at the Inter-American Parliamentary Group on Population and Development, and Benjamin Weil, International Planned Parenthood Federation, Western Hemisphere Region, Inc. Program Officer for the PASCA project (on file with author).

conventions to which the countries are signatories.<sup>22</sup> All six countries are signatories to the American Convention on Human Rights,<sup>23</sup> which is modeled closely on the U.N. Civil and Political Covenant, and includes due process and equal protection provisions. The Inter-American system involves petition by individuals or groups to the Inter-American Commission on Human Rights, which, if it finds cause (and that local remedies have been exhausted), informs countries that the matter may be referred to the Inter-American Court of Human Rights.<sup>24</sup> All six countries discussed herein have accepted the compulsory jurisdiction of the Inter-American Court of Human Rights.<sup>25</sup>

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<sup>22</sup> Preeminence is afforded to international rights in the Constitutions of Costa Rica, El Salvador, Guatemala, Honduras, and Panama. See Art. 7 of the Costa Rican Constitution of 1949 (describing treaties and international conventions, where ratified by the country, as superior authorities to national laws); Art. 144 of the El Salvadoran Constitution of 1982 (Decree No. 38, prioritizing treaties and international conventions over national law); Art. 46 of the Guatemalan Constitution (prioritizing human rights conventions to which Guatemala is a signatory over national law); Arts. 15, 16, and 18 of the Honduran Constitution of 1982 (adopting international rights favorable to human solidarity; ratified treaties become internal rights; and in the case of conflict between treaties, conventions and national law, the treaties and conventions control); and Art. 4 of the Panamanian Constitution of 1972, as amended 1983, 1993, 1994 (adopting the norms of international rights). Curiously, the Nicaraguan Constitution of 1987 has no such features.

<sup>23</sup> American Convention on Human Rights (also known as the Pact of San Jose), drafted November 22, 1969, O.A.S.T.S. No. 36, OEA/Ser. L/V/II.23 doc. Rev. 2,1 (entered into force July 18, 1978), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser. L. V/II.82 doc. 6 rev. 1 at 25 (1992) and signed by Argentina, Barbados, Bolivia, Brazil, Colombia, **Costa Rica** (ratified April 8, 1970), Dominica, Chile, Ecuador, **El Salvador** (ratified June 23, 1978), the United States, Grenada, **Guatemala** (ratified May 25, 1978), Haiti, **Honduras** (ratified September 8, 1977), Jamaica, Mexico, **Nicaragua** (ratified September 25, 1979), **Panama** (ratified June 22, 1978), Paraguay, Peru, the Dominican Republic, Suriname, Trinidad and Tobago, Uruguay, and Venezuela. All the Central American countries, with the exception of Honduras, are also signatories to the Additional Protocol of the American Convention on Human Rights with respect to Economic, Social and Cultural Rights, also known as the Protocol of San Salvador. This Protocol is akin to the U.N. Economic Covenant, and includes a right to health; however, the Protocol has not yet entered into force.

<sup>24</sup> A good explanation of the Inter-American system can be found in Jennifer Bol, *Using International Law to Fight Child Labor: A Case Study of Guatemala and the Inter-American System*, 13 AM. U. INT'L L. REV. 1135.

<sup>25</sup> The countries accepted the jurisdiction of the Inter-American Court of Human Rights on the following dates: Costa Rica (July 2, 1980), El Salvador (June 6, 1995),

## **Part II: Elements of the Legal Framework in the U.S.**

This section describes some of the major elements of the evolving legal framework for responding to the AIDS crisis in the United States, in the following areas: quarantine, testing and privacy, discrimination, criminalization of transmission, the right to marry and found a family, and legal reform.

Since lawyers and other consultants from the U.S. may provide technical assistance in the area of HIV laws in developing countries, at least limited discussion of the background history of the legal responses to the epidemic here may be useful. Most importantly, the structure of the national response is directly linked to advances in biomedical science, and a level of financial resources that is not available in many other countries. Protections offered to people living with HIV have sometimes developed through Constitutional jurisprudence and the crucible of the Supreme Court, and sometimes through purely legislative activity. The laws of the several states have taken different approaches, and provided evidence that has, sometimes, led to national legal reform. The role and constant vigilance of an organized and relatively resource-rich gay community in the United States cannot be over-emphasized. While many smaller countries may indeed learn some lessons from these kinds of experiences, much attention should be paid to different legal systems, Constitutions, resource environments, and local histories.<sup>26</sup>

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Guatemala (March 9, 1987), Honduras (September 9, 1981), Nicaragua (February 12, 1991), Panama (May 9, 1990). See <http://www.cidh.oas.org/Basicos/Basicos3.htm>.

<sup>26</sup> At the risk of stating the obvious, the U.S. response has not been perfect. Perhaps the most egregious contravention of human rights law was the bar (in effect until January 1, 2010) against travel to this country (without a waiver) or immigration of people living with HIV. It is for this reason that the world community and the International AIDS Conferences have not held a single consultation on AIDS in the United States since 1991. The matter cannot be entirely blamed on Senator Jesse Helms; it is a matter of national shame. It may be that, despite the application of human rights concepts in other areas of U.S. law, an area like immigration, which lacks a locally empowered constituency, is not likely to produce and maintain a positive legal framework.

## Quarantine

Quarantine has not been used for AIDS in the United States,<sup>27</sup> though in the early years of the epidemic some wondered why it was given such special treatment. As one commentator pointed out, “For communicable diseases, the powers of public health authorities are enormous [and include compulsory medical examination, hospitalization and treatment, and quarantine]. These are extraordinary powers, in many ways exceeding the powers given to criminal authorities.”<sup>28</sup> Ronald Bayer’s 1991 article on “HIV exceptionalism” argued that AIDS was not being treated as some public health principles might suggest.<sup>29</sup> But the reasons for treating AIDS differently from, say, tuberculosis are as follows: “First, AIDS is a fatal disease, having no known cure and treatment of limited effectiveness. Second, AIDS is not easily transmitted, and the uninfected, by their own actions, can effectively protect themselves from infection.”<sup>30</sup> Also, by the

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<sup>27</sup> For the purposes of an article on Central America, especially when one country, Nicaragua, undertook a Cuban- style revolution, the Cuban experience with AIDS quarantine provides some important background. Cuba is currently the only nation in the world that calls for quarantine of people living with HIV, and even they have relaxed this practice in recent years. The Cuban experience can only be considered bizarre. Obviously the Revolution has prided itself on the health indicators it has achieved with limited resources. Fidel Castro himself often presents papers at public health conferences, and at least once upbraided Bolivians, in a spontaneous radio interview there, for failing to take into consideration the p-value (a statistical tool) that would be produced testing a public health intervention in a certain size population. It is therefore not clear what possessed Cuba to test the whole island for HIV, given known parameters of the window period during which people with HIV still test negative for the antibodies, not to mention the more technically problematic issues of false positives and false negatives for people well beyond this window period. An international outcry followed when people with positive results were quarantined. Cuba responded by improving the conditions in the quarantine camps. New problems emerged when Cuba realized how expensive it is to keep people in such high-quality facilities, and when anecdotal reports started emerging of people intentionally becoming infected in order to have access to these facilities. Since 1993, Cuba has maintained limited quarantine facilities, and places a legal burden on physicians to supervise people living with HIV outside of quarantine; doctors may be punished for infections shown to be transmitted from their patients.

<sup>28</sup> Hermes Fernandez, *Is AIDS Different?*, 61 ALB. L. REV. 1053, 1066 (1998).

<sup>29</sup> Ronald Bayer, *Public Health Policy and the AIDS Epidemic: An end to HIV Exceptionalism?*, 324 NEW ENG. J. MED. 1500 (1991)

<sup>30</sup> Fernandez, *supra* at 1070.

time AIDS was understood, the number of infected people was so large as to render isolation and quarantine ineffective.<sup>31</sup>

Besides, gay men had found their political voice and grassroots power in the testing debate, as discussed here below.<sup>32</sup>

### Testing and Privacy

The contours of HIV testing have been hotly debated over the course of the AIDS epidemic in the United States. Should testing be voluntary or mandatory? And who should be tested? What privacy rights should be afforded to gays, sex workers, and others who seemed particularly vulnerable to infection? Bayer's seminal article on HIV exceptionalism analyzed such questions and noted a belief that there was an unwillingness to "seek HIV testing and counseling voluntarily;"<sup>33</sup> the hypothesis is rounded out in explanations that "without assurances of confidentiality, the populations at risk simply refused to engage in the health care system unless absolutely necessary."<sup>34</sup> Until AZT (which delays development from HIV to AIDS) was invented, there was little incentive, either practical or psychological, to get tested.<sup>35</sup>

Given resistance to voluntary testing, proposals for mandatory testing were not slow to surface. Gay activists in places like San Francisco held off such proposals, arguing that it would only drive the epidemic further underground.

But as AIDS treatments began to improve, the public health logic of testing grew stronger. The debate moved in many directions. One argument called for a continuation of voluntary testing of particularly vulnerable populations, coupled with a firm promise of confidentiality.<sup>36</sup> Another called for mandatory testing of pregnant women and newborns, as AZT proved

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<sup>31</sup> See Fernandez, *supra* at 1071-2; see also Bayer, *supra* at 1502.

<sup>32</sup> See Fernandez, *supra* at 1071-2; see also Bayer, *supra* at 1500-1.

<sup>33</sup> Bayer, *supra* at 1501.

<sup>34</sup> Fernandez, *supra* at 1073-4.

<sup>35</sup> See *id.* at 1074.

<sup>36</sup> See, e.g., Lawrence O. Gostin et. al., *The Case Against Compulsory Casefinding in Controlling AIDS – Testing, Screening and Reporting*, 12 AM. J.L. & MED. 7 (1986).

effective in preventing pre-, peri- and neo-natal infections.<sup>37</sup> Yet another called for named reporting of anyone else voluntarily being tested.<sup>38</sup>

New York State provides a useful case history of the development of AIDS law. In 1988, New York passed the AIDS Confidentiality Law,<sup>39</sup> which essentially places the burden of avoiding infection upon the uninfected.<sup>40</sup> The hope was that voluntary testing and the confidentiality of results would encourage people to learn of their status and obtain treatment, and counseling.<sup>41</sup> The legislative intent was to prevent the spread of infection while limiting the risk of discrimination.<sup>42</sup> Once tested, the law asked that people be encouraged to change behavior and adopt safe sexual practices, learn of available treatment and inform their partners of their status.<sup>43</sup>

As an exception to that general policy, since 1996, New York has mandated the testing of newborns,<sup>44</sup> which in an indirect way amounts to testing the mother, since a positive result for the child indicates that the mother is infected. If a baby tests positive for HIV antibodies, it is given a course of AZT, which may lower the risk that the child will develop AIDS.<sup>45</sup>

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<sup>37</sup> See, e.g., Christina Kent, *AMA Reaffirms Mandatory HIV Testing in Pregnancy*, AM. MED. NEWS, Dec. 23, 1996, at 8 (the American Medical Association recommended mandatory HIV testing of pregnant women).

<sup>38</sup> See, e.g., Lawrence O. Gostin & James G. Hodge, *The "Names Debate": The Case for National HIV Reporting in the United States*, 61 ALB. L. REV. 679 (1988).

<sup>39</sup> N.Y. Pub. Health Law §§ 2780 - 2787 (McKinney 1993).

<sup>40</sup> See Fernandez, *supra* at 1058.

<sup>41</sup> See *id.* at 1074. Studies suggest that client-centered counseling and health education reduce risks for HIV transmission. See M. Kamb et al., *Does HIV/STD Counseling Work? Results from a Randomized Controlled Trial (Project Respect)*, Address Before the Fourth Conference on Retroviruses and Opportunistic Infections (Jan. 22-26, 1997) (on file with author).

<sup>42</sup> See Fernandez, *supra*, at 1058 (citing to Act of Sept. 1, 1988, ch. 584, 1988 N.Y. Laws 1132, 1132 (enacted at N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney 1993))) (noting legislative intent seeks to prevent the spread of the infection while limiting the risk of discrimination by placing strict confidentiality standards on HIV-related information).

<sup>43</sup> N.Y. Pub. Health Law § 2781 (5) (c)-(e) (McKinney 1993).

<sup>44</sup> N.Y. PUB. HEALTH LAW § 2500(f) (McKinney Supp. 1998) (effective June 26, 1996) (providing for HIV testing of newborns); see § 2781(6)(d) (McKinney Supp. 1998) (amending Article 27-F of the Public Health Law so that the provisions under that article do not apply to tests conducted pursuant to § 2500(f) of the Public Health Law).

