ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

7857 • HOUSE JUDICIARY •

QUESTIONS AND ANSWERS ABOUT HIV AND RAPE

CAN HIV BE TRANSMITTED DURING A RAPE OR SEXUAL ASSAULT?

HIV can be transmitted through the exchange of blood or other bodily fluids, including semen. As it is possible for HIV to be transmitted during consensual sexual intercourse (vaginal, anal, or to a lesser extent, oral), it also is possible for HIV to be transmitted during a rape or a sexual assault that involves the exchange of bodily fluids. Note, however, that although the virus occasionally has been found in tears and saliva, no cases of AIDS have been traced to a transmission involving these fluids. If the virus has been transmitted, that means you are infected with the HIV virus.

WHAT IS THE LIKELIHOOD THAT HIV WILL BE TRANSMITTED DURING A RAPE?

The epidemiology branch of the AIDS Program at the Centers for Disease Control has estimated that the likelihood of male to female transmission of HIV is of the order of less than or equal to 0.2% per episode if the male is HIV infected. It is thought that the rate of transmission in the context of a rape may be somewhat higher; because of the involuntary nature of a rape, the woman's vaginal tract may suffer trauma, thereby creating small tears that would facilitate transmission of the virus and other microorganisms. Medical researchers stress that the estimated figure of 0.2% may change as additional data are collected.

IF I AM INFECTED WITH HIV, DOES THAT MEAN I HAVE AIDS?

No. There are many stages between first being infected with HIV and developing full-blown AIDS. The vast majority of people infected with HIV will experience no symptoms of infection, or minor symptoms, for many years. After an average period of five to seven years, although perhaps significantly longer for others, people infected with HIV will begin to develop increasingly severe symptoms of infection, including the opportunistic infections that are the hallmark of an AIDS diagnosis. Current medical consensus refers to this full range of symptomatology as "HIV disease."

IS THERE A CURE FOR HIV INFECTION OR FOR AIDS?

At this point there is not. However, there is one drug, called AZT, that is available to help slow down the progress of the virus. There are two additional anti-virals that are expected to be approved for use in the very near future. Equally important, medical researchers have developed prophylactic drugs to help prevent or delay the development of opportunistic infections in a person infected with HIV; in addition, treatments now exist to help deal with such infections when they develop.

HOW DO I KNOW WHETHER I HAVE BEEN INFECTED WITH HIV?

There is a series of tests available that can determine whether you have developed antibodies to the HIV virus. It is widely acknowledged today that the presence of the antibodies indicates that the person who was tested is infected with the HIV virus. (This is not true, however, for a newborn, who may test positive for antibodies which he or she has received from his or her mother, but who may not be infected with the virus.) HIV antibodies tend to start appearing approximately four to six weeks after exposure, but may appear earlier.

WHEN SHOULD I TAKE A TEST FOR HIV ANTIBODIES?

You first should be tested immediately after you have been exposed. This is suggested for two reasons. First, the sooner you know about your HIV status, the earlier you can begin to take an active role in treatment to help keep up your health. Second, it will be useful to know whether the source of infection came from the sexual assault or rape or whether you were infected prior to the incident. As noted above, HIV antibodies tend to start appearing approximately four to six weeks after exposure, but may appear earlier; therefore, it is prudent to get a baseline test as soon after the incident as possible.

WHEN WILL I KNOW WHETHER I HAVE BECOME INFECTED AS A RESULT OF THE SEXUAL ASSAULT OR RAPE? WILL THERE BE A TIME WHEN CAN I CONSIDER MYSELF TO BE HEALTHY?

You should be tested approximately every three months following the incident for six months to a year. The majority of people develop antibodies within three months of having been exposed to the virus; ninety percent develop antibodies within six months of exposure. The vast majority of the remaining ten percent will develop antibodies within a year of exposure; beyond the one year point, some will still "sero-convert," but it is very rare to test negative and to be infected beyond one year.

IF I THINK I HAVE BEEN EXPOSED TO HIV, ARE THEY ANY MEDICAL INTERVENTIONS AVAILABLE TO HELP PREVENT MY BEING INFECTED WITH THE VIRUS?

Some medical experts suggest that the anti-viral drug, AZT, be administered to the patient within 48 hours of exposure and be continued for a period of approximately six weeks (although doctors may vary the duration of treatment by a couple of weeks). Although administering AZT immediately after exposure has not been proven to prevent infection, this often is the general course of treatment made available to health care workers who are exposed to the virus in an occupational setting. Animal studies examining whether AZT is effective in this setting are inconclusive; human studies are incomplete. Nevertheless, AZT has not yet been discounted as a viable prophylactic and is the only form of medical intervention available that may work.

ARE THERE ANY SIDE EFFECTS TO TAKING AZT AS A PROPHYLACTIC FOR APPROXIMATELY SIX WEEKS?

In otherwise healthy people who are not already seropositive, doctors have found that taking AZT is not likely to result in the types of toxic side effects sometimes found in those who already are infected with HIV and are taking AZT to slow the progression of infection. Generally, toxic side effects have been found to be dose and duration related and reversible following discontinuation of treatment with the drug. A non-infected person taking a six week course of AZT may experience some insomnia, fatigue, and flu-like symptoms. Again, these effects would end upon discontinuation of treatment with the drug. The research on long term effects are not yet known. Some researchers have found that when given very high doses of AZT (well beyond the doses prescribed for humans), female mice may develop vaginal carcinomas. In addition, only very limited research has been performed on the effect of AZT on the male or female reproductive systems; as such, its mutagenic and teratogenic effects, if any, are not known. One might expect that these more long term side effects would not be found in persons who take AZT for the relatively short period of time suggested for those who have been exposed to the virus as the result of sexual assault or rape.

I UNDERSTAND THAT AZT LOSES ITS EFFECTIVENESS IN PEOPLE WHO ARE SEROPOSITIVE AFTER 12 TO 18 MONTHS; IF I AM EXPOSED, TAKE AZT, BUT STILL BECOME INFECTED, WILL I BE ABLE TO TAKE ADVANTAGE OF AZT AS A FORM OF TREATMENT LATER IN MY ILLNESS?

AZT loses its effectiveness when resistent strains of the virus develop in a person already infected with the virus. Such activity is not expected in a person who recently has been exposed to the virus; therefore, it is unlikely that use of AZT as a prophylactic immediately after exposure will affect a person's ability to use AZT later in the course of

illness, if it becomes necessary.

CAN I TRANSMIT THE VIRUS BEFORE I KNOW WHETHER I AM INFECTED?

If you are infected with the virus, you are capable of transmitting it; this is so even if your HIV antibody test comes back negative. Therefore, to protect your partner from infection, it is important, if you engage in sexual relations, that you use safer sex techniques throughout this period; in fact, unless you know for certain that neither you nor your partner are HIV-infected, you never should engage in unsafe sex. If you use intravenous drugs, you should avoid sharing works; if you do share works, always clean them with bleach and water following each use.

WHAT ELSE CAN I DO DURING THIS WAITING PERIOD?

The most important thing you can do is to take care of yourself. You may wish to seek counseling. It is important to seek support from your family, friends, and medical professionals. Also, this would be a good time to accomplish the elusive goals of eating better, getting more sleep, and relaxing more.

OTHER NEWS ...

Federal Year 2000 Plan

In keeping with objectives first enumerated by former U.S. Surgeon General C. Everett Koop, the U.S. Department of Health and Human Services is drafting national health goals for the Year 2000. Among those goals is the reduction of the rate of rape and attempted rape of women age 12 years and older to "no more than 107 per 100,000 women." (The rate was 119.7 per 100,000 in 1986.) The proposed method of reduction is the initiation of sexual assault awareness programs for adolescents and evaluation of these programs. Prevention education for adult women is not being considered as equally necessary to rape reduction. Nor are services to sexual assault victims included in the federal objectives, as are services to victims of domestic violence. [For further information, contact Gary Hogelin, Office of Surveillance, Communicable Disease Center, U.S. Department of Health and Human Services, Atlanta, GA. Telephone: (404) 639-2752.]

[EDITOR'S NOTE: The term "rape" is used herein because the term is employed by the published material cited.]

AIDS and Sexual Assault

The Department of Genitourinary Medicine of St. Mary's Hospital in London has reported the first known case of AIDS resulting from sexual assault. The seroconversion to human immunodeficiency virus (HIV) occurred during the three months following the assault in a woman who had no other identifiable risk factors for HIV infection (e.g., blood transfusions, intravenous drug use, sexual contact with other men in the previous nine months, etc.).

The sexual assault victim in this case had been forced to have vaginal and anal intercourse by a man known to her, who subsequently told her he had tested seropositive for HIV. Repeated testing of the woman for the HIV antibody also produced a positive result which doctors attributed to the sexual assault. Three other women tested positive at the same hospital following a rape. None had had blood transfusions or used intravenous drugs. However, one woman had a sexual partner from Central Africa, and serum taken at the time of the rape was not stored, so HIV infection could not be definitely attributed to the assault.

St. Mary's Hospital recommends that all adult victims of sexual assault be offered HIV testing, reassured that the risk of infection is low, and offered counseling.

In England, an assailant may be asked to supply samples and agree to be tested for sexually transmitted diseases. A refusal may be noted in court.

[Source: S. Murphy, V. Kitchen, J.R.W. Harris, and S.M. Forster. *Rape and subsequent seroconversion to HIV.* British Journal of Medicine.]

Child Sexual Abuse in Indian Territory

Federal officials have approved a $10.8 million payout to settle four consolidated lawsuits against the United States over the molestation of 58 Hopi children by a non-Indian teacher with the Bureau of Indian Affairs.

Between the end of 1988 and early this year, the Federal Bureau of Investigation investigated 130 reports of child sexual abuse in Indian territory.

Reported Rape in the United States on the Rise

According to the FBI, both reported forcible rape and aggravated assault showed a 10% increase in the first six months of 1990. Robbery rose 9% and murder, 8%. Data released on October 21, 1990 showed a decline in all property crimes, with the exception of motor vehicle theft. Geographically, the semiannual Crime Index total was up 3% in the Northeast and 1% in the Midwest, while both the South and West registered a 1% decline.

Sex Education in Schools

A recent report by the Sex Information and Education Council of the United States indicates more public schools are offering sex education to combat AIDS and teen pregnancy. But, school programs often sidestep sensitive issues such as acquaintance rape, interpersonal relationships, and sex roles. The 36 page report noted that little or no sex education is offered in the early grades.

News from the National Association of Crime Victim Compensation Boards

In 1990, the Mississippi, Georgia, and Vermont legislatures took action to establish and fund crime victim compensation programs in those states, bringing to 47 the number of states with compensation programs. Mississippi's program will begin paying claims July 1, 1991. South Dakota and Maine remain the only states without crime victim compensation legislation.

In other actions, the Connecticut legislature increased the maximum emergency award from $500 to $1,000. (At least 15 states now have maximums of $1,000 or more.) And, Wisconsin's legislature acted to extend coverage to on-duty police and fire fighters, including counseling for families of those killed in the line of duty.

As of October 1, 1990 states' crime victim compensation programs receiving federal VOCA funds were required to develop rules to guide them in making awards which avoid the unjust enrichment of offenders. In cases of child abuse and child sexual abuse, the National Association of Crime Victim Boards has recommended that third party payment be used whenever possible, and that states consider establishing trust agreements to guarantee that the award be

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO: CS HB109 (HES)

Revision Date: 3/17/93 Dept. Affected: Public Safety

Title: "An act relating to blood tests for persons charged with sex offenses: ..." BRU: Alaska State Troopers

Component: Detachments

Sponsor: Representative Kott

Requestor: House Judiciary COMPONENT SERIAL NO. 799

EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE FUND SOURCE:	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY 93) impact: $

ANALYSIS: (Attach a separate page if necessary.)
Passage of this legislation will prevent the loss of 10% of Federal Funds received by AST on a yearly basis from the Crime Control Act (Drug Control and System Improvement Grants). See Briefing Paper.

Prepared By: Francis C. Allan Phone: 269-5491

Division: Alaska State Troopers Date: 3/17/93

Approved by Commissioner: Date: 3/17/93

Agency: Richard L. Burton, Dept. of Public Safety

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information call the Governor's Legislative Office

Rev 11/92

3/15/93

BRIEFING PAPER
FOR

CS HOUSE BILL NO. 109 (HES)

Prepared by Department of Public Safety

"An Act relating to blood tests for persons charged with sex offenses; and providing for an effective date."

Since 1987, Alaska has received Drug Control And System Improvement Formula Grant Funds through the Office of Justice Programs, Bureau of Justice Assistance. The grant program is authorized by the Anti-Drug Abuse Act of 1988. The purpose of the funds is to provide assistance to the states for their law enforcement efforts to control the drug and violent crime problem. The allocation for each state and territory is primarily based on population.

For the first year, the allocation to Alaska was $823,000. In 1993, the allocation is $1,870,000.

Within the State, these funds are shared by state agencies and local units of government for the purpose of addressing the drug control problem through law enforcement, prosecution, and court system improvement programs.

In 1992, with federal allocation of $1,852,000, there were 5 state agency projects and 9 local government projects funded. Through these projects the funds provided 14 law enforcement officers throughout the State, enforcing the State's controlled substance laws through multi-jurisdictional task force, street level enforcement, and financial investigation efforts. These funds provided for two prosecuting attorneys to specialize in the prosecution of individuals violating the State's controlled substance laws. In addition, the funds provided for timely court processing and the identification of individuals with prior drug offense incidents through improvement of the court and criminal history record systems.

Beginning October 1, 1993, the Crime Control Act of 1990 requires that in order for the states to continue to receive their identified Drug Control and System Improvement Grant allocation amount, the states must have laws in place related to HIV testing of individuals convicted of a sexual offense. The result of a state not having such legislation enacted will be a 10% reduction to the state's identified allocation amount. This amount then will be shared by those states which have enacted such legislation.

For the State of Alaska to continue to receive its entire Drug Control and System Improvement allocation, avoid reducing its current drug control effort, and avoid providing 10% of its allocation to other states, passage of HIV testing legislation is necessary this session.