<sup>45</sup> PUB. HEALTH SERV. TASK FORCE, CTR. FOR DISEASE CONTROL & PREVENTION, *RECOMMENDATIONS FOR USE OF ANTIRETROVIRAL DRUGS IN PREGNANT HIV-*

The choice of testing newborns as opposed to pregnant women, however, was a significant one, given that it was well known that giving an infected woman AZT during her pregnancy dramatically lowers the risk that the child will become infected.<sup>46</sup> But at the time the policy of testing newborns was developed, there was a reason for not administering AZT to pregnant women. The most effective treatments for adults are provided in a combination of drugs, sometimes known as a “cocktail,” triple-combination therapy, or HAART (Highly Active Antiretroviral Therapy);<sup>47</sup> AZT is usually one of the pillars of the cocktail. One concern was that previous use of AZT alone might decrease the likelihood that the combination therapy would work.<sup>48</sup> Since there were questions about the toxicity of the other combination drugs for fetuses and newborns, women who elected to take just AZT by itself, for the benefit of the child, ran the risk of hurting their own chances of effective treatment.<sup>49</sup> The law was therefore careful to mandate testing only for newborns.<sup>50</sup>

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INFECTED WOMEN FOR MATERNAL HEALTH AND INTERVENTIONS TO REDUCE PERINATAL HIV TRANSMISSION IN THE UNITED STATES 75 (April 29, 2009), available at <http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>.

<sup>46</sup> See *id.* at 4.

<sup>47</sup> See *id.* at 33.

<sup>48</sup> PUB. HEALTH SERV. TASK FORCE, CTR. FOR DISEASE CONTROL & PREVENTION, RECOMMENDATIONS FOR USE OF ANTIRETROVIRAL DRUGS IN PREGNANT HIV-1-INFECTED WOMEN FOR MATERNAL HEALTH AND INTERVENTIONS TO REDUCE PERINATAL HIV-1 TRANSMISSION IN THE UNITED STATES 9, 10 (Feb. 4, 2002) at 19–20 (on file with the author).

<sup>49</sup> See *id.*

<sup>50</sup> It should be noted that the standard *medical* recommendation has changed over time, and is now to treat pregnant women who are HIV-positive with triple combination therapy. The rationale is as follows: “Treatment recommendations for pregnant women infected with HIV-1 have been based on the concept that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus or infant and unless these adverse effects outweigh the benefit to the woman.” See PUB. HEALTH SERV. TASK FORCE, CTR. FOR DISEASE CONTROL & PREVENTION, RECOMMENDATIONS FOR USE OF ANTIRETROVIRAL DRUGS IN PREGNANT HIV-INFECTED WOMEN FOR MATERNAL HEALTH AND INTERVENTIONS TO REDUCE PERINATAL HIV TRANSMISSION IN THE UNITED STATES 42, 43 (April 29, 2009), available at <http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>.

Critically, “no one has yet shown that pregnant women have avoided the health care system since that amendment for fear of [HIV] testing.”<sup>51</sup> At least one study suggests that most people do not even know whether or not there is reporting of test results. As Gostin and Hodge noted, “[a] multi-state survey of 2,387 persons at risk for HIV showed that only thirty-one percent of respondents in HIV reporting states were even aware of case reporting. Since most respondents were unaware of state legal requirements, it seems unlikely that they altered their behavior because of HIV reporting.”<sup>52</sup> Yet the availability of anonymous testing services where clients would not have to provide their names increased the likelihood of seeking HIV testing in this same population.<sup>53</sup> Gostin and Hodge have collected numerous studies that suggest that anonymous testing sites encourage voluntary testing.<sup>54</sup>

The debate over testing has also considered the options of anonymous versus named reporting. In anonymous testing, the clients are never required to give their names, and clients and test results are matched up with a number.<sup>55</sup> In named reporting, clients are required to give their names. Influential law and public health scholars such as Lawrence O. Gostin have changed their minds over time on the issue of named HIV reporting. In 1984, when the issue was first being considered in Colorado, Gostin testified against named HIV reporting, arguing, as did the community of people living with

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<sup>51</sup> Fernandez, *supra* at 1076. It might be argued that pregnant women face other positive law that forces them to receive prenatal services, so conclusions drawing from the behavior of pregnant women with regard to HIV testing should be tempered.

<sup>52</sup> Gostin & Hodge, *supra*, at 721 (citing F.M. Hecht et al., *Named Reporting of HIV: Attitudes and Knowledge of Those at Risk*, 12 J. GEN. INTERNAL MED. 108 (1997)).

<sup>53</sup> *See id.*

<sup>54</sup> *Id.* at 721 n. 232 (citing Laura J. Fehrs et al., *Trial of Anonymous Versus Confidential Human Immunodeficiency Virus Testing*, 2 THE LANCET 379, 379 (1988); Douglas Hirano et al., *Anonymous HIV testing: The Impact of Availability on Demand in Arizona*, 84 AM. J. PUB. HEALTH 2008, 2009 (1994); Susan M. Kegeles et al., *Many People Who Seek Anonymous HIV-Antibody Testing Would Avoid It Under Other Circumstances*, 4 J. AIDS 585, 585 (1990); Pamela A. Meyer et al., *Comparison of Individuals Receiving Anonymous and Confidential Testing for HIV*, 87 S. MED. J. 344, 344 (1990) (comparing the impact of anonymous testing in Georgia and North Carolina with residents of South Carolina, where name reporting is used); Kathryn A. Phillips, *The Relationship of 1988 State HIV Testing Policies to Previous and Planned Voluntary Use of HIV Testing*, 7 J. AIDS 403, 406 (1994) (comparing testing patterns in states with name reporting and states with anonymous testing).

<sup>55</sup> *See* Fehrs et al., *supra* note, at 379.

HIV, that potential for invasions of privacy, leading to discrimination in housing, employment, or insurance, was too great.<sup>56</sup>

The benefits of named reporting in 1984 were also too slim and distinguishable from those of other diseases with named reporting: “HIV infection was not transmissible through the air like tuberculosis; it was not treatable like hepatitis; and persons could not be rendered non-infectious as they could with syphilis or gonorrhea.”<sup>57</sup> Since 1997, however, Gostin has changed his position, advocating (along with Hodge) for named reporting. He argues that it will produce benefits, including: “1) improved monitoring of the epidemic; 2) enhanced ability to target prevention and other public health services; 3) linking HIV-positive persons with treatment opportunities and educational services, including partner notification support services; 4) fairer resource allocation; and 5) equitable determination of eligibility of infected individuals for government benefits.”<sup>58</sup> Gostin and Hodge state, “We have changed our mind about named HIV reporting, not because we have changed, but because the epidemic has changed.”<sup>59</sup> They add, “We propose that there are compelling justifications for a national system of HIV reporting on a named basis, provided legal and ethical concerns of infected individuals and others at risk are adequately addressed through privacy and anti-discrimination protections.”<sup>60</sup> Analysts certainly understand why privacy concerns are so substantially present here:

The American Civil Liberties Union (ACLU) cites reports that thieves stole a computer containing the names of sixty persons with AIDS in Sacramento, California and that a log of hundreds of people tested for HIV “vanished” from a public health clinic in New York. In Florida, a health official publicly revealed the names of an HIV registry without authorization. Courts have occasionally ordered HIV data to be disclosed for the purposes of litigation. . . . Illinois enacted, but never implemented, legislation requiring the state health department to identify HIV-positive health care workers by cross matching the state AIDS registry against health care licenser records. South Carolina health authorities legislatively are required to cross-

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<sup>56</sup> Gostin & Hodge, *supra* note, at 685–86, 686 n.36 (1988).

<sup>57</sup> *Id.* at 686.

<sup>58</sup> *Id.* at 687–88.

<sup>59</sup> *Id.* at 686.

<sup>60</sup> *Id.* at 710.

check prospective and existing public school teachers against state HIV/AIDS databases.

Although concerning, these examples and others are the rare exception rather than the norm....Failure to maintain the confidentiality of individuals in reporting registries in violation of these legal protections may subject responsible persons to criminal and civil sanctions.<sup>61</sup>

Constitutional jurisprudence is also a source of privacy protections for people with HIV in the United States. As Gostin and Hodge explain, with specific reference to *Whalen v. Roe*:<sup>62</sup>

[T]he Supreme Court has recognized a limited right to health informational privacy as a liberty interest within the Fifth and Fourteenth Amendments. Other courts have relied on state constitutional provisions in support of such rights. In either case, constitutional privacy rights are limited. Courts regularly allow infringements on informational privacy through the administration of a flexible test, balancing the invasion of privacy against the strength of the governmental interest.<sup>63</sup>

### **Discrimination**

The single most important piece of legislation relevant to AIDS-related discrimination in the United States is the Americans with Disabilities Act of 1990, which prohibits discrimination against persons with disabilities, in employment, public accommodations, and public services, by private actors and state and local governments.<sup>64</sup> Discrimination against people with

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<sup>61</sup> *Id.* at 732–33 (footnotes omitted).

<sup>62</sup> 429 U.S. 589 (1977).

<sup>63</sup> Gostin & Hodge, *supra*, at 728–29 (footnotes omitted). The authors cite *Whalen*, 429 U.S. at 598–604, which “found no unlawful violation of individual privacy rights as a result of the reporting requirement where the state had adequate standards and procedures to protect the privacy of the information.” *Id.* at 728 n.277.

<sup>64</sup> 42 U.S.C. §12101-12213 (1994). Gostin & Hodge summarize: “The federal acts specifically prohibit discrimination against disabled persons, which may include persons with HIV, in matters of employment, in places of public accommodation, and in the provision of public services. Persons discriminated against are entitled to bring civil suits requesting injunctive relief and request the U.S. Attorney General to investigate alleged violations. *See* 42 U.S.C. § 12188; 28 C.F.R. § 36.501-.502

disabilities including HIV in housing is prohibited under the Fair Housing Act,<sup>65</sup> and a variety of state and local laws. Perhaps the most salient point here is that the United States developed anti-discrimination legislation following debate over discrimination issues with other disabilities and diseases, including tuberculosis and STDs. Countries without such a background may find it hard to develop equitable principles in special legislation on HIV.

Some of the key concepts of the ADA itself stem from the Supreme Court's 1987 landmark decision in *School Board of Nassau County v. Arline*.<sup>66</sup> That decision involved tuberculosis, an infectious disease, and protection of people with tuberculosis under the ADA's predecessor, the Rehabilitation Act of 1973.<sup>67</sup> Brennan described the different treatment of the ill based on fear rather than the actual risks they posed. The Arline test allowed discrimination only in the presence of a "significant risk" to the health or safety of others, "which the court left undefined but which depended on an analysis of four factors extracted from the brief of the American

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(1997). Refusals to treat HIV-infected individuals by virtually all health care providers are prohibited by the ADA. See *id.* Also prohibited by the ADA is the unequal provision of services (such as the failure of a doctor to treat an HIV-positive individual for certain conditions which he would normally treat sero-negative patients), unless necessary. See 42 U.S.C. § 12182 (b)(1)(A)(iii). Separate or distinct provision of services (such as the use of special facilities for the treatment of HIV-positive persons) may not be used. See *id.* § 12182 (b)(2)(A)(i). Health care providers may not use eligibility criteria that effectually screen out HIV-infected individuals (such as a medical provider that requires prospective patients to demonstrate that they are HIV-negative), unless necessary. See *id.* § 12182(b)(1)(B). Places of public accommodation, which include virtually every public business and government-operated facilities, are prohibited from discriminating against persons with HIV. See *id.* § 12181 (7), 12131-12165. HIV-infected individuals who face unjustified discrimination at their place of employment in nearly any aspect of the employment relationship, can file complaints with the Equal Employment Opportunity Commission (EEOC), which is required to investigate merit-based allegations. See *id.* § 12112(a); 29 C.F.R. § 1630.4 (1994). After administrative remedies are exhausted, a grievant can file a civil suit against the employer to demand equitable relief (such as reinstatement and back pay in cases of wrongful termination) and seek compensatory and punitive damages where discrimination is shown to be intentional. See *id.*

<sup>65</sup> 42 U.S.C. § 3601 - 3631 (1994). Landlords and real estate agents risk being subject to civil suit. See *id.* §§ 3613, 3610, 3614(a).

<sup>66</sup> 480 U.S. 273 (1987).

<sup>67</sup> 29 U.S.C. § 794 (1994).