With a reduction of ten percent, or $187,000, to the State's annual grant revenue allocation, it will be necessary to fund ten percent of the law enforcement and prosecution effort currently addressing the State's drug control problem through State general funds and municipal revenues.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CS HB 109 (HES)

Revision Date:
Dept. Affected: Health and Social Services
Title: Blood Tests for persons charged with sex offenses
BRU: State Health Services
Component: Laboratories
Sponsor: Kott
Requestor: House Judiciary
COMPONENT SERIAL NO. #291

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES	27.9	27.9	27.9	27.9	27.9	27.9
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	27.9	27.9	27.9	27.9	27.9	27.9
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	27.9	27.9	27.9	27.9	27.9	27.9
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	27.9	27.9	27.9	27.9	27.9	27.9

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

This fiscal note is based on the costs for the laboratory testing alone. It does not take into account the costs of medical personnel to perform the requisite counseling and testing, travel for medical personnel to communities where qualified personnel are unavailable, shipment of specimens, cost to ensure chain of evidence, and documentation of procedures and test results.

In 1992, 339 charges were made for arrests for sex offenses. Using 350 as the base, the laboratory costs associated with HB 109 is as follows:

Prepared by: Peter M. Nakamura, MD, MPH
Division: Division of Public Health
Phone: (907) 465-3090
Date: 3/16/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: (2) Department of Health & Social Services
Date: 3/16/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

ANALYSIS (cont.):

1. Cost for initial HIV screening @ $16.30/test	5,705
2. Assuming that 0.9% initially screened were positive, the cost for HIV Western blot for making a positive diagnosis is $93.15/test	293
3. Cost for screening negative results after the six month window period for 347 @ $16.30/test	5,656
4. Cost for Western Blot for the 0.9% of those persons which tested positive after the 6 month window period	293
5. Cost of Hepatitis B screening @ $16.30/test	5,705
6. Cost of Hepatitis B testing on the 11.2% that will test positive @ $114.10/test	4,473
7. Cost of RPR test for syphilis @ $16.30/test	5,705
TOTAL	$27,..30

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CS HB109 (HES)

Revision Date:
Title: Blood tests for persons charged with sex offenses
Sponsor: Kott
Requestor: House Judiciary

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: Nursing
COMPONENT SERIAL NO. #288

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	45.5	45.5	45.5	45.5	45.5	45.5
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	45.5	45.5	45.5	45.5	45.5	45.5
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	45.5	45.5	45.5	45.5	45.5	45.5
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	45.5	45.5	45.5	45.5	45.5	45.5

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary)

Assuming a base of 200 individuals who would need testing and counseling and who would be presenting themselves to the Public Health Center for referral for these services, the costs of this bill for the Nursing Component are as follows:

Line 300 Contractual Services

200 draws & pre- & post-test counseling @ 1.5 hours x $65/hr for initial tests	19,500
400 draws & pre- & post-test counseling @ 1.0 hr x $65/hr follow-up testing	26,000
	45,500

Prepared by: Peter M. Nakamura, MD, MPH
Division: Division of Public Health
Phone: (907) 465-3090
Date: 3/16/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 3/16/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

ANALYSIS (cont.):

This fiscal note assumes:

1) testing and counseling is for individuals who are not being detained by the Department of Corrections or the Division of Family and Youth Services; and
2) individuals will present themselves to a Public Health Center for testing and counseling either through a court order or voluntarily will be referred to private providers for counseling.

COMMITTEES:
HEALTH, EDUCATION
& SOCIAL SERVICES
JUDICIARY
STATE AFFAIRS

SPECIAL COMMITTEES:
MILITARY & VETERANS AFFAIRS
OIL & GAS

Alaska State Legislature
House of Representatives

HOME:
9843 CHICHAGOF LOOP
EAGLE RIVER, AK 99577
PHONE (907) 694-7943

DURING SESSION:
STATE CAPITOL
JUNEAU, AK 99811
PHONE (907) 465-3777

Representative Pete Kott

MEMORANDUM

DATE: February 22, 1993

TO: Representative Porter
Chair, House Judiciary Committee

FROM: Rep. Pete Kott

RE: Request for hearing
HB 109, Blood Tests for Sex Crime Perpetrators

Please schedule HB 109 for a hearing before the House Judiciary Committee as soon as possible.

HB 109 is a victims rights bill which allows the victim of a sexual assault to petition the court to have the defendant tested for the presence of HIV antibodies and indications of other sexually transmitted diseases. The bill also provides that if the defendant is convicted, he must reimburse the state for the cost of the test.

The following items are attached:

- Sectional analysis of the HESS committee substitute
- New sponsor statement
- Letter from Dr. Peter Nakamura
- Chart showing increase in reported rapes in Alaska

If you have any questions on this bill, please call me or my Legislative Assistant, Jack Phelps, at 465-3777.

COMMITTEES:
HEALTH, EDUCATION & SOCIAL SERVICES
JUDICIARY
STATE AFFAIRS

SPECIAL COMMITTEES:
MILITARY & VETERANS AFFAIRS
OIL & GAS

Alaska State Legislature
House of Representatives

HOME
9843 CHICHAGOF LOOP
EAGLE RIVER, AK 99577
PHONE (907) 694-7943

DURING SESSION:
STATE CAPITOL
JUNEAU, AK 99811
PHONE (907) 465-3777

Representative Pete Kott

SPONSOR STATEMENT

HB 109 — HIV Testing for Sex Offenders

The purpose of HB 109 is to provide relief for victims of sexual assault. The threat of HIV infection and of infection from other communicable diseases, especially venereal diseases, is a serious complicating side-effect of being victimized by sexual assault. The state has a compelling interest in assuring that innocent victims of crime are afforded timely relief from the anxiety that may result from sexual assault.

It is true that the accused has certain rights that also must be protected by the state. The defendant's right to privacy and to due process is an important part of Alaska's judicial process. HB 109 includes several provisions designed to protect the defendant's rights while balancing those rights against the alleged victim's right to know if he or she has been exposed to infection. The following factors should be noted with respect to this concern:

1) The test is not automatically required, the victim must petition the court to request the test;
2) The court must find probable cause that there was a transfer of bodily fluids;
3) The release of information obtained as a result of the test is strictly controlled in that
   a) only the defendant, the victim, and officials of the defendant's place of incarceration are to receive the test results, except that the Department of Health & Social Services may receive statistical information;
   b) unauthorized disclosure of test results is strictly prohibited and is defined as a class A misdemeanor; and
   c) the time period during which the alleged victim may request the test is narrowly defined.

HB 109 also provides that the state must make available to both the victim and the alleged perpetrator counseling relating to HIV and AIDS which is medically appropriate for those persons.

Finally, HB 109 is designed to minimize the cost to the state of implementing this program. If the defendant is convicted, he or she must reimburse the state for the cost of the test. The court may order the Department of Corrections to provide for the reimbursement through garnishment. Furthermore, the Federal Crime Control Act of 1990 provided that states which do not have a law such as that proposed by HB 109 shall lose part of their law enforcement assistance grants. The loss to Alaska if we fail to pass such a law this year will be approximately $185,000 in FY94.

This bill can satisfy the Federal requirement and simultaneously form an integral part of an effort by the state of Alaska to ensure that victims of crime in our state are afforded every opportunity to find appropriate relief.

Sponsor Statement

CSHB 109
SECTIONAL ANALYSIS

"An Act relating to blood tests for persons charged with sex offenses; and providing for an effective date."

Section 1.

Adds new sections to AS 18.15 as follows:

AS 18.15.300

(a) makes a defendant (including a minor) charged with a sexual offense under AS 11.41.410 - 11.41.440 that includes sexual penetration as an element of the crime subject to an order of the court requiring testing for HIV and other communicable diseases.

(b) allows the alleged victim, or the prosecuting attorney on behalf of the alleged victim, to petition the court for an order requiring the defendant to be tested.

(c) requires the court to make a probable cause determination 1) that a crime has taken place under the specified statutes, and 2) that sexual penetration took place. Allows the court to conduct a hearing to receive evidence to make the determinations required under this subsection.

(d) requires the court to order the test if the court finds probable cause that a crime was committed and that sexual penetration took place.

(e) designates the authorized recipients of test results obtained under an order authorized by subsection (c) of this act. Authorized recipients are the defendant, the victim (or the victim's parents or guardian) and the officer in charge and the chief medical officer of the facility in which the defendant is incarcerated.

(f) places time constraints on when the order authorized under (c) of this act

may be filed. The test may not be ordered sooner than seven days after the arrest nor more than 90 days after the defendant has been convicted and sentenced. Additionally, a test may not be ordered after a finding favorable to the defendant.

(g) provides definitions for "disposition favorable to defendant," and "sexual penetration."

AS 18.15.310

(a) requires that blood drawn for a test under this act be drawn by licensed medical personnel according to AS 08.64.

(b) requires that testing on blood drawn under provisions of this act be conducted by a licensed medical laboratory and according to accepted medical standards.

(c) requires that positive test results be transmitted to the Department of Health & Social Services.

(d) requires test results to be sent to the designated recipients and requires a disclaimer to be attached to test results.

(e) requires the court to order persons who receive the test results to maintain the confidentiality of personal identifying data related to the tests. Provides certain exceptions to this confidentiality: (1) the defendant, and (2) the victim for such disclosures as are necessary to provide for the victim's own health and the health of the victim's spouse, family and household.

(f) prohibits the test results from being used as evidence in a criminal or juvenile proceeding.

(g) provides civil immunity for persons performing the duties authorized by this act.

(h) if the test results are positive, requires the Department of Health & Social Services to provide free counseling and testing to the victim and counseling to the defendant upon request. Also requires the department to provide referral for the victim to appropriate health care facilities and support services.

(i) defines "AIDS," "counseling," and "HIV." Counseling is defined as providing medically appropriate information including information on the diseases, their treatment and the medical and social implications of the diagnosis and the tests.

AS 18.15.320

(a) requires the Department of Health & Social Services to pay for tests ordered under this act.

(b) requires a defendant who is convicted of an offense for which a test was ordered under this act to reimburse the department for the cost of the test. Allows the court to order the Department of Corrections to garnish wages earned in correctional industries to pay for the test.

AS 18.15.330

provides that intentional unauthorized disclosure of information restricted by this act constitutes a class A misdemeanor.

Section 2.

Provides that the act takes effect immediately according to AS 01.10.070(c).

HB 109
SECTIONAL ANALYSIS

"An Act relating to blood tests for persons charged with sex offenses; and providing for an effective date."

Section 1.

Adds new sections to AS 18.15 as follows:

AS 18.15.300

(a) makes a defendant (including a minor) charged with a sexual offense under AS 11.41.410 - 11.41.440 subject to an order of the court requiring testing for HIV and other communicable diseases.

(b) allows the alleged victim, or the prosecuting attorney on behalf of the alleged victim, to petition the court for an order requiring the defendant to be tested.

(c) requires the court to conduct a hearing on a petition filed under subsection (b), and requires the court to order the test if the court finds probable cause that a transfer of bodily fluids took place between the defendant and the alleged victim.

(d) designates the authorized recipients of test results obtained under an order authorized by subsection (c) of this act. Authorized recipients are the defendant, the victim (or the victim's parents or guardian) and the officer in charge and the chief medical officer of the facility in which the defendant is incarcerated.

(e) places time constraints on when the order authorized under (c) of this act may be filed. The test may not be ordered sooner than seven days after the arrest nor more than 90 days after the defendant has been convicted and sentenced. Additionally, a test may not be ordered after a finding favorable to the defendant.

Sectional Analysis

AS 18.15.310

(a) requires that blood drawn for a test under this act be drawn by licensed medical personnel according to AS 08.64.

(b) requires that testing on blood drawn under provisions of this act be conducted by a licensed medical laboratory and according to accepted medical standards.

(c) requires that positive test results be transmitted to the Department of Health & Social Services.

(d) requires test results to be sent to the designated recipients and requires a disclaimer to be attached to test results.

(e) requires the court to order persons who receive the test results to maintain the confidentiality of personal identifying data related to the tests. Provides certain exceptions to this confidentiality: (1) the defendant, and (2) the victim for such disclosures as are necessary to provide for the victim's own health and the health of the victim's spouse, family and household.

(f) prohibits the test results from being used as evidence in a criminal or juvenile proceeding.

(g) provides civil immunity for persons performing the duties authorized by this act.

(h), if the test results are positive, requires the Department of Health & Social Services to provide counseling and testing to the victim; and counseling to the defendant upon request. Further provides that the Department's duty to provide counseling is satisfied if the Department delivers to the victim and the defendant a brochure containing the relevant information, and refers the defendant and victim to the Department for further information.

(i) defines "AIDS" and "counseling." Counseling is defined as providing medically appropriate information including information on the diseases, their treatment and the medical and social implications of the diagnosis and the tests.

AS 18.15.320

(a) requires the Department of Health & Social Services to pay for a test ordered under this act.

(b) requires a defendant who is convicted of an offense for which a test was ordered under this act to reimburse the Department for the cost of the test. Allows the court to order the Department of Corrections to garnish wages earned in correctional industries to pay for the test.

AS 18.15.330

provides that intentional unauthorized disclosure of information restricted by this act constitutes a class A misdemeanor.

AS 18.15.350

provides definitions of terms essential to the act.

Section 2.

Provides that the act takes effect immediately according to AS 01.10.070(c).

Sponsor Amendments to
CS for HB 109(HES)

Offered in House Judiciary
March 17, 1993

Amendment 1:

p. 1, l. 7, after "indictment," add "presentment,"

p. 1, l. 12, after "indictment," add "presentment,"

p. 1, l. 14, after "indictment," add "presentment,"

Explanation:

Article I, section 8 of the Alaska constitution provides that a grand jury may file charges by presentment or indictment. The difference between the two is that presentment is brought from the grand jury's own knowledge or observation without a bill of indictment being laid before it by the government prosecutor. Though presentment is rarely used in Alaska, it is provided for in our constitution. It therefore seems advisable to include it in the bill presently before us.

Amendment 2:

p. 2, l. 1, after "guardian" delete comma and add "of an alleged victim who is a minor or incompetent,"

Explanation:

When the bill was amended in HESS, an agreement was reached between the sponsor and the Department of Law to reword this part of the bill. Part of that agreement included adding this provision for the parent or guardian being able to request the test. The intent of that addition was to cover those situations in which a minor or incompetent person was the victim. As the bill now reads, however, it would seem to allow the parent of an emancipated adult to file a petition. The suggested amendment more accurately reflects the sponsor's intent, and brings the language of proposed AS 18.15.300(b) into line with AS 18.15.300(e) [see p. 2, l. 16 & 17].