Medical Association: ‘(a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long the carrier is infectious), (c) the severity of the risk (what is the potential harm to third parties), and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.’<sup>68</sup>

Around the same time as the Arline decision, there was some discussion of the need for a HIV-specific federal law, but the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended that “persons with HIV infection should be considered members of the group of persons with disabilities, not as a separate group unto themselves.”<sup>69</sup> By the time the ADA was passed, the Department of Justice, the Surgeon General, and the Presidential Commission assumed, following Arline, that HIV would be considered within the ADA’s scope.<sup>70</sup>

The ADA, however, was not clear enough to some.<sup>71</sup> In 1994, the dentist Dr. Randon Bragdon refused to treat HIV-positive but asymptomatic patient Sidney Abbott. The case made it to the Supreme Court, which reaffirmed that HIV infection is a “substantial impairment of a life function,”

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<sup>68</sup> This summary of the law is taken from Scott Burris, *Public Health, “AIDS Exceptionalism” and the Law*, 27 J. MARSHALL L. REV. 251, 264 (discussing *Arline*, *supra*, at 288 (quoting Brief from the American Medical Association as Amicus Curiae, at 19).

<sup>69</sup> Presidential Commission on the Human Immunodeficiency Virus Epidemic, Report to the President (Washington, D.C.: Presidential Commission, 1988) at 121. Wendy E. Parmet offers some history on the decision not to pass an HIV-specific law, in *The Supreme Court Confronts HIV: Reflections on Bragdon v. Abbott*, 26 J.L. MED. & ETHICS 225: “What form should antidiscrimination protection take? Some in the 1980s advocated enacting an HIV-specific federal law [*See, e.g.*, S. 1575, 100<sup>th</sup> Cong. (1987)]....There were substantial drawbacks to such an approach. First, there were the practical problems. Given the stigma of HIV, serious questions arose as to whether Congress would enact, or President Reagan would sign, a bill that undoubtedly would have been derided by its opponents as creating ‘special rights’ for people infected with HIV...Also critical was whether a law that treated HIV differently from other illnesses and conditions would reduce the stigma associated with the disease or inadvertently increase the distinctiveness and, ultimately, the stigma associated with the disease.” *Id.* at 226.

<sup>70</sup> See Parmet, *supra*, at 227.

<sup>71</sup> Some courts overlooked the legislative history of the ADA. *See, e.g.*, *Ennis v. National Assoc. of Bus. & Educ. Radio, Inc.*, 53 F.3d 55 (4<sup>th</sup> Cir. 1995) (HIV-positive child not disabled under the ADA); *Cortes v. McDonald’s Corp.*, 955 F. Suppl. 541 (E.D.N.C. 1996) (asymptomatic HIV-positive employee not disabled for purposes of the ADA).

eliciting antidiscrimination protection under the ADA.<sup>72</sup> While the discriminatory action in *Bragdon* was in violation of the ADA, the current threat is the Supreme Court's evisceration of the ADA's enforcement mechanisms on other grounds.<sup>73</sup>

### **Criminalization of Transmission**

Many people support specific criminalization of intentional transmission of HIV;<sup>74</sup> criminalization of transmission of other STDs has long been tolerated.<sup>75</sup> The movement to criminalize HIV transmission in the United States was accelerated by the concern over the case of Nushawn Williams, a young black man who apparently infected up to eleven women and girls in New York's Chautauqua County.<sup>76</sup> His name was released to state officials and the media pursuant to the "clear and imminent danger" provision of the New York Public Health Law.<sup>77</sup> Williams eventually pled guilty to statutory rape and reckless endangerment and was sentenced to four to twelve years in prison.<sup>78</sup> It is notable that New York State has not changed its law to meet AIDS-related challenges such as the ones presented by the

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<sup>72</sup> *Bragdon v. Abbott*, 118 S. Ct. 2196 (1998). Under *Abbott*, the ADA only protects HIV positive people who have an impairment of reproductive capacity (the "life function" referred to in the quotation) – it is not a blanket protection of all people with HIV.

<sup>73</sup> The Supreme Court's decision in *University of Alabama v. Garrett*, 531 U.S. 356, 121 S. Ct. 955, 148 L. Ed. 2d 866 (2001), analyzed the Constitutionality under the 11<sup>th</sup> and 14<sup>th</sup> Amendments, of the ADA's Title I provisions for suing states for employment discrimination. The Court concluded that Congress' provision of money damages in such situations violates state immunity, and is unconstitutional.

<sup>74</sup> See, e.g., Jodi Mosiello, *Why the Intentional Sexual Transmission of Human Immunodeficiency Virus (HIV) Should be Criminalized Through the Use of Specific HIV Criminal Statutes*, 15 N.Y.L. SCH. J. HUM. RTS. 595 (1999); Karen E. Lahey, *The New Line of Defense: Criminal HIV Transmission Laws*, 1 SYRACUSE J. LEGIS. & POL'Y 85 (1995).

<sup>75</sup> The Supreme Court's ancient decision in *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), allowed the states broad discretion to enact public health laws to protect public health and safety.

<sup>76</sup> Agnes Palazetti, *Chautauqua Names HIV Carrier Accused of Infecting at Least 11*, BUFF. NEWS, Oct. 28, 1997, at A1.

<sup>77</sup> N.Y. PUB. HEALTH LAW § 2785 (McKinney 1993).

<sup>78</sup> Associated Press, *Man Guilty of Spreading HIV* (Apr. 5, 1999) (on file with NYU Review of Law & Social Change).

Williams case, relying on its more general public health framework and existing criminal law.

Actual convictions, nonetheless, must overcome a number of difficulties. First, the matter of whether someone was infected by the accused or a third person may be difficult to establish. Second, whether the accused infected the accuser is also problematic, because in fact the reverse may be true. Finally, intent is difficult to prove. Given that all of the above types of proof involve exceptions to the general principle of confidentiality, which has purposes of its own, criminalization seems like an unwise policy directive.

Nonetheless, the federal government has encouraged criminalization of transmission. As Jodi Mosiello recounts:

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 was a catalyst which sparked legislative action to provide a means to prosecute for the intentional transmission of HIV. This Federal Act provides emergency AIDS relief grants if a State has statutes which allow a person to be prosecuted for intentionally transmitting HIV to another person. The States can fulfill this federal requirement by: amending their public health statutes to include HIV on their list of sexually transmitted diseases; using traditional criminal law statutes to punish HIV transmission; or enacting specific criminal statutes targeted at HIV transmission.<sup>79</sup>

The importance of the criminalization requirements of the CARE Act,<sup>80</sup> which apportions funding to regions that are especially hard hit by AIDS, cannot be understated since the financial incentives are enormous. From 1990 to 1998, \$6.4 billion were appropriated under the CARE Act.<sup>81</sup> Annual expenditures from 2003 through 2008 were greater than \$2 billion per year. The U.S. Health and Human Service's (HHS) Health Resources and Services

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<sup>79</sup> Mosiello, *supra*, at 599 (footnotes omitted).

<sup>80</sup> The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (1990) (codified in scattered sections of 42 U.S.C. (1990)) (amending the Public Health Service Act of 1970).

<sup>81</sup> See U.S. HEALTH AND HUMAN SERVICES, HHS FACT SHEET: THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT (1998), available at <http://www.os.dhhs.gov/news/press/1998pres/981218d.html>.

Administration (HRSA) estimates that CARE Act programs serve more than 500,000 people with HIV in a given year.<sup>82</sup>

### **The Right to Marry and Found a Family**

Many states have experimented with laws requiring HIV testing before marriage.<sup>83</sup> Some, like Utah, prohibited and declared void any marriage to an AIDS-infected person,<sup>84</sup> until Utah's law was struck down by a federal court in 1993.<sup>85</sup> Most, like Illinois, did not condition a marriage license on a negative test result.<sup>86</sup> Illinois' experience, however, shows why, from a practical point of view, pre-marital testing is an unreasonable approach. Illinois had mandatory testing from 1988 to 1989.<sup>87</sup> Researchers reported a twenty-two percent decline in marriage licenses in Illinois issued in 1988 from the previous year: "[a]t the same time, the number of Illinois residents applying for marriage licenses in counties of border states increased by about 490%."<sup>88</sup> Testing the general population is unreasonably costly when compared to benefits. According to one estimate, at least twenty million dollars were spent on premarital testing in 1988,<sup>89</sup> and only twenty-three people were found to be infected. This translates into a cost of almost \$900,000 for each HIV-positive identification.<sup>90</sup> In 1989, Illinois repealed its mandatory testing law, and the number of marriage licenses issued returned to 1987 levels.<sup>91</sup> While the cost per positive test result should decline as a larger percentage of the population is infected in a maturing epidemic, most countries with marriage-related testing have not calculated cost-benefit ratios, but should.

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<sup>82</sup> See U.S. HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION: FISCAL YEAR 2008 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *available at* <http://www.hrsa.gov/about/budgetjustification08/RyanWhiteHIV.htm>

<sup>83</sup> Michael Closten et al., *Mandatory Premarital HIV-testing: Political Exploitation of the AIDS Epidemic*, 69 TUL. L. REV. 71 (1994).

<sup>84</sup> See *id.* at 75 (citing Utah Code Ann. § 30-1-2(1) (1989 & Supp. 1994) (repealed 1993)).

<sup>85</sup> See *id.* at 100 (citing T.E.P. v. Leavitt, 840 F. Supp. 110 (D. Utah 1993)).

<sup>86</sup> See *id.* at 96-97.

<sup>87</sup> See *id.* at 96.

<sup>88</sup> *Id.* at 97-98.

<sup>89</sup> See *id.* at 99.

<sup>90</sup> See *id.* at 98-99.

<sup>91</sup> See *id.* at 97.

## Reform

It is arguable that AIDS is no longer an epidemic in the United States; that it has stopped expanding, and converted itself into an endemic situation affecting slightly less than 1% of the adult population. New infections have stabilized and bunched up where almost all health problems do: amongst the poor and people of color. Current treatment options have made AIDS a chronic treatable condition for people who are infected, if they have broadly defined access to such resources. As the pattern of legislation here has shown, we should not expect major changes in the legal response to AIDS unless AIDS itself changes. This could in theory happen, if HIV mutates in ways that open new modes of transmission, or treatments improve, or a vaccine is developed. In the meantime, AIDS exceptionalism should be expected to slowly disappear, and recourse to much more general use of public health law will solidify.<sup>92</sup>

“Civil rights lawyers can[not] credibly threaten to get undesirable HIV laws overturned after passage, because here the record is one of virtually total failure.”<sup>93</sup> Scott Burris’ pessimism aside, the example given above on an Illinois statute requiring premarital testing shows that bad laws can be repealed. Leading the charge at the national and even international level is Lawrence O. Gostin,<sup>94</sup> cited at length in earlier sections of this article. Gostin and Hodge assisted in a public health law reform process in Alaska, chronicled in their article entitled *The Public Health Improvement Process in Alaska: Toward a Model Public Health Law*.<sup>95</sup> They remind readers that “[p]ublic health powers that affect liberty (e.g. quarantine and directly

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<sup>92</sup> Indeed, “HIV exceptionalism” continues to be a crucible for hot debate on human rights principles and global efforts to scale up HIV testing. See e.g. Ronald Bayer & Claire Edington, *HIV Testing, Human Rights and Global AIDS Policy: Exceptionalism and Its Discontents*, 34 *J. Health Pol., Pol’y & L.* 301 (2009).

<sup>93</sup> Burris, *supra*, 259 (citing to *AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 115* (Scott Burris et al. eds., 1993)).

<sup>94</sup> Professor of Law, Georgetown University Law Center; Professor of Law and Public Health, the Johns Hopkins University School of Hygiene and Public Health; Co-Director, Georgetown/Johns Hopkins Program on Law and Public Health; Member, Advisory Committee on HIV and Sexually Transmitted Disease Prevention, Centers for Disease Control and Prevention (CDC); Member, Board on Disease Prevention and Health Promotion, Institute of Medicine (IOM), National Academy of Sciences.