Amendment 3:

p. 2, l. 8, after "may rely" add "exclusively"

Explanation:

This amendment is brought at the request of the Department of Law. They would like the language of the bill to indicate clearly that if the court deems probable cause to be adequately demonstrated at the grand jury proceedings or in a preliminary hearing, the court may proceed without an additional hearing.

Amendment 4:

p. 3, l. 31, after "immediate family," delete "or"

p. 4, l. 1, delete the period and add ", or a person in a dating, courtship, or engagement relationship with the victim."

Explanation:

This amendment is brought at the request of the Network on Domestic Violence and Sexual Assault. The existing language of the bill may work well for a victim who is a married woman or one living with a family. But what if the victim lives alone, or is not married, but engaged? This change borrows language from the domestic violence statutes, and closes these potential gaps.

Changes to HB 109 reflected in the blank Committee Substitute presented to the Committee on February 16, 1993

Line numbers refer to the original bill.

p.1, l.7 — adds "indictment, or information" to include the various forms of initiating a felony prosecution.

p.1, l.8&9 — uses more specific language denoting the acts for which the bill allows a petition to be initiated.

This change is to ensure that the statute as amended by HB 109 conforms to Federal guidelines set forth in the Crime Control Act of 1990.

p.2, l.1-6 — requires the court to find probable cause that a crime has been committed under the statutes cited in (a); and that probable cause exists that the crime included sexual penetration as defined in AS 11.81.900(b)(54).

adds a new subsection (d) which requires the court to order a blood test on a defendant if probable cause is found as required in (c).

This change is to ensure that the statute as amended by this bill conforms to the Federal guidelines set forth in the Crime Control Act of 1990.

p.2, l.7 — renumbers this subsection (e); and substitutes "provided" for "sent."

p.2, l.16 — renumbers this subsection (f).

p.2, l.22 — adds a new subsection (g) providing a definition of "disposition favorable to defendant." In the original version, this was found on p.5, l.3.

p.2, l.24 — adds "registered physician assistant" to the list of those authorized to draw blood for the purposes of this section.

This change was requested by the Department of Corrections.

p.3, l.4 — substitutes "provided" for "sent."

p.3, l.30 — deletes the sentence which begins, "If the department delivers a brochure . . ." Adds a sentence which provides for "referral to appropriate health care facilities and support services at the request of the victim."

p.4, l.5&6 — substitutes "HIV symptomatic disease" for "AIDS-related complex."

p.4, l.7 — adds a subsection containing the definition of "HIV." In the original version, this was found on p.5, l.9.

Bill No. HB 109
Bill No.***AST

Date: February 12, 1993

Contact: Joanne F. Lopez
Executive Director
CDVSA

DRAFT

POSITION PAPER - Council on Domestic Violence & Sexual Assault

Title: An Act relating to blood test for persons charged with sex offenses.....

A total of 530 rapes were reported in 1991. Rapes account for 15.5% of all violent crimes. There are concerns for victims who may become infected with human immunodeficiency virus (HIV). Cases have been reported.

The Council on Domestic Violence and Sexual Assault supports the concept of a bill that would allow a victim of sexual assault to learn if her/his assailant is infected with HIV.

The Council supports the concept in HB 109 to test at the time of the arrest and strongly recommends that the testing be conducted once probable cause for a violation in AS 11.41.410 - 11.41.440 has been established. If testing is postponed until after conviction, it take as long as two years to obtain this crucial information.

The Council recommends that the victim not be put through a legal procedure in order to force the blood test of the offender. To do so would re-victimization the victim which is unacceptable. Prosecutors would likely not force the blood testing issue if this were the case in order to save the victim this additional distress since the victim will be needed for testimony in the actual assault litigation.

The Council recommends that the victim be informed that because the offender's blood test is negative, it does not mean that they are safe. The nature of HIV is such that there is an incubation/latency period of six to eight months during which a carrier's blood will not reveal the presence of HIV but they can transmit the virus. Victims need to be aware that they should be (re)tested six to eight months later. The Council would like to see funding for the Department of Health & Social Services to pay for victim testing.

The Council also believes that the legislation should specify how the information will be transmitted to the victim. The Council recommends that the information should be provided to the victim only if the victim (or the victim's legal custodian, if the victim is a minor) wants the information. The information should never be transmitted by letter and the victim, or victim's legal custodian if the victim is a minor, should be allowed to name a designee to receive the information if the victim doesn't want to learn of it directly.

The Council recommends that counseling of victims concerning the results of the alleged offender's blood test need to be handled sensitively. A counseling brochure does not meet this standard. A trained counselor or nurse or other appropriate service provider needs to

POSITION PAPER – COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT

be available to help the victim deal with the situation and to counsel the victim on safe sex and protection of their partner due to the potential exposure.

Since there is a stigma involved with this condition, the Council suggests to consider protecting the confidentiality of HIV positive individuals, and suggests the court be required to order all parties to keep the information confidential.

Willie Kinnebrew, Acting Chair
Council on Domestic Violence &
Sexual Assault

Position Paper

Alaska Women's Commission
Post Office Box 82977
Fairbanks, Alaska 99708

Approval By Alaska Women's Commission
House Bill 109

This bill would require blood tests from persons charged with sexual offenses and provide an avenue for victims of the sexual assault to receive the results of those tests.

HB 109 provides victims of sexual assault a means to determine whether they have been exposed to communicable diseases. At the present time privacy laws prohibit this testing of alleged perpetrators of sexual assault or disclosure of test results. Victims have no recourse to determine if they have contracted a sexually transmitted disease. This bill would provide that recourse.

The Alaska Women's Commission supports HB 109. Victims of sexual assault are innocent people whose person and whose own right to privacy have been violated. The statutes should provide them access to the medical information about their attacker necessary to determine any medical treatment needed to preserve their physical – and mental – health. Sexual assault victims need a great deal of help and support for recovery. HB 109 provides an important remedy without compromising legitimate protection of the alleged attacker's rights.

The proposed bill appears to adequately address both the necessary protections and practical means of achieving the desired results. The Alaska Women's Commission supports HB 109 as written.

Alaska Women's Commission

Barbara B. Tyndall

Barbara B. Tyndall
Chair

POSITION PAPER— ALASKA WOMEN'S COMMISSION

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF EPIDEMIOLOGY

3601 "C" STREET, SUITE 576
P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249

WALTER J. HICKEL, GOVERNOR

INFECTIOUS DISEASES
AIDS/STD
TUBERCULOSIS
IMMUNIZATION 561-4406
CHRONIC DISEASES
DIABETES
INJURY CONTROL

February 8, 1993

Representative Brian Porter
State Capitol, Room 118
Juneau, AK 99801-1182

Dear Representative Porter:

Per your request, enclosed are materials related to HB 109 on the issue of mandatory HIV testing of persons charged with sexual offenses.

If our office can be of further assistance, please call.

Sincerely,

Penelope M. Cordes, Ph.D.

Penelope M. Cordes, Ph.D.
AIDS/STD Program

Enclosure

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF EPIDEMIOLOGY

3601 "C" STREET, SUITE 576
P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249

INFECTIOUS DISEASES
AIDS/STD
TUBERCULOSIS
IMMUNIZATION 561-4406
CHRONIC DISEASES
DIABETES
INJURY CONTROL

TECHNICAL ISSUES CONCERNING HOUSE BILL NO. 109

"An Act relating to blood tests for persons charged with sex offenses."

Summary

HB 109 provides for court ordered serologic testing for HIV and other communicable diseases of: (a) defendants charged with sexual assault; and (b) minors for whom a petition is filed alleging sexual assault.

HB 109 provides for notification of the results of such tests to:
(a) the defendant or minor; (b) the alleged victim, designee, or parent/guardian of a minor; and (c) the officer in charge and chief medical officer of the facility in which the defendant or minor is incarcerated or detained.

Discussion

The implied purpose of HB 109 is to obtain information related to an alleged sexual assault perpetrator's infectious disease status, especially HIV infection, and convey this information to alleged victims so that they may take measures to preserve their health and be spared groundless fear. The intended benefits to the victim cannot be achieved through mandatory serologic testing of the alleged perpetrator as proposed by HB 109.

Testing of the perpetrator will not give the victim information about her/his own health status and will not preclude the need for the victim to receive counseling and testing for sexually transmitted disease including HIV for the following reasons:

- If the suspect tests **negative** for HIV antibodies, it is not conclusive proof that the suspect is free of HIV infection. A person who is recently infected may not develop detectable HIV antibodies (seroconvert) for up to 6 months. Seroconversion for Hepatitis B ranges from two weeks to 6-9 months. Serologic testing for syphilis may also result in a false negative, i.e., the person is infected but it is not detected by the blood test.

- If the suspect tests positive for HIV antibodies, this does not give any information on the HIV status of the victim. **The risk of transmission of HIV through sexual assault is not known.** There has been one documented case of HIV transmission following a rape. There are anecdotal reports of victims of rape who are HIV positive, but the source of their HIV infection is not known. The theoretical risk of transmission of HIV from one episode of heterosexual intercourse is estimated to range from 1 in 100 to 1 in 1,000. While HIV can be transmitted in a single exposure, studies have shown that persons have remained uninfected despite multiple exposures over a prolonged period of time. Similarly, if the suspect tests positive for syphilis or Hepatitis B, this does not mean that the victim has been infected. Transmission depends on the stage of the illness in the source person and factors specific to the person exposed.

Thus, individualized counseling services for the victim regarding risks, safer sex, testing, and referrals for emotional support and medical care must be provided in order for the victim to know her/his own status, to make decisions about health care, and to cope with the trauma of assault. Reliance on perpetrator testing exaggerates the benefits of testing the source person and detracts attention from the counseling and medical needs of the victim.

Regardless of knowledge of the alleged perpetrator's HIV status, the victim should be counseled about baseline HIV testing to establish for the victim her/his HIV status before the assault, and retesting at intervals up to 6 month post-exposure to cover the "window period", i.e., the time from infection to seroconversion.

There is presently no cure for HIV disease nor treatment during the acute and early asymptomatic stages. Prophylactic use of AZT following a significant exposure to HIV in a health care setting is experimental and has not been proven effective in humans. Prophylaxis must begin within 24 hours of exposure. With currently available technology, reliable HIV test results on an alleged perpetrator would not be available within this time frame to assist a victim in making a decision about initiating prophylaxis.

Section 18.15.310(c) states that "copies of test results that indicate exposure to or infection by HIV or other communicable diseases shall also be transmitted to the department". This section needs clarification. To which department does this refer and what is the justification? HIV is not a reportable disease in Alaska. Disclosure of test results should be strictly limited to as few specifically designated persons as possible. The greater the number of persons with access to confidential information, the greater the possibility of breach of confidentiality and liability.

HB 109 goes beyond requirements of the federal Crime Control Act of 1990 which requires that states enact legislation for court ordered HIV testing of persons <u>convicted</u> of a sexual assault, or else lose 10% of their federal funding for public safety. Mandating HIV testing on persons <u>charged</u> with a sexual offense means performing an invasive medical procedure (phlebotomy), without consent, on a person whose guilt has yet to be determined. Challenges to the constitutionality of mandatory testing of either charged or convicted sexual offenders, and the attendant legal costs, should be anticipated.

The Section of Epidemiology has, in the past, opposed legislation similar to H.B. 109. These types of bills: provide no benefit in disease prevention nor dependable relief of fear and anxiety for victims of sexual assault; potentially infringe upon constitutionally protected rights to privacy; and deflect resources away from more appropriate medical and emotional supports for victims of sexual assault.

Problems with the language of certain sections of HB 109

Section 18.15.300(c): Delete reference to saliva and "other bodily fluids". Sexual transmission can occur through infected blood, semen, and vaginal secretions. Saliva and other external bodily fluids including sweat, vomitus, tears, urine, feces, and nasal secretions do not transmit HIV.

Section 18.15.300(e)(1): It is not clear what the reason is for this stipulation. There is no medical justification for a 7 day delay in testing.

Universally change "communicable" to "sexually transmitted disease" since the bill is for detection of diseases transmitted through a sexual assault.

Section 18.15.310(e): delete "immediate family, or persons occupying the same household as the victim." This phrase implies erroneously that these persons are at risk of acquiring HIV infection from the victim. HIV is not transmitted by non-sexual, family and household contact.

Section 18.15.310(h): The delivery of a brochure on HIV and AIDS to a person just informed of an HIV positive test result is an absolutely inappropriate way to discharge the professional and [illegible] responsibility to counsel a patient receiving a positive HIV test result and it would violate [illegible]olicy on HIV post-test counseling and the standard of practice as established by the [illegible] other professional bodies.

Section 18.15.310(h)(i1): delete "or AIDS related complex". HIV symptomatic disease is the term currently used to refer to the stage of the illness formerly referred to as AIDS related complex.

February 1993

usly underestimated." The study was conducted in Kigali, Rwanda. WHO's clinical definition of AIDS requires an HIV-positive patient to have at least two major and one minor symptom of the disease over the last year. Dr. Christina P. Lindan, a UCSF researcher and lead author of the study, published in the Feb. 16 issue of the *Annals of Internal Medicine*, said that based on the study, the true number of HIV-related deaths — among both males and females — in the central African country may be two to three times the 2,056 deaths officially reported by Rwanda in 1990.❑

Criminal Transmission

Testing Sex Offenders for HIV Can Create Dilemma, Group Says

State legislators are faced with a dilemma when considering the issue of HIV testing of offenders in sexual assault cases, according to a report from the National Conference of State Legislatures.

"Legislators may want to consult with legal counsel, rape victim assistance groups, other relevant community organizations, and public health personnel when considering appropriate responses," said a report of the organization, "Testing Sex Offenders for HIV," made public March 6.

The legal and practical considerations of testing must be confronted, while remembering that other options to legislation also exist, NCSL said. The group noted that as of last May, 23 states had approved laws concerning HIV testing of sexual offenders, and that some 70 bills were being considered in 26 states during the 1991 legislative sessions.

In the United States, an average of some 155,000 women annually have reported being raped, NCSL said. While they suffer physical and emotional trauma, the group said, "when the fear of being infected with [HIV] is added, the emotional burden increases. Because the victims not only have been assaulted but also possibly threatened with a deadly disease, they often want to know if their assailant is infected with HIV, and public senument tends to support requiring the accused to undergo HIV testing."

A 1990 federal law, NCSL said, pressures states to require HIV testing of convicted sex offenders at the victim's request or lose 10 percent of their victim's assistance funding [although the stipulation does not go into effect until fiscal 1995].

A Task of Balancing

"The states have the task of balancing the rights of victims and defendants," the report said.

Among practical considerations of HIV testing, NCSL said, is the risk of transmission of HIV from a single assault — "at most a 1-in-500 chance . . . from a single male-to-female exposure if the male is infected." Other practical considerations, the group said, are the cost and reliability of HIV tests and the usefulness of testing.

"Sexual assault victims might want information about the accused offender's HIV status for two primary reasons: concern for their own health, and concern for the health of their sex partners," NCSL said, adding that the victim also might request AZT treatment, which may delay the progression from HIV infection to AIDS.

But, NCSL said, time is also an issue and that "waiting until conviction, which can take up to three years, decreases the usefulness of the information to the victim. Testing all accused offenders may solve this problem but raises legal questions. If the offender is not tested promptly, then testing the victim provides at least as much useful information to the victim, because it may show the actual presence or absence of the virus."

Legal Considerations

Regarding legal considerations, NCSL said that "being infected with HIV is not a crime; infection only becomes relevant to criminal proceedings in the cases involving reckless endangerment, such as assault with intent to infect or deliberate transmission of the virus."

An HIV test is a "search" under federal law and requires a balancing test between the government's need to conduct the search and the invasion which the search entails, NCSL said.

Privacy is another legal consideration, NCSL said, adding that "if the defendant is tested before conviction, it may prejudice the presumption of innocence. On the other hand, if testing is restricted only to convicted sex offenders, it fails to allow for early medical intervention and provides little physical or emotional benefit to the victim."

Among "other options," the group said, are "an immediate assessment of the risk status of the accused offender, with or without HIV testing, to the extent possible within the legal limits of confidentiality."

Copies of the report are available for $5, plus $3 for shipping and handling, from the NCSL Book Order Department, 1560 Broadway, Suite 700, Denver, Colo. 80202; (303) 830-2200.❑

Copyright © 1992 by Buraff Publ
0887-1493

Our Files (from pg. 6)

EXHIBIT 5

MANDATORY/AUTHORIZED HIV TESTING FOLLOWING CERTAIN OFFENSES

FOR SEX OFFENSES FOLLOWING ARREST	FOR SEX OFFENSES FOLLOWING CONVICTION	FOR SEX OFFENSES FOLLOWING A GUILTY PLEA	FOR SEX OFFENSES NOT SPECIFIED	FOR DRUG OFFENSES
Arkansas	California	Georgia	Idaho	Idaho
Florida	Colorado	Maryland	Iowa	Illinois
Nevada	Florida		Louisiana	Indiana
Ohio	Illinois		Minnesota	
Oklahoma	Indiana		Wyoming	
South Dakota	Kansas			
Tennessee	Maine			
	Michigan			
	Texas			

MANDATORY/AUTHORIZED HIV TESTING FOR INSTITUTIONALIZED POPULATION

FOR MENTAL INSTITUTIONS	FOR PRISONS		
Missouri	Alabama	Illinois	North Dakota
Texas	Arizona	Iowa	Ohio
Wisconsin	Colorado	Kentucky	Rhode Island
	Connecticut	Maryland	South Carolina
	Delaware	Michigan	Texas
	Florida	Missouri	Utah
	Georgia	Montana	Wyoming
	Idaho	Nevada	

HIV TESTING WITHOUT CONSENT

FOLLOWING A SIGNIFICANT EXPOSURE IN A HEALTH CARE SETTING		FOLLOWING A SIGNIFICANT EXPOSURE IF BLOOD SAMPLE PREVIOUS AVAILABLE	IN A MEDICAL EMERGENCY OR WHEN MEDICALLY INDICATED	
Arkansas	Missouri	Connecticut	Arkansas	New Hampshire
Colorado	Nebraska	Louisiana	Connecticut	New Mexico
Delaware	New Mexico	Montana	Delaware	North Carolina
Florida	Ohio	Pennsylvania	Hawaii	Ohio
Hawaii	Oregon	Rhode Island	Idaho	Pennsylvania
Idaho	Texas	Wyoming	Iowa	Rhode Island
Iowa	Washington		Kentucky	West Virginia
Illinois	West Virginia		Montana	
Maine	Wisconsin			
Michigan				

Source: AIDS Policy Center, Intergovernmental Health Policy project

HIV testing. Historically, such tests have been voluntary and in most states, written informed consent prior to testing is required. There have always been exceptions, however — most notably in the areas of blood and organ donations, as well as in medical emergencies. As policy in this area has evolved, non-voluntary HIV testing, particularly among institutionalized populations, has increased.

Non-voluntary HIV testing can be classified in two ways. First, there are some state laws that mandate/require/authorize testing based on an individual's specific behavior. Second, there are laws that provide for testing without consent under certain conditions.

WHICH STATES REQUIRE HIV TESTS FOR INJECTION DRUG USERS ?(EXHIBIT 5)

Mandatory HIV testing of people convicted of drug offenders is specially prohibited in **California**. By way of contrast, **Idaho** and **Indiana** mandate testing for anyone convicted of drug-related charges; and **Illinois** mandates it for all inmates who have a history of injection drug use, before they can be released from prison; and **Indiana** requires anyone convicted of a drug offense take an HIV test.

WHICH STATES REQUIRE HIV TESTS FOR SEX OFFENDERS? (EXHIBIT 5)

Another group that has been targeted for mandatory HIV testing is sex offenders. Often, laws are different for prostitutes and

See *From Our Files* page 8

From Our Files (from pg. 7)

for other sex offenders. Also, a distinction is frequently made between people who have been arrested — as opposed to convicted — of a sexual offense.

Twelve states mandate HIV testing for individuals convicted of any sexual offense (CA, CO, IL, IN, MI, ND, OR, RI, SC, VA, WA, WV). Florida distinguishes between prostitution and other sexual offenses: testing is mandatory for prostitutes who have been convicted, but for sex offenses where there has been a transfer of body fluids, it is mandatory when a person is charged with such an offense. In Tennessee, testing is mandatory for a person arrested for prostitution; in Nevada and Ohio, it is mandatory upon arrest for any sexual offense. HIV testing is also mandated for sexual offenses in Iowa and Minnesota, and in Georgia and Maryland, if the person pleads guilty to the offense.

Several states authorize HIV testing after an arrest for a sexual offense (Arkansas, Michigan, Oklahoma, and South Dakota) or upon conviction (Kansas, Maine, Michigan, and Texas. In Louisiana and Wyoming HIV testing is authorized for sex offenses, no distinction is made between arrest and conviction.

Mandatory testing for prisoners is required in 23 states. In some cases, simply being incarcerated is sufficient to authorize or mandate HIV testing. In others, testing is mandated in specific circumstances, or when a physician or prison official believes it to be necessary. Three states (Missouri, Texas and Wisconsin) mandate testing for individuals in mental institutions, while in Oregon and West Virginia, the courts can act on a patient's petition and mandate testing for a health care worker in cases where there has been a significant exposure to body fluids.

WHICH STATES HAVE HIV TESTING WITHOUT CONSENT FOLLOWING A SIGNIFICANT EXPOSURE? (EXHIBIT 5)

States that allow HIV testing without consent under certain circumstances have tended to target their laws on notification and exposure in the workplace — particularly in medical settings.

For example: In cases where health care workers or emergency personnel have been significantly exposed to a patient's blood, HIV testing without consent is authorized in 15 states (AR, CO, DE, FL, HA, ID, IA, IL, MI, MO, NE, NM, TX WV, WI). If there is already a sample of the potential source patient's blood available for testing, testing without consent may proceed following a significant exposure in six states (CT, LA, MT, PA, RI, WY). And if, following a significant exposure, the potential source patient refuses consent for HIV testing, the court can require HIV testing in four states (ME, OH, OR, WA).

HIV testing without consent is also allowed in several states in medical emergencies, if the test is needed for diagnostic or treatment purposes, or if there is a threat to public health. If consent cannot be obtained because the patient is unable or unwilling, and if no agent of the patient is available to provide consent, testing will be done without consent in 16 states (AR, CT, DE, HA, ID, IA, KY, MI, MT, NH, NM, NC, OH, PA, RI, WV).

Consent for testing is implied when a patient has entered into medical treatment if: a physician determines a test is needed because the patient is at high risk for HIV and there is medical need (Alabama); HIV status is needed for further medical treatment (Arkansas); in the physician's judgement the test is medically needed (Illinois); or the test is necessary for diagnosis or treatment (Indiana). West Virginia allow testing without consent if a physician has cause to believe the test would be positive and knowledge of the patient's HIV status is medically necessary. And in Louisiana, consent is not required when in the medical opinion of the physician requesting it would be contraindicated, or in cases involving a child's medical treatment.

— Kate Cauley

INTERGOVERNMENTAL HEALTH POLICY PROJECT

Intergovernmental AIDS Reports is published six times a year by the AIDS Policy Center at the George Washington University Intergovernmental Health Policy Project. Its objective is to report on significant and exemplary AIDS-related program and policy initiatives occurring within state, county and municipal governments nationwide, and to review legislative and policy developments at the federal level which have an impact on the states. Important policy research findings, as well as interviews with state and local policymakers, will also be featured.

Intergovernmental AIDS Reports is made possible by support from the Ford Foundation and the Robert Wood Johnson Foundation. All material in the newsletter can be reproduced free of charge, with attribution to Intergovernmental AIDS Reports. Clippings of published material would be appreciated.

The Ford Foundation also supports the Intergovernmental AIDS Resource Network which serves the information, research and technical needs of state, county, municipal and tribal elected officials who are responsible for shaping solutions to the many public policy issues emanating from the AIDS epidemic. Organizations represented in the Network include: the National Association of Latino Elected Officials; the National Black Caucus of Local Elected Officials; the National Black Caucus of State Legislators; the National Conference of Black Mayors Inc.; and the National Congress of American Indians. Activities of these organizations are regularly reported in the Intergovernmental AIDS Reports, however, information presented and views expressed in the newsletter should not be interpreted as representing the official position of any of the organizations which comprise the Intergovernmental AIDS Resource Network.

For subscription information and rates please call or write Molly Stauffer:

Intergovernmental Health Policy Project
2021 K Street, N.W. Suite 800
Washington, D.C. 20006
Telephone: 202-872-1445
FAX: 202-785-0114

Mandatory HIV testing for sex offenders Helping or further harming rape victims?

The possibility that a rapist infected with HIV will transmit the deadly virus to his victims has emerged as one of the most frightening aspects of the AIDS epidemic. As the Presidential Commission on the HIV Epidemic noted in its 1988 report, it has "added a new and disturbing specter" to the problems faced by sexual assault victims. Indeed, several studies have documented that women are both aware of and concerned about the risks of contracting AIDS or the virus that causes it as a result of being raped.

Last November, in an effort to address the concerns of rape victims who may be exposed to HIV, Congress passed the Martin Amendment to the Comprehensive Crime Control Act of 1990. Sponsored by former Rep Lynn Martin, (R-IL), the amendment stipulates that states will lose 10 percent of their victim assistance funds if they do not mandate HIV testing for a convicted sex offender at the rape victim's request. It also requires that test results be disclosed to the victim and the convicted defendant. According to Martin, the amendment is important to ensure that rape victims do not have to live in fear that a rapist may have exposed them to HIV infection.

Even before the federal amendment was passed, nearly half the states had laws on the books mandating or allowing HIV testing for convicted sex offenders (or in some cases, individuals charged or arrested for a sexual offense) and providing for the subsequent disclosure of test results to the victim. As of May 6, more than 70 sex offender-rape victim related bills had been proposed in 26 states. (See Box, Sex Offenders).

RAPE AND HIV TRANSMISSION

The risk of contracting HIV from a rapist depends on several factors, the most obvious of which is whether the assailant is himself infected with HIV. According to studies reported in the *Journal of Interpersonal Violence* and the *Journal of Emergency Nursing* in 1990, other factors include the number of assailants, the size of the inoculum per exposure and the number of exposures, the virulence of the viral strain, the kind of assault (vaginal, anal or oral) and the victim's susceptibility to infection.

Statistics documenting heterosexual transmission of the virus serve as a basis from which to hypothesize the rate of HIV transmission from rape. Several studies calculate the per contact infectivity for male-to-female HIV transmission at less than or equal to 0.2 percent. If, as the Centers for Disease Control has said, local trauma that dissolves mucosal barriers to infection may increase a woman's risk of infection, the potential for a rapist with HIV to infect his victim is estimated to be greater than 0.2 percent.

TO TEST OR NOT: DEBATING MANDATORY HIV TESTING FOR SEX OFFENDERS

At first glance, the proposal to have convicted sex offenders undergo mandatory HIV testing and disclose the test results to the victim seems understandable and just. The issue is, however, complex and controversial, even among victims' rights organizations and women's groups advocating for rape victim-focused policies.

Arguments Supporting Mandatory Testing

Advocates of mandatory testing assert that the right of rape victims to know a convicted, and in some cases charged, offender's HIV status supercedes the offender's right to privacy. Florida's 1990 sex offender testing law — one of the nation's most stringent — declares, for example, that victims of sexual offenses are entitled to know at the earliest possible opportunity whether the person charged with the crime has tested positive for HIV. According to Pat Gleason, general counsel in the Florida Attorney General's Office, a key supporter of the law, "The Attorney General felt that it was inequitable that rape victims would not be able to get access to a convicted or charged offender's test results."

In the view of Mary Ann Largen, executive director of the National Network for Victims of Sexual Assault (NNVSA), mandatory testing accomplishes two goals: (1) it prevents convicted offenders from abusing the criminal justice system by bargaining for a lighter sentence if they volunteer to be tested; and (2) it provides a woman who has contracted HIV infection from a rape with evidence, should she wish to bring a civil suit against a convicted rapist. Largen acknowledges that mandatory HIV testing for convicted rapists does not preclude the need for victims to be tested for the virus as well.

Other supporters of mandatory testing for sex offenders contend — as does a 1991 Georgia law — that testing and disclosing test results are important to a victim's "psychological and physical well-being." Finally, some proponents posit simply that if an offender's blood is already available to be tested for evidence of other STDs, it might as well be tested for HIV so that the victim can act, if need be, to protect her own health.