<sup>95</sup> Lawrence O. Gostin & James G. Hodge, *The Public Health Improvement Process in Alaska: Toward a Model Public Health Law*, 17 *ALASKA L. REV.* 77 (2000).

observed therapy), privacy (e.g. reporting and partner notification), and autonomy (e.g. compulsory testing, immunization, or treatment) may undergo more careful scrutiny under the federal Constitution,<sup>96</sup> suggesting that lawmakers are not free to do whatever they please. Their guidelines for reform suggest that the ideal public health law should: 1) include a mission statement, 2) avoid separate disease classification and disease-specific laws, 3) base public health decisions on the best scientific evidence of significant risk, 4) provide a flexible range of powers for public health authorities, and 5) provide legally binding assurances of privacy to all personally-identifiable information.<sup>97</sup> Humbly, they admit that “[p]ublic health problems may not be remedied primarily through law reform, but rather through better leadership and training, improved infrastructure for surveillance and epidemiological investigations, comprehensive counseling and health education, and innovative prevention strategies.”<sup>98</sup>

Gostin and Lazzarini have written extensively for international audiences as well. They published a book entitled *Human Rights and Public Health in the HIV/AIDS Pandemic* in 1997, which included a seven-step checklist for policymakers called the Human Rights Impact Assessment (HRIA).<sup>99</sup> The seven steps they suggest are as follows: 1) find the facts, 2) determine if the public health purpose is compelling, 3) evaluate how effectively policy X would achieve the public health purpose: is the form of intervention appropriate and accurate? is the intervention likely to lead to effective action? has the person consented? will a particular policy be as effective as other policies (opportunity costs)?, 4) determine whether the public health policy is well targeted, 5) examine each policy for possible human rights burdens, 6) determine whether the policy is the least restrictive alternative that can achieve the public health objective, and 7) if a coercive measure is truly the most effective, least restrictive alternative, base it on the “significant risk” standard and guarantee fair procedures.<sup>100</sup> The implicit balancing test and terminology will not feel unfamiliar to American Constitutional scholars, finding analogs in due process and equal protection

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<sup>96</sup> *See id.* at 117.

<sup>97</sup> *Id.* at 122.

<sup>98</sup> *Id.* at 114.

<sup>99</sup> LAWRENCE O. GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC* 59-67 (1997).

<sup>100</sup> *Id.* at 58–67; *see also* The Siracusa Principles, U.N. Doc. E/CN.4/1984/4, 7 HUM. RTS Q. 3, 5 (1984).

exegesis.<sup>101</sup> While these ideas are not necessarily bad ones, one might question whether their application in a less litigious society or a society with a different history of jurisprudence would prove useful.

### Part III: The AIDS Epidemics in Central America, and Related Legal Cases

The measure of an epidemic is only as good as the surveillance system used to measure it, and decent HIV and AIDS numbers are not easy to come by in any country. Nonetheless, legal and other responses to the epidemic are in part driven by local perceptions of how bad the problem is. Of the six Spanish-speaking Central American countries analyzed in this article, Honduras appears to have the worst epidemic, but it is also thought to have the best reporting system, and has had the best reporting system, since the first cases.<sup>102</sup> The other countries' abilities to gather information on the epidemic may have been disrupted by war, civil war, revolution, and tourism, above and beyond real resource scarcity. The following table gives some summary information<sup>103</sup> on each of the countries discussed below:

Country	AIDS Cases	Notification Rate per 100,000 Inhabitants	Male:Female ratio 2001	Prevalence in Female Sex Workers 2001/2002	Prevalence in Men who have Sex with Men (MSM)
Costa Rica	2,546	61	4.4:1	0.8%	14.5%
El Salvador	7,148	99	3:1	3.6%	18.0%
Guatemala	8,685	53	2.5:1	8.7%	12.0%
Honduras	16,363	228	1.2:1	9.0%	13%
Nicaragua	1,402	12	4:1	1.7%	9.3%
Panama	7,111	211	3:1	2.0%	10.6%

<sup>101</sup> See Alissa Spielberg, *Human Rights and Public Health in the HIV/AIDS Pandemic*, 22 FLETCHER FORUM WORLD AFF. 125, 128 (1998) (book review).

<sup>102</sup> It is my personal belief that Jose Enrique Zelaya, who headed the National AIDS Commission (COMSIDA) within the Honduran Ministry of Health in the late 80s, can be largely credited for steering Honduras on this path. I believe he perceived that more international funds would be made available to Honduras if he could prove the depth of the problem.

<sup>103</sup> The World Bank, *Reducing HIV/AIDS Vulnerability in Central America; Regional HIV/AIDS Situation and Response to the Epidemic*, December 2006, Table 3 (p.4) available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources-/375798-1103037153392/CAHIVAIDSRegionalOverview.pdf>.

The epidemics in Central America are largely a heterosexual phenomenon, occurring in machista contexts wherein women find it very difficult to protect themselves.<sup>104</sup> Men who have sex with men nonetheless are an important aspect of the epidemics,<sup>105</sup> in contexts where only the passive male partner is considered “gay.” The epidemics are further propagated by the movement of men away from their communities, through migration, military service, and along trucking and shipping routes;<sup>106</sup> here, women engaged in sex work, which is legal throughout the region, are particularly vulnerable to infection.<sup>107</sup> Poverty is a risk factor for HIV vulnerability, and people separated from family and regular sexual partners for long periods find themselves in new peer groups, including sexual networks.<sup>108</sup> Discussions of sexuality are problematized by churches.<sup>109</sup> The following table gives some summary information<sup>110</sup> on each of the countries discussed below:

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<sup>104</sup> See The World Bank, *Reducing HIV/AIDS Vulnerability in Central America; Regional HIV/AIDS Situation and Response to the Epidemic*, December 2006, available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/CAHIVAIDSRegionalOverview.pdf> (stating at p.5 that “Some 70% of cases resulted from heterosexual exposure while 12% resulted from homosexual or bisexual exposure. Heterosexual transmission is increasing, while the other forms of transmission are decreasing.”); see also UNAIDS, *AIDS Epidemic Update*, December 2001, UNAIDS/01.74E (stating at p.20 that “Almost three-quarters of AIDS cases reported in Central America are the result of sex between men and women.”)

<sup>105</sup> See *id.*; [UNAIDS releases *Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections*; the year 2000 iterations showed that men who have sex with men constituted the following percentages of reported AIDS cases (by country): Costa Rica (53.8%); El Salvador (12.4%); Guatemala (17%); Honduras (9.3%); Nicaragua (41.9%); Panama (32.9%). Thus Costa Rica is the only country on the isthmus where homosexual sex is the predominant form of transmission; in each of the other countries, heterosexual transmission prevails epidemiologically].

<sup>106</sup> See generally UNESCO and UNAIDS, *MIGRANT POPULATIONS AND HIV/AIDS 1* (Geneva: UNESCO and UNAIDS, June 2000)

<sup>107</sup> See e.g. Annelise Hirschmann de Salazar & Martin Foreman, *THE HIDDEN DANGER: WOMEN AND AIDS IN MEXICO, CENTRAL AMERICA AND SPANISH-SPEAKING CARIBBEAN*, 1997, Panos Institute.

<sup>108</sup> See Population Reference Bureau, *Conveying Concerns: Media Coverage of Women and HIV/AIDS 19* (available at [www.prb.org/pdf/CC\\_AIDS\\_BW.pdf](http://www.prb.org/pdf/CC_AIDS_BW.pdf))

<sup>109</sup> See e.g. Family Health International AIDS Control and Prevention Project August 21, 1991 to December 31, 1997 Final Report Volume 2 December 31, 1997, available at [http://www.fhi.org/en/HIVAIDS/pub/Archive/aidscapeports-/aidscafina1vol2/FHI\\_AIDSCAP\\_Fnl\\_Rprt\\_Vol2\\_LAC\\_Major\\_Countries.htm](http://www.fhi.org/en/HIVAIDS/pub/Archive/aidscapeports-/aidscafina1vol2/FHI_AIDSCAP_Fnl_Rprt_Vol2_LAC_Major_Countries.htm)

Country	Population mid-2009 (in Millions)	GNI PPP <sup>111</sup> Per Capita, 2008 (US\$)	Life Expectancy	Total Fertility Rate	% of married women 15-49 using contraception	% of adults infected with HIV 2007/8	Estimated per capita global health expenditure in 2006 (PPP int. \$) <sup>112</sup>	Estimated per capita annual cost of anti-retroviral therapy <sup>113</sup>
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(“...[T]he Catholic Church in Honduras rigorously opposed the promotion of condoms.”)

<sup>110</sup> The figures provided in this table, unless otherwise noted, are from the POPULATION REFERENCE BUREAU, 2009 WORLD POPULATION DATA SHEET, available at [http://www.prb.org/pdf09/09wpds\\_eng.pdf](http://www.prb.org/pdf09/09wpds_eng.pdf)

<sup>111</sup> “GNI PPP” refers to gross national income converted to international dollars using a purchasing power parity conversion factor.

<sup>112</sup> See World Health Organization, World Health Statistics 2009, table 7 <http://www.who.int/whosis/whostat/2009/en/index.html>

<sup>113</sup> See Carlos Avila Figueroa, *La Epidemia de VIH/SIDA en el Contexto de las Reformas del Sector Salud en América Latina*, in *EL SIDA EN AMÉRICA LATINA Y EL CARIBE: UNA VISION MULTIDISCIPLINARIA* 184 table 3 (Sidalac/ Fundación Mexicana para la Salud/Onusida, 1999), [on file with the author]. The 1999 information in the table may be out of date, but per person costs are still relatively low; in fact, a table compiled by the World Bank from National HIV/AIDS Plans and PAHO/WHO Information sheets in The World Bank, *Reducing HIV/AIDS Vulnerability in Central America; Regional HIV/AIDS Situation and Response to the Epidemic*, December 2006, available at <http://siteresources.worldbank.org/INTHIVAIDS/Re-sources/375798-1103037153392/CAHIVAIDSRegionalOverview.pdf>. Table 5 at page 16 therein shows the following information:

Indicator	Guatemala	Honduras	El Salvador	Panama	Costa Rica	Nicaragua
Estimated number of people who require Anti Retroviral Therapy (ART)	12,333	5,550	4,911	3,040	2,821	1,092
Number of people who receive ART	4,193 (34%)	2,312 (18%)	2,235 (46%)	1,873 (61%)	1,850 (66%)	33 (3%)
Annual cost of first line drugs per person (US\$)	600	608	1,500	1,251	1,616	2,400

Costa Rica	4.5	\$10,950	79	1.9	80%	0.4%	\$779	\$2.27
El Salvador	7.3	\$6,670	71	2.5	73%	0.8%	\$360	\$1.72
Guatemala	14.0	\$4,690	70	4.4	43%	0.8%	\$267	\$.87
Honduras	7.5	\$3,870	72	3.3	65%	0.7%	\$226	\$5.20
Nicaragua	5.7	\$2,620	71	2.9	72%	0.2%	\$235	\$.17
Panama	3.5	\$11,650	75	2.4	N/A	1.0%	\$738	\$2.64
United States	306.8	\$46,970	78	2.1	73%	0.6%	\$6,719	\$18.50 <sup>14</sup>

The estimated cost of antiretroviral medications is included here because many people assume that these could never be paid for by developing countries. The U.S. has shifted AIDS funding into treatment, and it is more expensive than most countries can handle.<sup>15</sup> Yet Brazil's experience taking loans to finance antiretroviral therapy for all Brazilians with HIV suggests

Gap between current expense and amount required (millions US\$)	4.9	1.9	4.0	1.5	1.6	2.5
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The numbers here would indicate that an estimate of the per capita cost of antiretroviral therapy updated to December 2006 (multiplying the number of people requiring ART by the annual cost of first line drugs, and dividing by the population of each country) would be as follows: Costa Rica - \$1.01; El Salvador \$1.01; Guatemala - \$.53; Honduras - \$.45; Nicaragua - \$.46; and Panama \$1.09. This would suggest that the costs per capita of ART in Honduras and Nicaragua have converged since 1999. Part of this is due to the fourfold difference in the cost of medication between the countries.

<sup>14</sup> This is my own estimate, not Figueroa's, using data from the 339 NEW ENG. J. MED. *Editorial: Caring for People with Human Immunodeficiency Virus Infection* (No. 26, December 24, 1998) at <http://www.nejm.org/content/1998/0339/0026-1926.asp>, which notes expenditure of "\$5.1 billion, or \$22,200 per patient per year...this is less than 1 percent of annual expenditures for personal health care."

<sup>15</sup> In 2008, the United States federal government spent roughly 14% of the total budget for AIDS (approximately \$23.3 billion) on prevention. See the Congressional Research Service Report for Congress, *AIDS Funding for Federal Government Programs: FY1981-FY2009* (updated April 23, 2008), available at <http://fpc.state.gov/documents/organization/104280.pdf> (stating in the Summary that "Federal government spending on HIV (the human immunodeficiency virus) and AIDS (acquired immune deficiency syndrome) is estimated at \$23.3 billion in FY2008. Of the total, 63% is for treatment programs; research programs receive 13%; prevention programs receive 14%, and income support programs receive 10%.").

that the bottom line is a cost-benefit analysis: if it is more expensive to have people succumb to opportunistic infections, then antiretroviral therapy is an easy choice.