Arguments Against Mandatory Testing

Critics of mandatory testing say that by focusing on the offender, these laws divert attention from the psychological, medical and financial needs of rape victims. In their view, victims' interests would be better served through victim-focused services such as free anonymous HIV testing, counseling and early intervention.

Opponents counter many of the arguments made by mandatory testing supporters. They argue, for example, that mandatory testing for sex offenders does not provide victims with timely and reliable information about the risks of infection. Because of the potential for false test results and the delay in antibody formation (anywhere from three to six months), the American Public Health Association (APHA) says that relying on an offender's HIV test results may not be the appropriate standard of care for rape victims. Rather, the APHA recommends that victims be encouraged to seek HIV testing and counseling as soon as medically indicated, so that they may benefit from appropriate medical attention if they have become infected. Despite the lack of data regarding the efficacy of using AZT prophylactically, some medical experts recommend administering the AIDS drug within 48 hours of potential exposure. Thus, time is critical for a victim who chooses to take AZT after being raped.

Opponents also argue that mandatory testing is a misdirected and unrealistic ap-

proach to addressing the needs of rape victims. Susan Mooney of the National Coalition Against Sexual Assault (NCASA) notes that only one in ten rapes is reported to the criminal justice system and only 5 percent of rapes result in conviction. Laws that mandate HIV testing of rapists as a means of protecting the rights of victims, she contends, do not address the medical or psychological needs of the majority of individuals who are raped but do not report the assault to law enforcement authorities.

Marian Rosenberg, a former cooperating attorney at Lambda Legal Defense and Education Fund Inc., argues that mandatory testing misleads victims and in fact, provides no useful information to help them assess their needs for medical attention or civil restitution. Moreover, she notes, because the waiting period for convictions can range from six months to three years, rape victims who are eager to know their assailant's HIV test results are more likely to agree to requests to plea bargain for reduced charges or sentences in order to receive more timely test results.

Noting that empowerment is integral to psychological recovery from rape, rape crisis counselors assert that empowerment is best facilitated by restoring the victim's control over decisions about her life including if, when and how (anonymously or confidentially) she will be tested for HIV — not by making her psychological recovery contingent on the test results of her offender.

Finally, countering assertions that HIV testing should be treated like STD testing, Elizabeth Cooper, staff attorney of the American Civil Liberties Union (ACLU) AIDS Project, said that HIV is unique and distinguishable from other STDs in two important ways: (1) unlike STDs such as gonorrhea, chlamydia and syphilis, which are treatable, HIV is still incurable, and (2) HIV infection and AIDS are highly stigmatized diseases that can trigger discrimination on the basis of actual or perceived status.

RESPONDING TO RAPE AND HIV INFECTION: STATE LAWS FROM 1986 TO 1991

At least 24 states have moved to regulate HIV testing for alleged or convicted rapists and to disclose test results to rape victims. In the main, the laws mandate or allow alleged or convicted offenders to be tested if: (1) the crime involves transmission of body fluids from one person to another; (2) a court determines that the offender may have significantly exposed the victim to HIV infection; or (3) the victim requests that the convicted sex offender be tested for HIV infection.

Testing Alleged and Convicted Sex Offenders

Presently, ten states (CA, FL, IL, IN, ND, OR, SC, TN, VA and WV) mandate HIV testing for convicted sex offenders, and four others (KS, MI, TX and WA) allow a court to order testing.

Mandating HIV testing for people who have been arrested but not yet tried and

1991 HIV/AIDS bills for sex offenders

Mandatory HIV testing for convicted, and in some cases charged, sex offenders, continues to be the major focus of state AIDS legislation. As of May 10, 70 sex offender testing bills had been introduced in 26 states, making it the most visible AIDS issue of the 1991 sessions. The bills can be categorized as follows:

MANDATORY TESTING FOR CONVICTED SEX OFFENDERS

o Legislation introduced in AL, CT, DE, IA, MD, MA, MS, NH, NJ, PA, SD, TX, VT and WI would mandate HIV testing for convicted rapists. All of the bills allow a rape victim to be notified of a convicted offender's HIV test results.

TESTING INDIVIDUALS ARRESTED FOR SEXUAL OFFENSES

o Bills in AR, DE, GA, HI, MD, MT, NJ, NY, OK, SC and WA would mandate or allow HIV testing for individuals arrested for sexual offenses. Maryland's bill requires that the defendant's blood sample to be destroyed if he is not convicted of rape. Four states (IL, MD, SC and SD) allow rape victims to request that a charged or arrested defendant be tested for HIV infection and allow the test results to be disclosed to the victim. Bills in New York and Oklahoma allow for the notification of a rape victim of the test results if she requests it.

o Legislation in Delaware and New Jersey would allow individuals arrested for sexual offenses to be tested for HIV voluntarily. For defendants who object to testing in Delaware, a judge decide would decide whether the test is to be performed.

o An Indiana bill would mandate HIV testing for individuals arrested for rape if the victim becomes pregnant as a result of the rape.

HIV COUNSELING FOR RAPE VICTIMS

o Bills in five states (AL, AR, GA, PA and SC) mandate providing rape victims with "appropriate" counseling upon disclosure of a tested individual's test results.

o A Maryland measure requires institutions or physicians treating rape victims to inform them of anonymous HIV testing sites and counseling centers. A New Jersey bill requires the Commissioner of Health to develop a testing program for rape victims and a counseling program for victims who test positive for HIV infection.

PAYING FOR HIV TESTING AND COUNSELING FOR RAPE VICTIMS

o A bill in New York amends existing law to include exposure to HIV within the definition of "out-of-pocket loss" for compensating rape victims for the costs of testing, counseling and prophylactic treatment prescribed by a physician. Legislation introduced in South Dakota pays for voluntary HIV testing for rape victims if the rape has been reported to the state.

CRIMINAL RECORDS AND PROCEEDINGS

o Bills in Iowa and New Jersey provide that a convicted rapist's positive test results will become part of his criminal history record. Iowa's bill would allow this information to be considered in sentencing. A bill in Georgia would allow the court ordering the arrested individual's HIV test to make the report a part of the criminal record and consider it in granting bail and imposing a sentence, though the report would be confidential. A South Dakota bill would prohibit a defendant's test results from being used to establish his guilt or innocence of the crime. And a Vermont bill would allow the fact that a defendant has been voluntarily tested for HIV to be admissible in sentencing if he has been convicted of the offense.

convicted of a crime raises serious legal and constitutional questions. According to the ACLU's Cooper, the constitutional questions include violations of the presumption of innocence until proven guilty; rights to unwarranted search and seizure; and rights to privacy. As an alternative to mandatory testing, the APHA has proposed that HIV testing should be offered to individuals arrested for sex offenses since their behaviors may place them at high risk for HIV/AIDS.

Despite concerns about constitutionality, four states (CO, FL, NV and OH) — mandate HIV testing for individuals charged or arrested for a sexual offense under specified circumstances, and six others (AR, GA, ID, MI, TX and VA) allow such testing. Individuals arrested in Arizona must consent to testing and release of test results before HIV testing may be performed.

Regulating the Use of Confidentially Disclosed Information

Under most state laws, confidentiality provisions prohibit HIV test results from being disclosed to anyone other than the offender himself, the rape victim (or her parents or legal guardian if she is a minor) and designated authorities such as local health or corrections officials. Five states further regulate the use of confidential information. California's law, for example, allows victims to disclose test results as deemed necessary — such as in a civil proceeding — but prohibits the results from being used in criminal proceedings. Four other states — FL, GA, OH and TX — prohibit the fact that the test was performed or the results to be disclosed in criminal proceedings.

HIV/STD Counseling and Testing for Rape Victims

Nine states (AR, CA, FL, GA, IL, IN, KS, MI and MN) mandate HIV counseling for rape victims upon disclosure of the offender's HIV test results. This means that rape victims must wait until the offender, assuming that he is charged or arrested, is convicted and tested before the victims would receive counseling.

Only California has legislated counseling for rape victims unrelated to the disclosure of an offender's HIV test results. Under the law, county health officers must establish counseling programs for sexual offense victims who choose to be tested for HIV infection. California and Minnesota also require that rape victims be notified about the risks of HIV exposure. California's Health Department has been directed to develop a brochure about exposure to HIV infection for rape victims, while Minnesota's law requires hospitals to provide written notice about STDs to anyone receiving medical services who reports or shows evidence of a sexual assault.

No states provide HIV testing for a rape victim or reimburse a victim for the costs of testing except Missouri, where the Health Department pays for testing if the convicted sex offender tests positive for HIV.

ANALYZING SEX OFFENDER TESTING LEGISLATION

The frequency with which states have passed and continue to introduce sex offender testing legislation suggests that this legislation may be more of an emotional response to a very sensitive and complex issue, rather than a rational or carefully researched response. According to Lisa McGiffert, Legislative Coordinator of the Texas Senate Committee on Health and Human Services, Texas' 1987 law — the first to allow a rape victim to request that an accused offender be tested for HIV infection — was the result of a specific incident brought to a Senator's attention in which a rape victim in Fort Worth, Texas was prohibited from requesting that an alleged rapist be tested for HIV infection. The bill, which was discussed on the House floor was added as an amendment to the state's Penal Code but was never the subject of a legislative hearing or staff analysis.

In formulating Arizona's 1990 victim's rights and sex offender testing law, Jan Kenney, former co-chair of Arizona's Governor's Task Force on AIDS, cautions that it was important to have thoroughly researched the ramifications for rape victims of testing sex offenders for HIV before presenting the issue to the legislature. Kenney notes that involving state policymakers and community groups such as victims' rights organizations in ongoing debates and discussion on HIV infection and rape was one of the most positive aspects of Arizona's legislative process.

Most policymakers and victims' rights groups agree that laws and policies must directly address the needs of rape victims but part company over how those needs may best be met. For example, the Center for Women Policy Studies (CWPS) recommends that state and federal laws and policies should develop free, voluntary and anonymous HIV testing and counseling programs and services for rape victims. According to Kathleen Stoll, Director National Resource Center on Women and AIDS, "What good is it for a rape victim to know that a rapist is HIV positive if she cannot afford to pay for her own HIV testing, counseling or medical care?"

However, Largen of the NNVSA responds, "I'm not sure that requiring states to pay for a victim's HIV testing is an alternative that might help a rape victim; rather, it may be more harmful in the long run [in terms of a victim's right to privacy]." Largen believes that promulgating proper guidelines for training rape crisis counselors may be a more effective way of addressing the needs of rape victims. Although devoted to the same goal — providing for the best interest of rape victims — Stoll's and Largen's arguments exemplify the complexity of this issue.

Because the issue of rape and HIV infection is complex, states may wish to consider establishing commissions or task forces to develop the most effective way to address the medical, psychological, and financial needs of victims who may contract HIV infection as a result of a sexual assault. A well-balanced approach would, consistent with the 1988 Presidential Commission on the HIV Epidemic's recommendation, consider "both the emotional impact of an assault and the possible exposure to HIV." It would also "balance the rights of the victims to be treated with fairness and dignity with the due process rights of the perpetrators."

The Commission warned, "the victims of sexual assault deserve consideration and must be given attention and support so that they will not be forgotten in the tragedy surrounding the HIV epidemic." Focusing solely on the test results of charged or convicted sex offenders without concomitant focus on rape victim-focused services might in fact succeed in making rape victims the forgotten individuals in the HIV/AIDS epidemic.

by Lisa Bowlegs

percent of the cases and IV drug use among heterosexuals, 11 percent. People who had practiced both homosexual risk behaviors and used IV drugs made up 1 percent of cases.

Looking as hospital practices, the survey revealed that 28 Illinois responding hospitals had adopted confidentiality policies for HIV/AIDS patients, 20 had developed specialized treatment policies for PWAs and 26 had policies that dealt specifically with HIV/AIDS infected employees. Twenty-seven of the 34 responding hospitals offered some type of AIDS or HIV-related community education, 25 offered individual counseling and support services and five offered group counseling and support.

DIVISIONWIDE VARIATIONS

Across Division 4, Indiana hospitals reported treating the smallest number of patients: 99. Wisconsin and Michigan reported treating 107 and 188 respectively. Of the 114 responding hospitals throughout the division, the average number of PWAs treated per hospital was 14, with Wisconsin representing the low end of the range at six patients per hospital. Hospitals in Michigan reported the highest average days per patient per year (25.5 days) where Indiana reported the lowest (9.2 days). Average length of stay was highest in Michigan (16.1 days), and Ohio claimed lowest average length of stay (12.0 days). Michigan and Wisconsin led Division 4 in terms of hospitals that had developed AIDS specific policies for PWAs. In Indiana, 90 percent of the responding hospitals had developed HIV/AIDS policies for infected employees (See Table 1, pg. 10).

Persons engaged in homosexual risk behavior represented the largest number of infected patients at reporting hospitals in Division 4, although the range — from 50 percent in Indiana to 74 percent in Illinois — was quite broad. Many of Indiana's PWAs (38 percent) were IV drug users, compared to only 12 percent in Illinois and 15 percent across the division. Throughout Division 4, 3.6 percent of PWAs treated at responding hospitals were either children of or sexual partners of individuals in other risk group categories.

Of the PWAs treated in Ohio and Michigan, 74 per cent were white, compared to Michigan and Illinois where half of the PWAs were white. In Michigan, 41 percent of patients were black, compared to 32 percent nationally and 29 percent overall in the North Central Division. Throughout the division, 95 percent of the PWAs were male, with the exception of Michigan, where 13 percent were female (See Table 2, pg. 10).

Intergovernmental AIDS Reports will continue to present NPHHI highlights from the 1988 U.S. Hospital AIDS Survey, focusing on the scope of the epidemic in different Census Divisions and states.

1991 legislative initiatives address broad range of issues

Five months into the 1991 legislative sessions, HIV/AIDS-related bills have been introduced in 45 of the 46 states meeting this year. In addition, eight states have revised or amended existing AIDS and HIV-related laws.

The more than 400 bills introduced to date cover a broad range of areas including: testing of sex offenders (26 states); discrimination protections (19); AIDS education and prevention (18); worker notification and exposure (18); victims' access to HIV test results (17); confidentiality (16); HIV reporting requirements (15); criminal penalties for knowingly exposing another person to the virus (14); testing of health care workers (9); exceptions to informed consent (7) testing of prisoners (7); pediatric AIDS (7); testing of blood and organ donations (7); partner notification (6); patient care (5); testing of marriage license applicants (5); AIDS drug reimbursement (4); women and AIDS (4); testing of hospital patients (3); classification of HIV infection (3); and testing of food handlers (2). Single bills introduced address the areas of isolating HIV-infected psychiatric patients, testing newborns, testing immigrants and the availability and distribution of condoms.

HIGHLIGHTS

Although most of legislation introduced addresses familiar issues, frequently revising or amending already existing law, a number of bills represent significant changes in the public health policy of a state; and some of the bills represent subjects which continue to enjoy legislative introduction but which have not seen passage into law over several legislative sessions.

In **Colorado**, for instance, where the law now requires HIV reporting with names and identifiers, except at the state's one anonymous test site, pending legislation would exempt individuals involved in research protocols from reporting requirements. The bill would exempt physicians from reporting information on patients involved in medical research studies of HIV treatment or vaccine effectiveness when the study is "an approved research protocol."

A **Missouri** measure would require the state to establish 12 anonymous test sites. Under current state law, most HIV testing requires reporting with names and identifiers, though there is some opportunity for anonymous testing. The bill would expand the opportunity for anonymous testing and reporting without names or identifiers.

Over the last few years, a number of states have imposed criminal penalties for knowing exposure or transmission of HIV. In 16 states (AL, AK, CO, GA, ID, IL, KY, LI, MD, MI, MO, NV, OH, OK, SC and TX), an HIV-infected person who, through sexual or needle sharing behavior, exposes another person to the virus without mentioning the risk can be found guilty of an infraction, misdemeanor or felony.

A bill pending in **Illinois** would amend the state's Criminal Code to make the offense of criminal or aggravated sexual assault or sexual abuse first degree murder, if the victim subsequently dies of AIDS. Additionally, a **Wisconsin** bill provides that anyone who intentionally transmits the virus to another person could be subject to life imprisonment if the victim dies as a result of HIV infection.

Mississippi's legislature is again debating a bill requiring food handlers to certify they are free from HIV infection. Although there have been no documented cases of HIV transmission through food handlers and although the legislature has defeated similar bills every year since 1988, the 1991 bill calls for food handlers to be certified every six months by the State Department of

Mandatory Testing

N.Y. Appeals Court Says Lower Panel Has No Authority to Order HIV Tests

New York state laws do not give county judges the authority to compel a defendant in a criminal action to be tested for HIV antibodies when the results were not to be used as evidence in that action, a state appeals panel ruled April 24.

"Public Health Law §2785 (2) does not authorize court ordered testing to determine the HIV status of a person," the state Supreme Court, Appellate Division, Fourth Department, ruled in a unanimous decision. "That section authorizes court ordered disclosure of confidential HIV-related information only in specific circumstances not present here."

In addition, the court said, there could be no available corrective action should HIV test results be disclosed, and "no appeal would lie from such an order since it would be neither an order issued as part of the criminal proceeding nor an order issued in a separate civil proceeding."

The case involved "John Doe," the defendant in a criminal action in Monroe County, N.Y., County Court, who was charged with rape and sodomy. During the proceedings, the district attorney's office sought an order from Judge John J. Connell directing Doe to provide a blood sample to be tested for HIV and that the results be provided to the woman who was the complainant in the criminal action and to her husband.

The information was to be used by the woman "only . . . in an effort to relieve and recover from her emotional trauma."

Connell orally granted the motion, which had been made under provisions of the state Public Health Law, but before an order was issued directing the test, Doe filed the appeal.

Agreeing with Doe's contention that Connell had exceeded his authorized powers, the appeals court noted that "while County Court unquestionably has jurisdiction over the pending criminal action," Public Health Law "did not confer jurisdiction on County Court. Indeed, the People cite no statutory authority that grants jurisdiction to County Court either to compel a defendant in a criminal action to submit to a blood test for the purpose of determining his HIV status or to direct disclosure of the results of that test where, as here, the test results sought were not for any use in any aspect of the criminal action."

Evan Wolfson, a staff attorney at Lambda Legal Defense and Education Fund in New York, said the decision, although drawn narrowly on New York criminal and public health statutes, would seem to have broader implications in other states. "Largely, this issue has come up in the context of legislation [rather than judicial decisions]," he said. (*Doe v. Connell*, NY SupCt AppDiv 4th Dept, No. 557, 4/24/92)

■ In a similar ruling also involving a court decision on HIV-related information, the U.S. District Court for Southern New York held April 22 that the plaintiff in a civil lawsuit may see medical files of the man he says infected him with HIV during a seven-year homosexual relationship.

"Plaintiff has demonstrated a compelling need for discovery of HIV-related information," said Judge Robert P. Patterson Jr. "Information relating to the defendant's alleged infection with HIV is central to plaintiff's claim. To prove that defendant knew or should have known that he was infected with the virus when he allegedly exposed plaintiff to it, plaintiff must have access to records indicating when defendant became infected and when he became aware of that fact. Without this information, plaintiff's claim may fail for lack of proof."

Patterson stipulated that because of "the possible abuse in suits of this nature, plaintiff Francisco Martinez Jr. must show good faith by first providing the court and defense

Copyright © 1992 by Buraff Publications, Washington, D.C. 20036
0897-1493/92/$2.50

counsel a medical report and supporting affidavit demonstrating that he is infected with HIV. The medical files of the defendant, Alan P. Brazen, will be accessible only to the parties in the suit, their attorneys, expert witnesses, and the court, Patterson said.

The decision was immediately criticized by an attorney for Lambda Legal Defense and Education Fund in New York, who said it strains the confidentiality protections set up by state Public Health Law allowing disclosure of HIV medical records only when a "compelling need" is shown.

The case, said staff attorney Michael T. Isbell, "reflects a troubling trend, not only in the courts but among policymakers, and that is 'who gave what to whom,' rather than dealing with the disease itself. This is the latest exasperating example of that mindset."

Even though Patterson held that Martinez must demonstrate his seropositivity to secure Brazen's medical records, Isbell said, "This doesn't persuade me very much [that Brazen was necessarily the source of Martinez's infection]. There's between 1 million and 2 million HIV-infected persons in the U.S., and studies have shown that most people have multiple sexual partners. That, plus the fact of the long incubation period of HIV, doesn't go very far in identifying the source of infection."

Martinez has charged that he and the defendant had a homosexual relationship from the summer of 1984 through April 1991. He said that Brazen told him in January 1991 that he was HIV positive after telling him repeatedly during their relationship that he was not infected.

Martinez is seeking $135 million in compensatory and punitive damages on claims of fraud, battery, intentional infliction of emotional distress, and negligence.

Patterson said that the tight restrictions he has imposed on availability of Brazen's medical records were "due to the unfortunate societal stigma associated with HIV and AIDS," and that "substantial embarrassment and discrimination may result from disclosure of the identity of persons infected with the virus." Nevertheless, both plaintiff and defendant were identified by name in the ruling. (*Martinez v. Brazen*, DC SNY, No. 91 Civ 7769 (RPP), 4/22/92)❑

More Harm than Help:
The Ramifications for Rape Survivors of Mandatory HIV Testing of Rapists

CENTER FOR WOMEN POLICY STUDIES

About the Center

The Center for Women Policy Studies (CWPS) was established in 1972 as the first independent national policy institute focused specifically on issues affecting the social, legal, and economic status of women. The Center's policy research, development, and advocacy programs concentrate on educational equity, work and family issues, reproductive rights and health, violence against women, and AIDS -- recognizing that all issues affecting women are interrelated.

Underlying all of the Center's work is the premise that sex and race bias throughout society must be addressed simultaneously; policies and programs for "women in general" or "minorities in general" are not enough. The Center's programs look at the impact of combined race-plus-sex bias on women of color, women from diverse socioeconomic backgrounds, women with disabilities, and women of different ages.

The Center's current programs include: the Educational Equity Policy Studies Program, the National Resource Center on Women and AIDS, the Law and Pregnancy Project, the Violence Against Women Program, the Brain Trust on Economic Opportunity for Low Income Women, and a Washington policy internship program for women of color. The Center receives support from foundations, corporations, and individuals.

The National Resource Center on Women and AIDS was established in 1987 as a program of the Center for Women Policy Studies, to fill the vacuum in public policy discussion of AIDS and women and to address the critical policy issues for women,

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

576(2/77)

More Harm than Help:
The Ramifications for Rape Survivors of Mandatory HIV Testing of Rapists

CENTER FOR WOMEN POLICY STUDIES

Additional copies of this publication are
available for $10.00 each from:

PUBLICATIONS

Center for Women Policy Studies
2000 P Street, NW, Suite 508
Washington, DC 20036
(202)872-1770

(c) copyright Center for Women Policy Studies, 1991
This publication may not be reproduced.

ISBN 1-877966-08-8

About the Center

The Center for Women Policy Studies (CWPS) was established in 1972 as the first independent national policy institute focused specifically on issues affecting the social, legal, and economic status of women. The Center's policy research, development, and advocacy programs concentrate on educational equity, work and family issues, reproductive rights and health, violence against women, and AIDS -- recognizing that all issues affecting women are interrelated.

Underlying all of the Center's work is the premise that sex and race bias throughout society must be addressed simultaneously; policies and programs for "women in general" or "minorities in general" are not enough. The Center's programs look at the impact of combined race-plus-sex bias on women of color, women from diverse socioeconomic backgrounds, women with disabilities, and women of different ages.

The Center's current programs include: the Educational Equity Policy Studies Program, the National Resource Center on Women and AIDS, the Law and Pregnancy Project, the Violence Against Women Program, the Brain Trust on Economic Opportunity for Low Income Women, and a Washington policy internship program for women of color. The Center receives support from foundations, corporations, and individuals.

The National Resource Center on Women and AIDS was established in 1987 as a program of the Center for Women Policy Studies, to fill the vacuum in public policy discussion of AIDS and women and to address the critical policy issues for women,

particularly women of color and low income women, in the AIDS crisis from women's diverse perspectives. The Resource Center serves as a centralized resource for researchers, policymakers, advocates, and caregivers. During its first three years, the Resource Center published the first annual **Guide to Resources on Women and AIDS**; produced a landmark video, **Fighting for Our Lives: Women Confronting AIDS** and an **Action Kit** to accompany it; and developed the first federal legislative proposals to address the need for HIV/AIDS research, prevention and outreach programs targeted specifically to women.

During 1991 and 1992, the Resource Center's focus is on the creation of a **National Collaboration for AIDS Policy for Women** that brings together the expertise of scientists, ethicists, policy analysts, service providers, and advocates for women in a process that will build consensus in support of women and AIDS legislative and administrative initiatives. This policy paper is the first in a series that will be developed by the National Collaboration with funding from the Ford Foundation and the George Gund Foundation.

Acknowledgements

More Harm than Help: The Ramifications for Rape Survivors of Mandatory HIV Testing of Rapists was written by Lisa Bowleg and Kathleen D. Stoll. Christine Ogu and Nancy Yamaguchi prepared the manuscript for publication. The Center for Women Policy Studies thanks the AIDS Policy Center of the Intergovernmental Health Policy Project, George Washington University, for granting access to state HIV/AIDS legislation related to sex offenders and rape survivors. We are particularly grateful to Elizabeth Cooper, Chai Feldblum, Karen Friedman, Jeff Levi, Catherine Lynch, Tom Stoddard, Jennifer Woolard and Jane Roberts Chapman who generously shared their ideas with us and reviewed the manuscript.

Development of this policy paper was made possible by grants from the Ford Foundation and the George Gund Foundation, for the Center's National Collaboration for AIDS Policy for Women.

Table of Contents

Preface

Since its founding in 1972, the Center for Women Policy Studies has conducted research, developed policy options, and provided technical assistance to policymakers and advocates alike on issues of violence against women. During the 1970s, for example, the Center was instrumental in defining rape as a federal policy issue and contributed to development of the Rape Prevention and Control Act. With support from the federal government over several years, the Center also established a national Resource Center on Family Violence and published the journal, **Response to the Victimization of Women and Children**, which continues to be edited by CWPS co-founder Jane Roberts Chapman and published by Guilford Press. The Center's most recent policy paper addressing violence against women was published in June of 1991; **Violence Against Women as Bias Motivated Hate Crime: Defining the Issues** provides statistics on rape and other forms of violence against women and defines violence against women in the context of widely accepted definitions of bias-motivated hate crimes.

With this policy paper, we bring together our long history of work on issues of violence against women with the Center's current policy development efforts focused on women's needs in the continuing AIDS crisis. Unfortunately, the issue of mandatory HIV testing of charged or convicted rapists has been sensationalized in recent years and the Congressional debate on this issue has been virtually nonexistent, while the vote on the

amendment to the Comprehensive Crime Control Act of 1990 requiring testing of convicted rapists was falsely characterized as a vote either "for women" or "for rapists."

The Center for Women Policy Studies is in a unique position to bring some clarity to this complex and clouded issue. As advocates both for women survivors of rape and for sound and humane AIDS policies, we have carefully examined this issue and have come to the conclusion that mandatory HIV testing of rapists is bad policy for women. Our analysis of this difficult issue is based on our primary interest -- meeting the needs of the rape survivor. Indeed, the lack of needed health care and emotional support services for all survivors of rape is not addressed by a mandatory testing policy. The need for self-empowerment for women is not served by a policy that encourages manipulation and disempowerment of survivors through misperception and misinformation about HIV transmission and testing. And finally, this policy sets a dangerous precedent for legislative expansion of mandatory HIV testing and punishment of women who are sex workers or pregnant.

Confronting these difficult issues will be a continuing struggle for advocates of woman-sensitive policies at both the federal and state level. We hope that this policy paper will help legislators formulate and implement sound public policy that will truly meet rape survivors' and all women's needs.

Leslie R. Wolfe
Executive Director

July, 1991

More Harm than Help:
The Ramifications for Rape Survivors of
Mandatory HIV Testing of Rapists

Introduction

Surviving a rape is an emotionally, psychologically and physically traumatic experience that now is compounded by the possibility that a rape survivor may contract HIV infection from an infected rapist.[1] According to a study reported in the Journal of Interpersonal Violence, fears about contracting HIV as a result of rape appear to exacerbate the psychological trauma associated with sexual assault (Baker, Burgess, Brickman, and Davis, 1990). This finding underscores the survivor's need to have access to anonymous HIV testing and to effective rape and HIV counseling that includes accurate and reliable information about a rape survivor's risk of contracting HIV infection as a result of rape. Yet AIDS laws and policies have virtually ignored the real psychological, medical and financial needs of rape survivors.