The estimates in the last two columns of this table suggest that providing antiretroviral treatment to people living with HIV would, assuming no growth in the epidemics, add less than 1% to per capita spending on health in most of the countries. Even with these added expenditures, however, Honduras would still be paying less per capita in global health expenditure than the other Central American countries. Generally, estimates based on international pharmaceutical sales figures suggest that Central America has among the world's lowest antiretroviral drug expenditures per person living with HIV.<sup>116</sup> Health care in Central America is generally provided in mixed systems, in which most people receive subsidized care from ministries of health, some people receive care through separate government facilities financed through a social security system, and yet others receive care through private or NGO clinics.<sup>117</sup> One study showed that the social security systems provide better care than ministry of health clinics, but that the majority of people with HIV do not have the kinds of jobs that qualify them for social security care.<sup>118</sup> Despite a global push by the United Nations to prevent maternal-fetal transmission of HIV by providing antiretroviral therapy, such therapies in 2001 were only routinely available in Costa Rica, Guatemala and Panama.<sup>119</sup>

### Legal cases

Before passage of its HIV law in 1998, the Costa Rican government was sued for its failure to provide antiretroviral medications to people living

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<sup>116</sup> See AE Webber et al, *Hope is not enough: pan-national estimated of anti-retroviral use based on data from select nations around the globe*, in Program and Abstracts of the XIII International AIDS Conference, July 10, 2000; Durban, South Africa. Abstract MoPeC2482 (cited in David A. Wheeler et al, *Availability of HIV Care in Central America*, 286 JAMA 853 (2001).)

<sup>117</sup> See David A. Wheeler et al, *Availability of HIV Care in Central America*, 286 JAMA 853.

<sup>118</sup> See *id.* Honduras only covers 10% of its population through the Social Security Institute. Nicaragua's social security system is not separate from its ministry of health clinics, and Wheeler reports that there is "virtually no publicly funded HIV-specific care available within the country." Only in Costa Rica do people have universal access to the social security health system, which provides a broad range of treatment services to people with HIV.

<sup>119</sup> See *id.*

with HIV.<sup>120</sup> The Costa Rican Supreme Court ruled in favor of William Garcia on 23 September, 1997, ordering the Costa Rican Social Security system to supply him with a prescribed cocktail of AZT, 3TC, and Crixivan.<sup>121</sup> At Garcia's trial, the Social Security agency claimed it could not afford the cocktails, which it priced at US\$900 per month; it estimated that at the time, there were 300 people in need of antiretroviral medication. Garcia's lawyer responded that the government regularly gets discounts of up to 50% from pharmaceutical companies, since as the "sole legal source of medication in the country"<sup>122</sup> (in the context of a national health care system), it is a large buyer of medications. Garcia died on 12 October, 1997, but the precedent was followed in the cases of two other patients who brought separate suits.<sup>123</sup>

In El Salvador, as in Costa Rica, the main issue that has come before any court is the issue of free and effective access to medications. Unlike in Costa Rica, the case was brought to the national court after the passage of an HIV statute; unfortunately, the statute itself merely directs CONASIDA to develop guidelines, and does not enumerate rights to treatment. Two years after submission of a case brought by 36 people living with HIV, the Supreme Court of El Salvador had failed to decide whether the Social Security Institute was obligated to provide antiretroviral therapies.<sup>124</sup> The same group brought its claim before the Organization of American States' Inter-American Commission on Human Rights, which issued a warning to the government that the matter could proceed to the International Court of Human Rights, based on provisions in the American Convention on Human Rights.<sup>125</sup> Ten of the complainants died before the Social Security Institute agreed to provide

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<sup>120</sup> Reporting of such cases is hard to come by. The information in this paragraph was published by Mark E. Wojdik, *International Health Law*, 32 INT'L LAW 539 (1998).

<sup>121</sup> See Kai Wright, *Court Ruling Gives Man 'A Chance to Make It,'* WASH. BLADE, Oct. 10, 1997, at 12.

<sup>122</sup> *Id.*

<sup>123</sup> See Rex Wockner, *Costa Rican AIDS Pioneer Dies*, CHI. OUTLINES, Oct. 29, 1997, at 11.

<sup>124</sup> The information in this paragraph came from a story by Ena Rivas, *Crítica Situación de pacientes con SIDA: Los afectados podrían demandar al Estado ante la Corte Interamericana de Derechos Humanos*, LA PRENSA GRÁFICA ONLINE, at <http://archive.laprensa.com.sv/20001024/nacionales/nac12.asp> (October 24, 2000).

<sup>125</sup> See Jorge Odir Miranda Cortez y otros v. El Salvador, Caso 12.249, Informe No. 29/01, Inter-American Commission on Human Rights, at <http://www/oas.org/cidh/annualrep/2000sp/CapituloIII/Admisible/ElSalvador12.249.htm>.

medications to the remaining 26 people with HIV from the Asociación Atlacatl, by the end of 2000. The Social Security Institute cited budgetary and processing problems as reasons for delay in procuring antiretrovirals. In 2001, the Salvadoran Social Security Institute was providing antiretrovirals to 144 people, including 44 pregnant women.<sup>126</sup> After the Inter-American Commission issued its warning, the Salvadoran Supreme Court ruled in favor of Odir Miranda, citing Constitutional authority of the right to life and the right to health to require the Social Security Institute to provide access to antiretroviral medications.<sup>127</sup> The case continued to be pursued by a class of people living with HIV to recover costs they incurred for their own treatment prior to September 2001.<sup>128</sup> The Inter-American Commission on Human Rights' most recent (2009) report on the case indicates that El Salvador is still in violation of the American Convention on Human Rights since its *amparo* procedure (for injunctive relief for individual constitutional protections) is not adequately simple, prompt and effective in providing relief under the American Convention on Human Rights.<sup>129</sup>

Similar treatment issues were litigated nationally in Guatemala in an *amparo* proceeding after an appeal to the President based on Guatemala's

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<sup>126</sup> Boletín Acceso Centroamerica #2, July 31, 2001, published by Aguabuena in Guatemala with funds from PASCA (quoting Odir Miranda from Atlacatl) available at <http://www.aguabuena.org/boletines/marzo172001.html>.

<sup>127</sup> See Sentencia de la Sala de lo Constitucional de la Corte Suprema de 4 de abril de 2001, 348-99, at <http://www.uc3m.es/uc3m/inst/MGP/JCI/04-noticiasw-elsida.htm>. The Salvadoran Supreme Court declined to reach the claims under the American Convention of Human Rights, and denied an equal protection claim based on Art. 3 of the Salvadoran Constitution. It based its decision establishing the right to antiretrovirals on the right to life (Art. 2) and the right to health outlined in Art. 65: "The health of the inhabitants of the Republic is a public good. The State and the people are obliged to care for the preservation and reestablishment of health. The State will determine national policy and will control and supervise its application." Curiously, no claim was brought under Art. 66 of the Salvadoran Constitution, which states that: "The State will give free assistance to ill people lacking resources, to residents in general when the treatment constitutes an efficacious means of preventing the dissemination of a transmittable illness. In this case, all will be obliged to submit themselves to such treatment." (Decree No. 38: Political Constitution of the Republic of El Salvador, 1982).

<sup>128</sup> Correspondence with Licida Bautista, PASCA representative in El Salvador, 9 Aug. 2001.

<sup>129</sup> See the Inter-American Commission on Human Rights Report No. 29/09 on Case 12.249 Merits (Publication) regarding Jorge Odir Miranda Cortez et al v. El Salvador (March 20, 2009) available at <http://www.cidh.oas.org/annualrep/2009eng/ElSalvador12249eng.htm>.

AIDS law foundered, and the result was frustrating enough to people living with AIDS that they successfully petitioned the Inter-American Commission on Human Rights to issue a “precautionary measure” to Guatemala in 2004 and admit their case in 2005.<sup>130</sup> The Commission has also issued precautionary measures, which under its Rules of Procedure are issued in serious and urgent cases to request that a State adopt precautionary measures to prevent irreparable harm to persons, to Honduras and Nicaragua.<sup>131</sup>

Notably, cases involving discrimination generally have not been prosecuted in Central American courts. In Honduras, where the Special Law follows some of the principal preoccupations and specific abuses seen during the epidemic, a literature review revealed three cases of documented workplace discrimination against infected women:

- 1) In the northern part of the country, a 26 year-old manufacturing supervisor, after she became increasingly ill, was told by her boss to get an HIV test. The day she got her positive result, she was fired and given her severance pay. She has a child, remains in her home; her aunt pays the rent and feeds them.
- 2) A 24 year old worked in a maquiladora, but was fired when her test results became known; management intimidated her and asked if she had dated any other workers at the factory.
- 3) A 38 year old with three children, the youngest of whom is HIV-positive, was fired from her maquiladora when her test results became known. Her husband had died two years earlier. She has not looked for new work because most employers ask for test results. She is not yet ill.<sup>132</sup>

None of these cases, all reported prior to 1999, were brought before a court.

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<sup>130</sup> See the Inter-American Commission on Human Rights, Report No. 32/05, Petition 642/03, Admissibility, Luis Rolando Cuscul Pivaral et al. (persons living with HIV/AIDS), Guatemala, March 7, 2005, available at <http://www.cidh.oas.org/annualrep/2005eng/Guatemala642.03eng.htm>.

<sup>131</sup> See e.g. the Inter-American Commission on Human Rights, Precautionary Measures, available at <http://www.cidh.oas.org/medidas/2002.eng.htm>

<sup>132</sup> All three cases are reported in Rocio Tabora, *VIH/SIDA y violencia en Honduras: Nuevas formas de control y sospecha sobre los cuerpos de las mujeres*, in CUADERNOS MUJER SALUD/3 (1998): MUJERES, VULNERABILIDAD Y VIH/SIDA, (Adriana Gomez ed., published by the Red de Salud de las Mujeres Latinoamericanas y del Caribe, 1998).

More recently, the lack of reported cases before any court may be the result of recourse to national ombudsmen's offices, which have become more active in the area of HIV and AIDS.

### Cases Addressed by National Ombudsmen's Offices

Since 2002, the Central American Council of Human Rights Ombudsmen, with funding from UNFPA and technical support from the Inter-American Institute of Human Rights, has developed specific activities through its member national ombudsmen's offices with respect to human rights and HIV and AIDS.<sup>133</sup> For 2006, Honduras' ombudsman received the most number of complaints related to HIV and AIDS, at 44, compared to 41 in Panama, 12 in Costa Rica, and 3-5 each in El Salvador, Guatemala and Nicaragua.<sup>134</sup> A report on best practices and lessons learned in the region noted that in El Salvador, there is not a culture of lodging complaints, possibly because of a lack of trust in the system, since the AIDS law there tends to be coercive with respect to people living with AIDS, and few complaints have been resolved by the national human rights ombudsman.<sup>135</sup>

In Nicaragua, the national ombudsman noted violations of Nicaragua's Law. No. 238 in several instances, finding that the National AIDS Commission, the institution that is supposed to implement the Law, did not aggressively sanction the offending institutions.<sup>136</sup> Panama's ombudsman invoked its national AIDS law to resupply triple combination therapy to 1,156 people living with HIV; to reinstate an HIV+ worker at the Ministry of Education who had been fired; and to allow a girl whose mother was rumored to have died of AIDS to return to school.<sup>137</sup> In Guatemala, the Supreme Court provided injunctive relief when the Value Added Tax was charged on imported antiviral medications.<sup>138</sup> Unfortunately, the report does not provide

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<sup>133</sup> Laura Guzmán Stein, *Informe Diagnóstico sobre Buenas Prácticas y Lecciones Aprendidas del Trabajo en Materia de Derechos Humanos y VIH y SIDA y Derechos Reproductivos en las Oficinas del Ombudsman Integrantes del Consejo Centroamericano de Procuradores de Derechos Humanos (CCPDH)*, May 2007, at p. 6, available at [www.iidh.ed.cr/.../Varios/Documentos/BD\\_541409364/Informe%20buenas%20practic%20CCPDH.doc](http://www.iidh.ed.cr/.../Varios/Documentos/BD_541409364/Informe%20buenas%20practic%20CCPDH.doc).

<sup>134</sup> Id. at 28.

<sup>135</sup> Id. at 32.

<sup>136</sup> Id. at 39.

<sup>137</sup> Id. at 44-46.

<sup>138</sup> Id. at 47-48.

emblematic interventions by the Honduran ombudsman's office, which started its AIDS-related activities in 1995.<sup>139</sup>

#### **Part IV: Central American HIV Laws in Comparison**

The HIV laws of the six Spanish-speaking Central American countries have important differences, but because of international influences are structured very similarly. Each country, in the first place, has a law that is specific to HIV, as opposed to simply incorporating a response into broader public health legislation. Each law defines a commission with multisectoral participation, which should be seen as a result of the early United Nations initiatives to create a National AIDS Programme in every country, and the subsequent UNAIDS emphasis on responses to AIDS involving nearly every branch of government and nongovernmental agencies. Each law outlines rights and responsibilities, as applying to people living with HIV, the national population and migrants.

Perhaps the most striking feature of the laws, however, is that despite the obvious traces of international debates over rights and responsibilities, much of this emanating from Anglo-American jurisprudence, there is no indication that the laws are being used in Central American courts by people claiming such rights.<sup>140</sup> What limited jurisprudence on issues relating to HIV that has occurred to date has involved the claims of organized people living with HIV who are seeking enhanced state action in providing treatment. These claims have not relied on the HIV-specific laws.

It may be most useful, therefore, to consider the laws as expressions of the aspirations of the people who participate in their drafting, a trait that has sometimes been generally ascribed to the civil law traditions in Latin America.<sup>141</sup> These aspirations are usually the expression of how people

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<sup>139</sup> Id. at 22.

<sup>140</sup> This article was written with extensive input from AIDS activists, most of them associated with the Central American AIDS Action Program (PASCA). By country, the lack of litigation based on the HIV laws was reported by: Licida Bautista (El Salvador), Xiomara Bu (Honduras), Manuel Burgos (Panama), Norma Garcia de Paredes (Panama), Victor Hugo Fernandez (Guatemala), Eugenia Monterroso (Guatemala), Cesar Antonio Nuñez (Guatemala), and Joselina Paz (Honduras).

<sup>141</sup> A provocative, if somewhat offensive, view of law and legislation in Latin America was presented in John Linarelli, *Anglo-American Jurisprudence and Latin America*, 20 *FORDHAM INT'L L.J.* 50 (1996). Linarelli follows the lead of the controversial sociologist Hernando de Soto, whose book, *The Other Path*, showed that

within a particular country should interact with one another when confronting HIV; so it is that Nicaraguan groups take copies of the Nicaraguan law to pueblos to promote a general message of anti-discrimination. Issues of treatment, however, involve outside actors like pharmaceutical companies and run straight to budgets and limitations on the use of state resources. It should not be surprising that cases involving treatment are more likely than other kinds of cases to go to international courts. It will be interesting to see if there will be a next wave of legislation around treatment issues in particular, and what form such laws might take.

Differences in the laws of the Central American countries, to which I now turn, might be considered in terms of the aspirations of the national populations. Such aspirations are mediated in complicated ways, and can be expected to change over time. As such, the laws are difficult to compare, since they were drafted over the course of the last two decades.

One might explore the Central American laws through the prism of the different countries' situations with respect to human rights discourse. Nicaragua, most obviously, became steeped in human rights discourse throughout the Sandinista revolution, and drafted a new national constitution during that time.

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Peruvian laws imposed so many costs on business, and were so inconsistent with one another, that they inevitably gave rise to an enormous informal sector, which forged workable rules of its own. "Latin Americans have an ambivalent relationship with law. In one respect, they ignore it. On the other hand, they possess a basic faith, an idealistic belief in the legislative paradigm, that legislation can solve all problems. For example, Professor Keith Rosenn recounts a satire of lawmaking in Brazil, told by the former Planning Minister of the country, Roberto de Oliveira Campos. De Oliveira Campos suggested a Decree Law No. 001, which 'regulates the law of supply and demand and prohibits the scarcity of money or merchandise.' The decree repeals inflation and the shortage of credit. Passage of such idealistic legislation continues today." *Id.* at 59-60 (citing to Keith S. Rosenn, *The Jeito, Brazil's Institutional Bypass of the Formal Legal System and its Development Implications*, 19 AM. J. COMP. L. 514, 529 n.43 (1971)). Linarelli presses further, arguing that "Legislatures in Latin America have not been in a position to promulgate laws that respond to societal needs and contexts," *Id.* at 63, noting a tendency to transplant laws from other countries that don't satisfactorily resolve conflicts between local interests. "In Latin America, U.S. law is a significant influence, due in no small part to the fact that many Latin American lawyers study law in the United States." *Id.* at 77 (citing to Ugo Mattei, *Why the Wind Changed: Intellectual Leadership in Western Law*, 42 AM. J. COMP. L. 195, 207 (1994)).

Guatemala also became steeped in human rights discourse after years of civil violence. Representative Zury Rios Montt, granddaughter of the General who led a coup in Guatemala in 1982 and has been accused of major human rights violations in the country's civil war,<sup>142</sup> has been one of the main forces behind the new General Law to Fight HIV and AIDS and to Promote, Protect and Defend Human Rights in the Context of AIDS.<sup>143</sup> She wrote in a letter to fellow legislators in 1997:

Despite the fact that our Constitution, in its 4<sup>th</sup> Article, leaves no room for discriminatory practices, nor for abuses of human rights against people affected by and exposed to the risk of HIV/AIDS, we learn daily of unjustified layoffs, of leaks of confidential information from medical centers and laboratories, of medical professionals who refuse to treat patients with HIV/AIDS, to mention only a few examples<sup>144</sup>....Considering that community participation is a

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<sup>142</sup> The UN Historical Clarification Commission reported in February 1999 extensive genocide carried out under General Efraim Rios Montt's regime. The Guatemalan Commission for Historical Clarity documented 623 massacres during the Guatemalan civil war, the majority of these occurring in the period 1981-83.

<sup>143</sup> Decree No. 27-2000, Ley General para el Combate del virus del Inmunodeficiencia Humana - VIH - y del Síndrome de Inmunodeficiencia Adquirida - SIDA - y de la Promoción, Protección y Defensa de los Derechos Humanos ante el VIH/SIDA, 2 June 2000; *reglamentado* by Acuerdo Gubernativo Número 317-2002, dated Sept. 6, 2002.

<sup>144</sup> Documents prepared by the Programa Acción SIDA Centro America (PASCA), a project funded by USAID in Central America, and awarded to the Academy for Educational Development (AED), make reference to unconfirmed nonconsensual testing, among people admitted to hospitals, prisoners, and prostitutes. Mandatory testing of sex workers, as well as people with TB, is reported in AIDS IN THE WORLD II, *supra*. In the past, tests were demanded for immigrants, homosexuals (AIDS IN THE WORLD, *supra*, reported testing of homosexuals before 1991), pregnant women, and women seeking fertility treatment. Isolated cases of testing as a prerequisite for a marriage license were imposed by Notaries, with apparent support from the Civil Code of 1969 (Decree Law 106, 1 July 1969 Art. 97), which calls for a medical exam to show that the engaged person is free from "infectious incurable disease." Much of the above would have found legal support in Governmental Agreement 342-86, which envisioned case finding through voluntary testing, contact tracing, and testing of blood donors, sex workers, and people seeking health cards and prenuptial cards (Governmental Agreement 342-86 Art. 7). Governmental Agreement 342-86 gave explicit guidelines for state regulation of sex work; Art. 30, for example, required sex workers to show their health booklet to clients and, "insofar as possible, visually examine clients for signs of venereal diseases." Testing of

complementary and effective mechanism in planning, executing and evaluating public undertakings, like health, I attach the following bill...

Three years later, and despite the fact that another law on AIDS had been passed in 1995,<sup>145</sup> a modified version of her proposal was passed by the legislature.

In Guatemala, the effort at Constitutional exegesis did not stop at Article 4, which simply provided that “In Guatemala all human beings are free and equal in dignity and rights.”<sup>146</sup> Decree No. 27-2000 points to Articles 93, 94, and 95, defining health as a fundamental right, and a public good, which the State must pursue.<sup>147</sup> In some public health circles, there has long been suspicion that the number of AIDS cases is underreported for

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known drug addicts was also not unheard of. Perhaps most surprisingly, all employees of the Guatemalan Social Security Institute (IGSS) at one time were tested; research at PASCA could not turn up the source of the instruction to do so.

<sup>145</sup> It is of interest to note that Decree No. 27-2000 replaced (as declared in Art. 60 of the new law) Decree No. 54-95, which already had a short clause on human rights. Article 10 of the 1995 law stated that:

Any regulation with regard to prevention of sexually transmitted infections and HIV/AIDS, must respect the human rights of patients, the dignity of people affected, strict medical confidentiality, taking into account, additionally, the international covenants to which Guatemala is a signatory.

The new law, as is shown below, is much longer and contains much more detail. The old law placed responsibility for program development in different state agencies. It also contained language requiring educational efforts to “focus on the family unit and conjugal fidelity as the best means of prevention” (Art. 3) and to focus on “especially vulnerable groups, such as prisoners” (Art. 8); such language has been dropped out of the new law.

Zury Rios Montt’s bill in 1997 included some terms, which never made their way into the law, actually passed. She and Representative Rafael Barrios Flores introduced separate bills that referred to the provision of condoms in 1997; as in the law in Honduras, no specific reference is made to condoms in the new law. Rios Montt’s bill included a right to privacy: “People living with HIV/AIDS are not obliged to give health care personnel information about their personal lives or the identity of their sexual contacts;” as seen below, such guarantees did not make it into the final version of the law.

<sup>146</sup> The Guatemalan Constitution dates from 31 May, 1985. This Constitution was drafted in response to the civil war in Guatemala.

<sup>147</sup> The “Considering...” sections of Decree No. 27-2000 also refer to Art. 6 of the Constitution, but oddly make no reference to Art. 98, which defines as a right and a responsibility the “participation of communities in health programs.”

policy considerations, including fear of diminishing tourism.<sup>148</sup> It is notable, therefore, that the opening paragraphs of the new law refer to the “alarming dimensions” of the AIDS epidemic in Guatemala, and further: “that at the moment, information and education are the best ways to combat this illness, and as such, denying, hiding, or diminishing the problem signifies an attempt against human life.”

But despite such temptations to draw some exploratory conclusions about the laws based on different countries’ situations with respect to human rights discourse (or some other vector, like the centrality of the Catholic Church in society) it is also useful to focus on the gulf between the laws of Nicaragua and Honduras. The two countries neighbor one another in the middle of the Central American isthmus, and are by far the poorest countries in the region. Nicaragua has always had the lowest percentage (at 0.2%) of adults infected in the region,<sup>149</sup> and has adopted the most human rights centered law.<sup>150</sup> Honduras at the time its AIDS law passed in 1999 had the highest percentage of adults infected (at 1.92%),<sup>151</sup> and the least rights-centered law. The contours of these differences are explored in further detail below.

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<sup>148</sup> As explained earlier in this article, AIDS reporting is most developed in Honduras, which had less tourism than some of its neighbors, and which perceived that accurate surveillance would prove useful in international fund-raising. Experts have long decried underreporting in the other Central American countries, for reasons having to do with tourism in Guatemala, and revolutionary pride in Nicaragua.

<sup>149</sup> As noted earlier, these percentages come from surveillance systems of varying quality, and generally should not be taken at face value. For the purposes of my argument regarding national aspirations, however, it is enough that public perception of the AIDS epidemic traces not the real incidence of infections, but the measured incidence. A woman with AIDS in Nicaragua may be perceived to die of diarrhea and an acute respiratory infection, while the same woman in Honduras is perceived to die of AIDS.

<sup>150</sup> For an epidemic that is sharply correlated with poverty, Nicaragua, one of the poorest countries in the Western Hemisphere, appears to be dodging a bullet. At least since the beginning of the Sandinista revolution in 1979, and even after the Sandinistas lost the presidency to Violeta Chamorro in 1990, the country has focused on health care, public education, and not surprisingly, rights. The Sandinistas drafted a new Constitution under Ortega in 1987.

<sup>151</sup> UNAIDS/WHO Epidemiological Fact Sheet on HIV/AIDS and other sexually transmitted diseases 2000 Update: Honduras, at p. 3, available at <http://www.paho.org/English/HCP/HCA/Honduras.pdf>.

### The National AIDS Commission

All the laws described in this article assign principal responsibility for a response to the epidemic to multiple agencies. Panama passed the first HIV law in the region in 1992, identifying the Ministry of Health as the key agency, but outlining a role for the Ministry of Education too.<sup>152</sup> In 1993, El Salvador established a commission including the Ministries of Health, Justice, Education, and Interior; the Military Health Department; the Public Health Council; the Red Cross; and the Salvadoran Social Security Institute.<sup>153</sup> This group was additionally to oversee coordination of the NGO sector.<sup>154</sup> In 1999, Costa Rica established that the National AIDS Program would have one representative each from the Ministries of Health, Public Education, and Justice; one representative from the Social Security institute; one representative from the University of Costa Rica; and two representatives from NGOs, one of whom must be a person living with HIV.<sup>155</sup> In 2000, Guatemala created a National Program within the Ministry of Health and a Multisectoral Commission, with membership left open, but to include at least the Ministries of Health; National Defense; Education; Communications; Infrastructure and Housing; Governance; and Labor; the Social Security Institute; the office of the Attorney General of Human Rights in Guatemala; the Supreme Court; the National Youth Council; the Higher Education Council; the College of Doctors and Surgeons of Guatemala; NGOs working on sexual and reproductive health; and business groups.<sup>156</sup> The 2000 law in Panama simply noted that AIDS is considered a national problem requiring an intersectoral response, from state agencies and NGOs.<sup>157</sup>

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<sup>152</sup> See Law No. 26, Prevention and Control of AIDS, passed Dec. 12, 1992, arts. 4, 6 (Pan.).