Since 1980, according to Federal Bureau of Investigation statistics, rape has increased more than any other violent crime but only an estimated 10 percent of rapes and sexual assaults are reported to the police, making rape the most underreported crime in the United States (Congressional Caucus on Women's Issues, 1990; Harlow, 1991; Koss, *et al.*, 1990). Fewer than 40 percent of reported rapes result in charges against perpetrators, and

only 3 percent of these cases result in conviction (Congressional Caucus on Women's Issues, 1990).

Laws designed to help rape survivors cannot be limited to the few rape cases where there is an arrest and certainly not to the even smaller number of cases that actually end in a conviction. Rather, laws must recognize that the majority of rape survivors do not enter the criminal justice system at all; any purported attempt to meet their needs must reach them through the system of rape crisis centers and other support systems that they are much more likely to encounter.

Rape and HIV Transmission

A rape survivor's risk of contracting HIV from a rapist depends on several factors, the most obvious of which is whether the assailant is infected with HIV. Other factors associated with a survivor's risk of acquiring HIV infection include the number of assailants, the size of the inoculum per exposure, the virulence of the viral strain, the number of exposures, the kind of assault (vaginal, anal or oral), and the survivor's susceptibility to infection[2] (Burgess, Jacobsen, Thompson, Baker, and Grant, 1990; Jenny, Hooton, Bowers, *et al.*, 1990). Although survivors' fears about contracting HIV have been documented, (Burgess, Jacobsen, Thompson, Baker, and Grant, 1990; Jenny, Hooton, Bowers, *et al.*, 1990; Presidential Commission on the HIV Epidemic, 1988) the actual potential for HIV transmission through rape has received virtually no public health attention.

The lack of research and data on HIV transmission through rape is indicative of the status of women's health concerns within AIDS policy research. In its 1988 report to the President, the Presidential Commission on the HIV Epidemic stated that "victims of sexual assault deserve consideration and must be given attention and support so that they will not be forgotten in the tragedy surrounding the AIDS epidemic" (Presidential Commission on the HIV Epidemic, 1988). Three years after the Commission's report and more than ten years into the epidemic, the lack of research and data on the risks of acquiring HIV as a result of rape indicates that, indeed, rape survivors have been forgotten in the AIDS epidemic.

Anecdotes about rape survivors who have contracted HIV subsequent to a sexual assault are reported, but this risk remains unestablished. According to a study reported in the **New** England Journal of Medicine, because of the difficulty in ascertaining whether infections were present before a rape or acquired during it, the risk of acquiring a sexually transmitted disease (STD) as a result of rape is unknown (Jenny, Hooton, Bowers, *et al.*, 1990). This rationale does not explain the absence of adequate research on the potential for HIV transmission through sexual violence (rape, incest, child molestation, and sexual assault) in light of the abundance of research identifying the risks of contracting HIV infection through consensual sexual behavior (Baker, Burgess, Brickman, *et al.*, 1990; Burgess, Jacobsen, Thompson, *et al.*, 1990).

Instead, in cases of sexual violence, research seems to assume that a rape survivor may already be infected with HIV, thus emphasizing the survivor's sexual history while de-emphasizing the crime of rape. Yet, research has been conducted to estimate the transmission rate of other STDs, such as gonorrhea, through rape. Similar research could be conducted on HIV transmission from rape.

In the absence of hard evidence from research, policymakers must rely upon extrapolations and hypotheses about the risks of contracting HIV from rape. Presently, the available statistics on HIV transmission in consensual sexual behavior are the only source of information; the rate of HIV transmission from rape must be extrapolated from these data. Several studies calculate the per contact infectivity for male-to-female HIV transmission as less than or equal to 0.2 percent (Peterman, Stoneburner, Allen, Jaffe, and Curran, 1988; Padian, Wiley, and Winkelstein, 1987; Hearst and Hulley, 1988). Because local trauma which dissolves mucosal barriers to infection is expected to increase a woman's risk of HIV infection (Centers for Disease Control, 1989), the risk of contracting HIV from rape is estimated to be greater than 0.2 percent (American Civil Liberties Union AIDS Project, 1991). Even so, HIV is not as efficiently transmitted as other STDs (Alexander, 1990; Holmberg, Horsburgh, Jr., Ward, and Jaffe, 1989).

Victoria Brownworth (1990), a medical reporter, extrapolated the risk of contracting HIV infection as a result of rape by a

person with unknown HIV status as 6 percent, using CDC's estimation that the transmission rate for HIV versus other STDs (syphilis, gonorrhea, and chlamydia, for example) is 50 percent and then dividing that figure by 12 percent, the percentage by which a recent study (Schwarcz and Whittington, 1990) indicated that survivors of reported rapes contracted STDs other than HIV from the attack. Brownworth bases her deduction on CDC's claim that the amount of HIV in the U.S. population and the amount of syphilis are equal (Brownworth, 1990). Brownworth's contention is clearly more speculative than scientific but the fact that this figure is widely quoted reveals the need for research and conclusive data on the potential of contracting HIV infection as a result of rape.

The Mandatory Testing Debate

Mandatory HIV testing is one of the most controversial and hotly debated AIDS policy issues. Policymakers and public health officials agree that voluntary anonymous HIV testing is critical to public health efforts to reduce the transmission of HIV infection, but since the advent of the HIV antibody test in 1985, they have debated the medical, political, psychological, and ethical ramifications of mandating HIV testing for individuals who may be deemed to engage in high risk behaviors. Proponents of mandatory testing contend that it is essential as a way to identify infected individuals, provide them with access to early intervention services, reduce the stigma of HIV testing, and

ultimately prevent further transmission of HIV (Americans for a Sound AIDS Policy, 1988). Opponents of mandatory testing, on the other hand, assert that mandatory testing is unethical and unjustified in the absence of therapeutic treatment (Levine and Bayer, 1989); does not change behavior more effectively than voluntary education, counseling and testing (Working Group on HIV Testing of Pregnant Women and Newborns, 1990); infringes upon individual liberties and rights to privacy, may be a pretext for discrimination, and is not the least restrictive measure to protect the public health (Hunter, 1987); and is inflexible for responding to new developments in therapy and treatment (Institute of Medicine, 1991).

These compelling arguments also apply to convicted or charged rapists. But it also is essential that policies that will be truly helpful to survivors of rape are developed. The Center for Women Policy Studies (CWPS), with a long tradition of leadership in research and policy analysis on violence against women, suggests that laws mandating HIV testing of charged or convicted rapists dangerously misdirect the policy focus away from the psychological and medical needs of rape survivors.

Reviving the Mandatory Testing Debate: HIV Testing of Convicted Rapists

The passage of former Representative Lynn Martin's (R-IL) amendment to the Comprehensive Crime Control Act of 1990 (P.L. 101-647) revived the mandatory HIV testing debate at the federal and state level. This time, however, the debate focused on

mandating HIV testing for convicted rapists who may have exposed a rape survivor to HIV infection. The Martin Amendment stipulates that a state will lose ten percent of its federal victim assistance funds if it does not establish laws that mandate HIV testing for a convicted rapist upon a rape survivor's request. The amendment also requires test results to be disclosed to the survivor and to the convicted defendant. In Martin's opinion, the amendment was important to ensure that rape survivors did not have to live in fear that a rapist may have exposed them to HIV infection (Martin, 1990).

Martin's concerns about survivors' fears are well-founded but her solution is dangerously misguided. Sexual assault survivors are aware of the risk of contracting HIV infection and many request to be tested for HIV (Presidential Commission on the HIV Epidemic, 1988; Jenny, Hooton, Bowers, *et al.*, 1990). Although most policymakers and survivors' rights organizations agree on the need for laws and policies that address the psychological and medical needs of rape survivors, they disagree about how these needs can best be met. Mandatory HIV testing for charged or convicted rapists and disclosure of test results to survivors is the prevailing legislative trend at both the state and federal levels. Yet, the lack of legislative history and debate on mandatory HIV testing for rapists and its ramifications for rape survivors suggests that this legislation is based more on emotion than on logic or thoughtful planning to meet women's needs. These responses are reminiscent of much of the AIDS

hysteria of earlier years when the public and some public health officials suggested quarantine and isolation for people infected with HIV and AIDS as a valid public health measure.

Arguments for Mandatory HIV Testing of Convicted Rapists

Advocates for mandatory testing of convicted rapists assert that a rape survivor's right to know a convicted offender's HIV status supersedes the offender's rights to privacy. According to Mary Ann Largen, Executive Director of the National Network for Victims of Sexual Assault (NNVSA), mandatory HIV testing of convicted rapists also accomplishes two important goals: it prevents convicted offenders from abusing the criminal justice system by plea bargaining for lighter sentences if they volunteer to be tested; and it provides a rape survivor who has contracted HIV infection from a rape with evidence should she wish to bring a civil suit against a convicted rapist. Largen acknowledges that mandatory testing for convicted rapists will not preclude the need for rape survivors to be tested for HIV infection (Largen, 1991).

Other proponents justify involuntary HIV testing of alleged rapists because blood is already available for evidentiary reasons or for STD testing, so it might as well be tested for HIV infection and the test results disclosed to a rape survivor. However, HIV testing is unique and distinguishable from STD testing in two important ways: unlike STDs (gonorrhea, chlamydia, and syphilis) which are curable, HIV disease cannot be cured or

rendered noncommunicable; and HIV infection and AIDS still are highly stigmatized diseases, subjecting people to discrimination on the basis of actual or perceived HIV or AIDS status. In the prison system, the discrimination is severe. As one inmate described it, "if the guys in the general population suspect that someone has AIDS, first they throw water into that person's cell when he is not there. If that doesn't work, they burn out the cell" (Kurtz, 1988).

Further, if HIV transmission becomes an issue in a criminal proceeding or a civil suit for damages, defendants may be able to submit evidence of the survivor's sexual or drug history, to try to establish a doubt that the rape was the source of infection by showing that the rape survivor had engaged in high risk behaviors and had been previously exposed. Pauline Bart, co-author of **Stopping Rape: Successful Survival Strategies**, believes that a woman who claims to have contracted HIV infection from a rapist "will open the door to examining her entire sexual history [because] the defense would attempt to prove she could have gotten it from somebody else" (Salholz, 1990). Examining the survivor's sexual history may succeed only in further victimizing the survivor, prolonging her anguish, and delaying her psychological recovery.

Arguments Against Mandatory HIV Testing of Convicted Rapists

Instead of concentrating on testing convicted rapists, the concerns and interests of rape survivors would be better served

through funding of survivor-focused services such as free anonymous HIV testing, counseling, and early intervention. There is no doubt that part of the appeal of mandatory HIV testing of convicted rapists for policymakers is that it appears to "help" survivors of rape without the expenditure of funds. We do not doubt the sincerity of their desire to help survivors, but we challenge policymakers to carefully examine the needs of all rape survivors and make these needs a budget priority.

Mandatory HIV testing of convicted rapists is a misguided approach, for at least five reasons: (1) it does not provide survivors with timely and reliable information about their risks of contracting HIV infection; (2) it is a misdirected and unrealistic approach to addressing the real needs of rape survivors; (3) it perpetuates the dangerous misperception that information about a rapist's HIV status is critical to a rape survivor's health; (4) it does not facilitate a rape survivor's psychological recovery; and (5) it sets a dangerous precedent for extending mandatory testing to others, such as pregnant women and sex workers. These five issues are discussed in more detail below.

(1) Mandatory HIV Testing of Convicted Rapists Does Not Provide Survivors With Timely and Reliable Information About Their Risks of Contracting HIV Infection

Although detectable HIV antibodies usually develop within three months after infection, the CDC notes that antibody tests

cannot rule out HIV infection from a recent exposure, and recommends that HIV testing for a specific exposure be repeated three and six months after the exposure (CDC, 1989). Because of the potential for false test results and delays in antibody formation, the American Public Health Association (APHA) believes that relying on an offender's HIV test results is not the appropriate standard of care for rape survivors (APHA, 1989). The APHA recommends that a rape survivor be encouraged to seek her own HIV testing and counseling as soon as she is psychologically ready so she can make her own decisions about medical attention based on an accurate understanding of her own test results.

Despite the lack of conclusive data regarding the efficacy of using AZT prophylactically to prevent HIV infection, some medical experts recommend administration of AZT within 48 hours of potential exposure to HIV infection (ACLU, 1991). Thus, time is crucial to a rape survivor who chooses to take AZT subsequent to rape. She has no time to wait for a perpetrator to be arrested, charged, convicted (on average, the time period from arrest to conviction is six months to three years), tested and re-tested three to six months later.

While delays in conviction may prompt proponents of mandatory testing to suggest testing for arrested or charged rapists, this too would be an absolutely worthless mandate for the vast majority of rape and sexual assault survivors, who do not report the crime, or, if they do, do not see the perpetrator

arrested or charged. In those comparatively few cases where there is an arrest, it is extremely doubtful that the alleged rapist's test results would be available in a timely manner for a decision on AZT prophylactic treatment. Most important, even if the test results were available in less than 48 hours, and even if the test were negative, the survivor would have no guarantee that she has not been exposed to the virus. If she is seriously considering using AZT prophylactically, it would be wrong for her to change her mind simply based on the alleged rapist's test results, as he may not have developed antibodies to his own recent infection.[3]

The most obvious problem with the rationale which justifies mandatory testing by pointing to the survivor's need to decide about using AZT prophylactically is that it wrongly assumes that all survivors will have access to this very expensive drug if they do want it. A policy that helps survivors also would fund programs providing comprehensive health care services to survivors, including coverage for AZT.

(2) Mandatory HIV Testing of Convicted Rapists is a Misdirected and Unrealistic Approach to Addressing the Needs of Rape Survivors

Since it is estimated that only one in 10 rapes are reported to the police, fewer than 40 percent of reported rapes result in charges, and only three percent of rapes result in conviction (10% x 40% x 3% = 0.1%), laws that mandate HIV testing of

convicted rapists as a means of protecting the rights of survivors ignore the reality of rape and offer no help to the majority of survivors. These laws also presume that most rapists are strangers, when in fact more than half of rapes are committed by an assailant that the rape survivor knows (Harlow, 1991) and one who may repeatedly rape her. Published studies on heterosexual HIV transmission suggest that while each exposure to HIV is associated with a small probability of infection, multiple exposures appear to increase the probability of HIV transmission (Padian, Marquis, Francis, Anderson, Rutherford, O'Malley, and Winkelstein, 1987).