<sup>153</sup> See Decreto No. 53: Reglamento Para la Investigación, Prevención y Control del Síndrome de Inmunodeficiencia Adquirida (SIDA), published in 320 DIARIO OFICIAL (San Salvador, 9 July 1993), arts. 2-3 (El Sal.).

<sup>154</sup> See *id.* art. 6. The Salvadoran commission, called CONASIDA, was somewhat retooled in Article 12 of a more recent law, Decreto No. 588, passed Oct. 24, 2001 to expand representation to the national human rights ombudsman, a media representative, an NGO representative (no longer specific to the Red Cross), the Ministry of Labor, a business group (the Asociación Nacional de Empresa Privada), the Medical College, and the Secretaria Nacional de la Familia.

<sup>155</sup> See Decree No. 27894-S of June 3, 1999, art. 2 (Costa Rica).

<sup>156</sup> See Decree No. 27-2000 art.6 (Guat.).

<sup>157</sup> See General Law on Sexually Transmitted Infections and AIDS, Law No. 3 of Jan. 5, 2000, arts. 2, 4 (Pan.). This Law was *reglamentado* by Decreto Ejecutivo No. 119, dated May 29, 2001; the *reglamentación* somewhat expanded roles played by

The Nicaraguan law, passed in 1996 and given binding effect in 2000, created a commission including government agencies and civil groups,<sup>158</sup> and now includes at least one person living with HIV.<sup>159</sup> Honduras was relatively late in drafting its comprehensive HIV law, centering its approach in the Ministry of Health until 1999. In 1999, Honduras created its own commission, to consist of 15 voting members, to be presided over by the Ministry of Health, and including 10 other state agencies.<sup>160</sup> The Catholic Church and the Association of Evangelical Churches are each afforded a permanent seat; the Network of NGOs Against AIDS has one seat and may nominate a person living with AIDS for the last seat.<sup>161</sup>

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other agencies, such as the Ministry of Government and Justice, and the Ministry of Youth, Women, Children and the Family, among others.

<sup>158</sup> See Law for the Promotion, Protection and Defense of Human Rights in the Context of AIDS, Law No. 238 of Dec. 6, 1996, arts. 1, 3. (Nic.)

<sup>159</sup> See Regl. Arts. 31-33. (Nic.).

<sup>160</sup> See Special Law on HIV/AIDS, Decree No. 147-99 of [September 30], 1999, art. 8 (Hond.).

<sup>161</sup> See *id.* The question, both generally and in the Honduran context, of whether the Church has helped or hurt in responding to the AIDS epidemic, is beyond the scope of this article. My own experience in Honduras from 1989-92 only made me realize how complex the role of the Church is. I base what follows on reading the daily papers, discussing matters with Honduran Ministry of Health officials, and talking with the local priests in the eastern province of Olancho. One thing to note about the Catholic Church in Honduras is that almost all priests are imported from other countries (the ones I spoke with were from El Salvador and Malta), and I can only speculate, preaching the secular religion of the Peace Corps as I was, that being an outsider, particularly a relatively recent arrival, entails peculiar dynamics with respect to community reception.

When I arrived in Honduras, the Ministry of Health (MOH) had already internalized the Church's position that sexuality should be governed by religious morality. Thus the main message from the MOH was that abstinence was best; but if one did have sex, precautions should be taken. The implicit equilibrium with respect to the Church was occasionally disrupted by the Church, sometimes by the Archbishop, but usually through statements of new foreign priests quoted in the papers. One such priest claimed, for example, that condom use led to increased risk of HIV infections, because condoms break. Exasperated, MOH officials responded, also through the press, that their scientific studies suggested otherwise, and that if the Church were to be believed, they should produce some data. Such data, needless to say, was never forthcoming.

MOH officials also put pressure on the Church to stay in line with respect to safer sex educational efforts, and this was done by appealing to the Church's message of compassion. MOH officials complained that Church moralizing about how only

Honduras' closed voting structure maintains the centrality of the Ministry of Health and other state agencies, and is the only structure that institutionally establishes church power. Like the Guatemalan law, there is no mention of condoms, and this is probably a result of church pressure. The Honduran law evidences more church influence than the Guatemalan law, however, since it requires public advertisements about the epidemic to "respect morality and the religious conditions of Hondurans."<sup>162</sup>

### **Criminalization of Transmission**

Whether or not the HIV-specific laws of the country mention some criminalization of transmission, each country except El Salvador does in fact have law criminalizing some kinds of infection. In 1992, Panama's HIV law reiterated criminal sanctions as provided in its Penal Code for intentional and negligent infection, or attempted infection.<sup>163</sup> The 2000 law defines as a "crime against public health" the intentional infection of an uninfected person, punishable by a prison term of 2 to 5 years.<sup>164</sup> El Salvador's 2001 law (like the 1993 law it supersedes) does not mention criminal sanctions for transmission, nor does it make reference to a law that imposes sanctions.

Costa Rica's 1998 law includes penalties of 3 to 8 years in prison for health care workers to put clients at risk of infection, and 12 to 20 years for

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sinners became infected led to outright ostracism of those who fell ill, rejections by their families and communities, and other failures of compassion. The Church, to its credit, took such criticism to heart, and attempted to open several AIDS hospices.

The Church's position on HIV matured, in my opinion, once it was directly involved in the care of people living with HIV. They saw the people in the communities come out with their machetes when the hospices were opened, demanding that the hospices be closed, but the Church persisted in its efforts, and stayed. They heard the actual stories of how people were infected, and learned the futility of blame. The Church's more outrageous pronouncements on AIDS seemed to diminish over a period of just a few years.

I disagree with the Church's positions on condoms and sex education, but I can't say that they should categorically be excluded from participation on the National AIDS Commission, because they are now a major caretaker for people living with AIDS, and in some ways are more in touch with the relevant issues than other institutions.

<sup>162</sup> *Id.* art. 19.

<sup>163</sup> See Law No. 26 of Dec. 12, 1992, *supra*, art. 18 (Pan.).

<sup>164</sup> See General Law on Sexually Transmitted Infections and AIDS, Law No. 3 of Jan. 5, 2000, *supra*, art. 47 (Pan.). See also Decreto Ejecutivo No. 119 of May 29, 2001, *supra*, Title III, Chapter II, art. 110 (Pan.).

actual cases of infection by health care providers.<sup>165</sup> Costa Rica's HIV law also modifies the Penal Code, such that "A prison term of 3 to 16 years will be imposed on whosoever, being infected with a contagious illness posing a grave risk to life, physical integrity or health, infects another under the following circumstances: a) donating blood or its derivatives, semen, breast milk, tissues or organs; b) having sexual relations with another without informing that person of one's infection; c) utilizing an invasive object, knife or needle previously used by the infected person."<sup>166</sup> Guatemala's 2000 law makes reference to the Penal Code, which establishes that "Whosoever intentionally propagates a dangerous or contagious human illness, shall be imprisoned from one to six years."<sup>167</sup>

Nicaragua's HIV law does not mention criminalization of transmission. Article 333 of the 1974 Nicaraguan Penal Code, however, provides that "whosoever intentionally and by any means propagates a dangerous or contagious illness, or acts in ways which may transmit such illnesses, will be punished by 5 to 15 years in prison." Article 334 states that: "When any of the events described in the preceding articles is committed negligently, or through inexperienced agency, or failure to observe a regulation, a fine will be imposed...if no one is injured, but a prison sentence of 1.5 to 4 years and a fine...will be imposed if someone falls ill or dies." Honduras's HIV-specific law makes reference to the 1984 Penal Code, which established that "Whosoever intentionally propagates a dangerous illness or causes an epidemic by means of diffusion of pathogenic germs will be jailed for 3 to 6 years...If...a death results, the responsible person will be tried for simple homicide (*homocidio simple*) or qualified homicide (*homocidio calificado*), depending on the circumstances."<sup>168</sup> The Honduran Penal Code also provides penalties of 2 to 4 years in prison in cases of negligent transmission.<sup>169</sup>

Despite some minor variation in prison terms, the important point is that there are generally criminal sanctions available in each of the Central American countries discussed here. Furthermore, these sanctions are located, in the final analysis, in the general Penal Codes, which in turn contemplated

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<sup>165</sup> See General Law on AIDS, Law. No. 7771 of Apr. 29, 1998, art. 41 (Costa Rica).

<sup>166</sup> See *id.* art. 51.

<sup>167</sup> See Penal Code, Decree No. 17-73 of April 1973, art. 301. (Guat.).

<sup>168</sup> Penal Code, Decree No. 144-83, March 12, 1984, art. 184 (Hond.).

<sup>169</sup> See *id.* art. 191.

crimes against public health before the onset of serious AIDS epidemics in the region, and therefore cannot be characterized as newfangled responses to the epidemics in the different countries. The fact that there is no record of anyone with HIV actually being prosecuted under these Codes underscores, from a legal realist approach, that the national responses have not been punitive, at least in terms of use of formal legal apparatuses.

Viewed as public statements about the nature and aspirations of a response to the AIDS epidemic, however, the HIV laws, considered alone, display a significant difference. The HIV laws in El Salvador and Nicaragua do not mention the existence of criminal sanctions, whereas each of the other countries at least acknowledges a potential criminal component, albeit normally consistent with pre-existing rules for prosecution.

### **Privacy and Confidentiality**

HIV laws address what the state needs to know about a person's HIV status while addressing the situations in which leakage of such information might damage the individuals to whom the information adheres. The Central American laws authorize surveillance for its usual purposes, including protecting the blood supply, informing prevention efforts, and regulating legal prostitution, among other reasons. Each law also defends the principle of confidentiality, and outlines sanctions in cases of violations of confidentiality in Costa Rica, Guatemala, Honduras, Nicaragua, and Panama.

The law in Nicaragua is unusual insofar as it states that HIV positive people need not inform health authorities about their status or the identity of their sexual partners.<sup>170</sup> Honduras, on the other hand, is notable because it allows a spouse to demand that their partner be tested.<sup>171</sup>

### **Discrimination**

Each of the Central American laws addresses discrimination against people living with HIV, in areas such as work, education, and freedom of movement. Discrimination in the areas of marriage and the family, and medical treatment, are discussed later in this Part.

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<sup>170</sup> See Law for the Promotion, Protection and Defense of Human Rights in the Context of AIDS, Law No. 238 of Dec. 6, 1996, art. 27; *see also* Regl. Art. 26. (Nic.)

<sup>171</sup> See Special Law on HIV/AIDS, Decree No. 147-99 of September 30, 1999, art. 32 (Hond.).

As a preliminary matter, some of the laws address discrimination against groups particularly vulnerable to infection. Although obligatory testing (i.e. testing without informed consent) targeted at any particular group (e.g. sex workers) is, according to the UNAIDS Handbook for Legislators, “a violation of the nondiscrimination principle under international human rights law,”<sup>172</sup> Honduras and Panama mandate testing and other control of sex workers,<sup>173</sup> in the context of legalized prostitution.

Employers in the region generally may not discriminate based on HIV status.<sup>174</sup> El Salvador has a legal framework in which employers can fire sick workers<sup>175</sup> and generally require them to submit to medical exams “for the purpose of verifying their medical condition;”<sup>176</sup> and CONASIDA was given discretion to allow HIV testing for certain professions,<sup>177</sup> but lobbying of the

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<sup>172</sup> UNAIDS Handbook for Legislators, *supra*, at 42.

<sup>173</sup> See Special Law on HIV/AIDS, Decree No. 147-99 of September 30, 1999, art. 30 (Hond.); see also General Law on Sexually Transmitted Infections and AIDS Law No. 3 of Jan. 5, 2000 art. 6, § 5 (Pan.).

<sup>174</sup> See General Law on AIDS, Law No. 7771 Art. 4 (Costa Rica); see also Decree No. 27-2000 arts. 37, 42-43 (Guat.); see also Special Law on HIV/AIDS, Decree No. 147-99 of September 30, 1999, arts. 52-53 (Hond.); see also Law for the Promotion, Protection and Defense of Human Rights in the Context of AIDS, Law No. 238 of Dec. 6, 1996, art. 22 (Nic.); see also General Law on Sexually Transmitted Infections and AIDS Law No. 3 of Jan. 5, 2000 arts. 31-32, 37-38 (Pan.).

<sup>175</sup> See Labor Code, Decree No. 38 of June 23, 1972 art. 36 (El Sal.).

<sup>176</sup> See *id.* at art. 31, para. 10 (requiring employees to “submit to a medical exam when required by the employer or by administrative authorities for the purpose of verifying their medical condition.”); see also The World Bank, Reducing HIV/AIDS Vulnerability in Central America: El Salvador: HIV/AIDS Situation and Response to the Epidemic, December 2006, available at <http://siteresources.worldbank.org/INT/HIVAIDS/Resources/3757981103037153392/CAHIVAIDSElSalvadorFINAL.pdf> (arguing at p. 17 that this provision of the Labor Code “contradicts” El Salvador’s HIV Law. The report also noted at p. 18 that “In 2005, of the 50 complaints that the Atlacatl Association supported and processed, 25 involved firing of people from their jobs, and 20 resulted in favorable decisions for the employee. However, no affected person was rehired because no one wanted to go back.”). El Salvador’s Labor Code was amended in 2005 to make it illegal to demand HIV tests either of job applicants or during the course of employment, or directly or indirectly make any distinction, exclusion or restriction among employees, based on their HIV status, or divulge their diagnosis; see the Labor Code at art. 30, paras. 14-15, available at [http://portal.oit.or.cr/dmdocuments/sst/legis/elsalvador/els\\_codigo\\_trabajo.pdf](http://portal.oit.or.cr/dmdocuments/sst/legis/elsalvador/els_codigo_trabajo.pdf).

<sup>177</sup> See Rules for Research, Prevention and Control of AIDS, Decree No. 53 of July 9, 1993, art. 20. (El Sal.)

Salvadoran Congress by interested NGOs succeeded in dropping a provision in their 2001 law that would have allowed HIV testing as a precondition to employment.<sup>178</sup> Penalties are provided in cases of workplace discrimination or preemployment testing in Costa Rica,<sup>179</sup> Honduras,<sup>180</sup> Guatemala,<sup>181</sup> Nicaragua<sup>182</sup> and Panama.<sup>183</sup>

### Marriage and the Family

Panama's 2000 law and Honduras' law require HIV testing in order to obtain a marriage license, though the laws do not prevent HIV-positive people from marrying.<sup>184</sup> In Costa Rica, a Court may order an HIV test in a divorce proceeding.<sup>185</sup>

The Nicaraguan law is silent on marriage issues. In Honduras, if a spouse suspects that their partner is infected, the partner is legally obligated to be tested.<sup>186</sup> If both spouses are infected, they may not adopt children.<sup>187</sup> The anti-adoption rule seems to suggest that the prognosis for people living with HIV is death; if this is so, the underlying vision of the potential of antiretroviral medication in Honduras is also dim.

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<sup>178</sup> See Alberto Lopez. "Impugnan ley del SIDA" in El Diario de Hoy, Dec. 1, 2001 (regarding excision of Art. 16(d) from Decreto No. 558 of Oct. 24, 2001, which would have allowed HIV testing in those cases contemplated in Art. 31(10) of the Labor Code), available at <http://www.elsalvador.com/noticias/2001/12/1-/NACIONAL/nacio9.html>.

<sup>179</sup> See General Law on AIDS, Law No. 7771 Arts. 47-48 (Costa Rica); employers may not demand HIV test results, but they may, in the case of domestic workers, require a certificate of good health, under Art. 103 of the Labor Code (Law No. 2, 26 August 1943).

<sup>180</sup> See Special Law on HIV/AIDS, Decree No. 147-99 of September 30, 1999, art. 53 (Hond.).

<sup>181</sup> See Decree No. 27-2000 art. 52 (Guat.) (sanctions only outlined for preemployment testing, not for workplace discrimination).

<sup>182</sup> See Reglamentación, Art. 5 (Nic.).

<sup>183</sup> See General Law on Sexually Transmitted Infections and AIDS Law No. 3 of Jan. 5, 2000 art. 45 (Pan).

<sup>184</sup> See Special Law on HIV/AIDS, Decree No. 147-99 of September 30, 1999, art. 32 (Hon.); see also General Law on Sexually Transmitted Infections and AIDS Law No. 3 of Jan. 5, 2000, art. 6, § 6 (Pan.).

<sup>185</sup> General Law on AIDS, Law No. 7771 Art. 9 (Costa Rica).

<sup>186</sup> Decree 147-99 Art. 32 (Hon.).

<sup>187</sup> See *id.* Art. 79.

## Treatment

Panama's 1992 law makes no mention of treatment. The 2000 law makes it a "crime against public health" to deny health services to people with HIV.<sup>188</sup> In Costa Rica, people living with HIV have a right to treatment,<sup>189</sup> and the Social Security system is responsible for importing antiretrovirals.<sup>190</sup> Honduran health care workers are subject to civil remedies if they deny treatment to people living with HIV.<sup>191</sup> Medical treatment is a right under the Guatemalan law,<sup>192</sup> with sanctions for denying medical treatment,<sup>193</sup> and the Ministry of Public Finance and Economy is called upon to facilitate access to high-quality antiretroviral medications at affordable prices.<sup>194</sup> In Nicaragua, the state is responsible for promoting health care for people living with HIV or AIDS.<sup>195</sup>

As discussed above, the Costa Rican, Guatemalan and Salvadoran governments have been sued over treatment issues. In the context of a national health care system in Costa Rica, the case, which predated the passage of an HIV law, was successful in the Costa Rican Supreme Court. In El Salvador, in the context of an HIV law silent on the issue of providing antiretrovirals, the Supreme Court delayed making a decision in the case. The Salvadoran case was subsequently taken to the Inter-American Commission on Human Rights; with the case open in this latter court, the government agreed to provide antiretrovirals, but there was a long delay in procuring the medications. In Guatemala, another treatment case on behalf of a class of

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<sup>188</sup> General Law on Sexually Transmitted Infections and AIDS, Law No. 3 of Jan. 5, 2000, Art. 48 (Pan.).

<sup>189</sup> General Law on AIDS, Law No. 7771, Art. 7 (Costa Rica).

<sup>190</sup> *See id.* Art. 12.

<sup>191</sup> *See* Decree 147-99 Arts. 47-49 (Hon.).

<sup>192</sup> *See* Decree No. 27-2000 Art. 35 (Guat.).

<sup>193</sup> *See id.* Art. 52.

<sup>194</sup> *See id.* Art. 49.

<sup>195</sup> Nicaragua (1996) Law No. 38 art. 19, Regl. (2000) Art. 20. One group, ASONVIH/SIDA, presented a complaint before the Attorney General for Human Rights and the Nicaraguan Commission for Human Rights on 11 July, 2001, stating that not one of 250 people living with HIV in Nicaragua was being given antiretroviral treatment. Boletín Acceso Centroamerica #1, July 17, 2001, available at <http://www.aguabuena.org/boletines/marzo172001.html>.

people living with HIV was admitted before the Inter-American Commission on Human Rights in 2005.<sup>196</sup>

In April 2001, PASCA drafted “A Legal Framework towards Action in HIV and AIDS Prevention and Care: A Key Area for an Effective and Sustainable Response.” The document outlines five points to consider with respect to HIV-related legislation: 1) countries should sign on to international human rights instruments,<sup>197</sup> 2) countries should examine their patent law and the World Trade Organization’s TRIPS (Trade-Related Intellectual Property rights) agreement, with respect to required licensing, parallel importation, and dates of market presentation for antiretroviral medications, 3) countries should streamline registration and distribution of antiretrovirals, 4) countries should include specific prevention actions, including care of HIV positive people, in their national laws, and 5) countries should establish holistic care modalities for people living with HIV, to include both clinical and non-clinical aspects. Taken together, one might conclude that PASCA has found that international human rights norms are as powerful as national pieces of legislation, but that the applicability of the next wave of legislation will be on the issue of accessibility of medications.

## Conclusion

The few cases that have been tried in Central America have been in the area of positive (social and economic) rights to treatment, rather than negative (political) rights to non-discrimination. HIV-specific legislation in Central America has rarely been used beyond its administrative purposes of establishing National AIDS Programs, and as such its framework of rights and responsibilities cannot be said to function as much more than a vision of the

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<sup>196</sup> See the Inter-American Commission on Human Rights, Report No. 32/05, Petition 642/03, Admissibility, Luis Rolando Cuscul Pivaral et al. (persons living with HIV/AIDS), Guatemala, March 7, 2005, available at <http://www.cidh.oas.org/annualrep/2005eng/Guatemala642.03eng.htm>.

<sup>197</sup> I can only assume that this point is designed with Honduras in mind, to get it to sign the Protocol of San Salvador, which corresponds to economic and social rights, and includes a right to health more positive in spirit than that found in civil and political instruments. The most powerful international instruments for Central American purposes are not U.N. instruments, but those emanating from the Organization of American States. As discussed in Part II, all the countries analyzed in this article are signatories to the American Convention on Human Rights, and all but Honduras have signed on to the Additional Protocol (of San Salvador). The civil and political rights of the American Convention on Human Rights are enforceable through the Inter-American Court of Human Rights.

way people should behave; the judicial resources of the state are almost never brought to bear to impose standards of behavior in the population in accordance with this vision.

In the final analysis, it is hard to argue that U.S.-based notions about the legal response to the HIV epidemic has been overbearing or particularly hegemonic, despite the obvious role of USAID money in organizing legislative advocacy, through the PASCA project. The bad example set by the United States in prohibiting entry of people living with HIV was followed by Panama in its 1992 law, but was set aside there in its more recent law. The other countries in the region, by contrast, do not appear to be overly concerned with the question of the HIV status of migrants. In the area of named reporting of HIV test results to public health authorities, this article showed how a switch from anonymous to named reporting occurred in the U.S. in the context of realistic improvement in treatment options, and access to them.

The Central American countries studied here have largely adopted named reporting, but have lagged in their ability to provide access to effective treatment regimes. However, in the context of substantial Central American activism, backed by strong legal arguments, to gain access to such treatments, the reporting mechanisms should not be viewed as out of line with local preferences. Lastly, with respect to approaches to discrimination, the U.S. response is statutory and/or framed within Constitutional jurisprudence; the Central American response, while not without support in national constitutions, is much more oriented toward international human rights instruments.

A comparative analysis of the HIV laws in Central America suggests that the vision of the epidemic has changed over time, generally becoming more rights oriented. However, the country in the region with the most exposure to and experience of the epidemic, Honduras, currently has the least progressive vision. Honduras is the only country in the region where spouses can force their partners to be tested for HIV; where the law, implicit in its anti-adoption provision, seems to codify the futility of antiretroviral treatment; and where the Catholic Church, which kept mention of condoms out of the law, is institutionally empowered in the National AIDS Commission. By contrast, the country with the lowest indicators of infection, Nicaragua, has a law that does not mention criminalization of transmission; that was the first to include a person living with HIV on the National AIDS Commission; and that rejects mandatory HIV contact tracing.

This article began with the proposition by Dr. Jonathan Mann that “In each society, those people who, before HIV/AIDS arrived, were marginalized, stigmatized and discriminated against, became over time those at highest risk of infection.”<sup>198</sup> Discrimination, considered as a vector, may lead in multiple ways to heightened infection rates: through poverty and its attendant barriers to safer sex (e.g., via sex work, or women’s sexual disempowerment in household economic dependency), or through low self-esteem and risk taking (e.g., via internalized racism, homophobia and other psychological mechanisms). This in turn suggested that perhaps society-wide, legally instituted anti-discrimination measures would be a useful approach, among an array of other human rights approaches.

This article has shown that Mann’s broad focus on anti-discrimination efforts, emphasizing generally that discrimination leads to new infections, has generally *not* trickled down into HIV-specific laws in Central America. The Central American laws do not in general address discrimination against women, or men who have sex with men. Rather, significant attention is afforded in those laws to discrimination against people living with HIV, emphasizing the problems of discrimination *after* infection occurs, along the lines of the U.S. model. Honduras, hardest hit with roughly 37% of all AIDS cases in the six Spanish-speaking countries in Central America, has the epidemic that has most affected women. Costa Rica’s epidemic, by contrast, is predominantly focused among men who have sex with men. While there has been some grassroots activism among vulnerable groups, it has not been on the scale of such activism in the United States, nor has it included significant visibility of people from such groups who publicly tell the stories of how they became infected. It is not easy to ascertain whether a broad anti-discriminatory approach would be more fruitful in preventing new infections in Central America. More research, and more activism, is needed in each country.

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<sup>198</sup> *Id.* at 201.