Thus, mandating HIV testing for convicted rapists fails to respond to women who have been victimized through child molestation, incest, marital, and long-term acquaintance rape. Although these are more likely to be repeated and increase a survivor's risk of HIV infection, they are less likely to result in reporting, arrest, or conviction. In order to benefit the majority of rape and sexual assault survivors, rape crisis centers and service providers need sufficient funds to provide free, voluntary, anonymous HIV testing and counseling, and follow-up treatment, to any rape survivor in need of their services regardless of the prosecution status of the rape. With recent media attention to this issue, it is critical that policymakers seize the opportunity to draft real solutions. Passing a law that requires HIV testing of rapists may be an appealing, inexpensive, and emotionally satisfying response to a

complex problem. But real solutions for women require a focus on meeting the still unfunded needs of rape and sexual assault survivors in the AIDS epidemic.

(3) Mandatory HIV Testing of Convicted Rapists Perpetuates Misinformation that Knowledge of a Rapist's HIV Status is Critical

Although proponents of mandatory testing contend that it deters plea bargaining, legal advocates argue that mandatory testing actually encourages it (Rosenberg, 1990). In other words, because the waiting period for rape convictions is so long, rape survivors who are eager to know a perpetrator's HIV test results are more likely to agree to a defendant's request to plea bargain for reduced charges or sentences. The existence of the law may even give added credibility to the claim that the convicted rapist's test results are valuable to the survivor. In a recent New York rape case a man who pleaded guilty to raping an undergraduate in her dorm at knife point was promised a reduced sentence in exchange for agreeing to be tested for HIV infection and to allow his test results to be disclosed to the rape survivor (Salholz, 1990). A more direct and simple solution to the problem of plea bargaining is legislation which amends state criminal procedural law and prohibits the entry of a plea bargain conditioned upon an agreement to submit to testing for HIV.[4]

Supporters of mandatory testing also claim that knowing that a convicted rapist is HIV infected provides a rape survivor who

may have contracted HIV from rape with valuable evidence should she wish to bring a civil suit against a convicted rapist. However, because conviction may be delayed from six months to three years, knowing a convicted rapist's HIV status does not prove that the assailant was HIV positive at the time of the rape and did not contract HIV infection during the period before arrest or between arrest and conviction. Again, the survivor herself should be tested as soon as possible after the rape; if she tests negative and later tests positive, this may help her establish that the exposure to infection did not occur prior to the rape. Further, this type of civil suit for damages is very difficult to win; it could involve a very painful public examination of the survivor's sexual history before and after the rape, as rape shield laws would not apply. At issue would be every sexual encounter or other behavior that could have been the source of HIV infection to the rape survivor.

(4) Mandatory Testing of Convicted Rapists Does Not Facilitate a Rape Survivor's Psychological Recovery

An important, but often overlooked, survivor's right is the right to know the truth about all aspects of her risk of HIV infection. Research indicates that survivors are aware of the potential of contracting HIV from rape and many request to be tested (Baker, Burgess, Brickman, *et al.*, 1990; Burgess, Jacobsen, Thompson, *et al.*, 1990; Presidential Commission on the HIV Epidemic, 1988). Laws and policies that focus on the rapist

and his test results, but fail to provide the survivor with honest and accurate information about her risk of contracting HIV infection, the need for her to be tested for HIV infection, and the delays and improbability of conviction are deceitful and further victimize and disempower the survivor. This is especially important, as psychologists and rape crisis counselors note that empowerment is integral to psychological recovery from rape (Mooney, 1990). Restoring a survivor's control over her own life is key; and this includes the power to make decisions about all aspects of her life including if, when, and how (anonymously or confidentially), she will be tested for HIV (Mooney, 1990). Focusing on testing rapists perpetuates the notion that a rapist's HIV test results will be accurate and that knowing his serostatus will alleviate a survivor's anxiety. It is critical that the survivor understand that she must be tested herself regardless of the results of the rapist's HIV test, to safely determine her own serostatus.

The potential for a rape survivor to contract HIV infection from a rapist poses an ethical dilemma for many health care providers (Burgess, Jacobsen, Thompson, *et al.*, 1990). Traditionally, they have understood their duty not to inflict further harm on a traumatized survivor as preventing them from informing her of a potential risk for HIV infection (Burgess, Jacobsen, Thompson, *et al.*, 1990). Counseling by health care providers who are knowledgeable about survivor trauma and care and trained in counseling for HIV testing and results may

alleviate much of this dilemma (Minden, 1989).

(5) Mandatory Testing of Convicted Rapists Sets A Dangerous Precedent for Extending Mandatory Testing to Others -- Particularly Pregnant Women and Sex Workers

Women, under HIV/AIDS laws and policies, are viewed primarily as vectors of heterosexual or perinatal transmission. Thus, instead of addressing the unique prevention, health care, social service and legal needs of women, laws and policies focus on women's potential to transmit HIV infection to others and seek to control women accordingly. The readiness and frequency with which state legislatures have introduced and enacted legislation mandating HIV testing for convicted rapists under the guise of protecting the rights of rape survivors sets a dangerous precedent for the extension of mandatory testing to pregnant women to protect the "rights" of fetuses and to women convicted of prostitution to protect their male customers. In all three scenarios, there is an assumption that it is appropriate to set aside the rights of a possibly infected person (the rapist, the prostitute or the pregnant woman) in favor of the rights of a possibly to-be-infected person (the survivor, the customer, or the fetus). The precedent of mandatory HIV testing to protect "innocent victims" of rape can easily be expanded to include testing of pregnant women and prostitutes as the vectors of transmission to other so-called "innocent victims."

PREGNANT WOMEN

CDC already recommends "routine" HIV testing and counseling for all pregnant women at risk [sic][5] for HIV to "allow" HIV infected women to avoid pregnancy and subsequent intrauterine perinatal transmission (CDC, 1987). The odds of an HIV positive woman bearing an HIV positive infant are estimated by the CDC to be less than 1 in 3.[6] CDC's recommendation assumes that all pregnant women who are HIV infected will determine that these odds are an unacceptable risk; thus women are denied their right to make their own reproductive choices. By choosing to focus only on the infants, two-thirds of whom will not actually be infected with HIV, CDC's recommendation succeeds in ignoring HIV infected women who are in need of their own medical care and social services.

CDC's recommendation to test "at risk" [sic] pregnant women also has the effect of discriminating against women who are African American and Latina who, because they are disproportionately affected by HIV/AIDS, are likely to be targeted for HIV testing based solely on race and ethnicity, rather than on high risk behavior. In its 1991 report, the Institute of Medicine's Committee on HIV Screening of Pregnant Women and Newborns offers a sound alternative to CDC's recommendation. The Committee proposes voluntary HIV screening, with informed consent, for all pregnant women in jurisdictions with a high prevalence of HIV infection among women of childbearing age and believes that the potential for discrimination and stigmatization can be reduced by

selecting large jurisdictions, such as states or counties, to target for voluntary testing (Institute of Medicine, 1991).

WOMEN CONVICTED OF PROSTITUTION

At least 25 states have already enacted HIV-related laws regulating prostitutes -- even though they may engage in activities that involve no direct sexual contact capable of transmitting HIV infection -- making this one of the most frequently legislated HIV/AIDS policy issues. Despite evidence that the risk of a prostitute transmitting HIV infection to a client is low (National Research Council, 1990; Seidlin, Krasinski, Bebenroth, Itri, Paolino, and Valentine, 1988; Cohen, Alexander, and Wofsy, 1989), public health officials continue to implicate prostitutes as vectors of heterosexual transmission. Even CDC officials acknowledge that the risk for women is greater; since more men are infected with HIV, and since male to female transmission is more efficient (CDC, 1989), the chances are greater for women that a random heterosexual male partner of a woman will be HIV infected (CDC, 1989). Yet CDC's acknowledgement that women are at a greater risk for heterosexual transmission compared to men is inconsistent with their condemnation of women sex workers. Instead, CDC could focus prevention messages and punitive policies on prostitutes' male customers, who are willingly spreading HIV to their paid partners. Indeed, these laws reinforce a double standard of morality, under which men patronize prostitutes with relative

impunity while women who engage in prostitution risk arrest, conviction, incarceration and forced HIV testing. These laws ignore the real needs of women who are sex workers because it is their most lucrative (or only) alternative to earn money to feed their families, or because treatment for an addiction, that may have started as a response to multiple levels of oppression and disadvantage, is unavailable.

Proponents of mandatory testing of rapists may not see that these policies are part of a dangerous pattern of mandatory testing policies that blame women for HIV transmission; they may not carefully examine any precedents for expanded mandatory testing in light of that reality. Although proponents may envision a law that singles out men convicted of crimes of sexual violence against women, this is unrealistic. Instead, most of these laws do not distinguish between a male client's consent to engage in sexual relations with a prostitute and the violence of rape; both are included in the general category of sex-related crimes. Thus, both the prostitute and the rapist are guilty of "sex crimes" and must be tested for HIV.

The next step legislators will consider is to enhance the penalty or provide for a separate crime for willful or deliberate transmission of HIV.[7] It is clear that prostitutes and pregnant women will be targeted by this next wave of laws. In reality, such laws only divert resources from effective HIV/AIDS prevention efforts. Prostitutes at risk may avoid being tested to protect themselves from prosecution for knowingly exposing a

client to HIV infection; pregnant women may avoid prenatal care and early testing to avoid both prosecution and the loss of their children to foster care for alleged "abuse" (Weissman, 1991).

The Role of the Media in the Debate

Through its many stories about HIV and rape, the print and broadcast media have played an important role in raising the awareness of the public and policymakers about rape and the threat of HIV infection. To garner support for her amendment, for example, Representative Martin circulated a **Newsweek** article entitled "A Frightening Aftermath: Concern About AIDS Adds to the Trauma of Rape" (Salholz, 1990) to members of Congress. However, the media has also played an active role in manipulating and attempting to simplify the issue of testing rapists for HIV as one in which opponents to testing are viewed as pro-rapist and supporters of testing are viewed as pro-woman. Framing the issue in this manner denies the complexity of the issue and the real needs of rape survivors; it also plays on the cynical manipulation of survivors' feelings of anger, frustration and fear. In fact, some survivors' and women's rights organizations committed to the best interests of survivors also oppose mandatory testing of charged or convicted rapists.[8] For example, the National Coalition Against Sexual Assault (NCASA) formally voted to oppose all forms of mandatory HIV testing. NCASA also voted to stress the importance of the availability of free,

anonymous or confidential HIV testing and counseling for survivors (Mooney, 1990).

Constitutional Issues

Experts in criminal law are confident that testing prior to conviction is unconstitutional because it violates an arrested individual's constitutional rights to a presumption of innocence, to a constiutional protection from unwarranted search and seizure, and to privacy and confidentiality (Cooper, 1991). A person who has not been convicted of a crime retains the presumption of innocence and constitutional protections which exceed those of convicted persons. Thus, forcing arrested persons to be tested against their will would violate the constitutional rights to informational privacy and the Fourth Amendment; if such information then were used at a criminal trial, the testing might also violate the Fifth Amendment. It is also futile because the rape survivor will still need to be tested for HIV infection.

Testing of convicted rapists, on the other hand, is potentially constitutional because, once an individual is convicted of a crime, he loses depth and breadth of constitutional protections and thus may be tested (as in the case of prisoners) in the interest of maintaining security. But, although the convicted rapist loses a certain degree of constitutional protection because of his conviction, convicted persons do retain constitutional rights; thus, testing convicted

persons does raise constitutional issues concerning the right to privacy and the Fourth Amendment right to be free of unreasonable searches. HIV testing of prisoners has been upheld against constitutional challenge where the state's interest in such testing was for prison security. However, testing convicted rapists to disclose test results to a survivor does not raise the issue of security; rather, it requires a balancing of the interests of the state (which the state extends to the interests of the rape survivor) against the rapist's fundamental right to privacy.

This equation will not automatically lead to mandatory HIV testing, because testing the offender will not preclude the need for the rape survivor to be tested for HIV infection. It is arguable that the survivor's emotional need to know an offender's HIV status is a worthwhile and legitimate state interest. This argument is the most compelling part of the case for mandatory HIV testing of rapists. However, there are more medically sound and appropriate ways for the state to meet this very real need; a survivor's own testing and counseling will allow her to feel absolutely sure of her own HIV status. Limited funds should be spent on needed services for rape survivors rather than on litigation to defend laws with a minimal impact on survivors.

State Legislative Responses to Rape and Potential HIV Transmission

As of June, 1991 laws in at least 23 states regulate HIV testing for charged or convicted rapists. Consistent with the

justification for the Martin Amendment to the Comprehensive Crime Control Act of 1990, state legislators and policymakers contend that rape survivors have a right to know a convicted -- and in some cases, charged -- offender's HIV test results; these legislators view mandatory testing laws as integral to protecting the rights of rape survivors. However, the inadequacy of the policy is evident; beyond notifying the survivor of the offender's HIV status, these provisions do little to address the medical, psychological or financial needs of survivors.

The readiness with which state legislatures have enacted and continue to introduce mandatory HIV testing legislation suggests that legislators and policymakers are responding to the issue of rape and potential HIV transmission emotionally, rather than rationally. They may want to "help" women and to express their outrage at the pervasiveness of sexual violence against women; but, though this intention to help survivors may be sincere, when no funding for even basic access to HIV testing and counseling is included in a mandatory testing legislative initiative, it is doubtful that the commitment to helping survivors is serious enough to involve expenditures of funds.

In 1991 Texas became the first state to allow a rape survivor to request that an accused sex offender be tested for HIV infection. According to Lisa McGiffert, Legislative Coordinator of the Texas Senate Committee on Health and Human Services, this law was the result of a specific incident in which a rape survivor in Fort Worth, Texas was prohibited from

requesting that an alleged rapist be tested for HIV infection (McGiffert, 1991). The bill was discussed on the House floor and was added as an amendment to the state's Penal Code, but was never formally heard or analyzed in writing.

Florida's 1990 law mandating HIV testing for both charged and convicted sex offenders upon a survivor's request is the most stringent in the nation. The law's legislative intent states:

> The Legislature finds that a victim of sexual offense is entitled to know at the earliest possible opportunity whether the person charged with the offense has tested positive for human immunodeficiency virus (HIV) infection. The Legislature finds that to deny victims access to HIV test results causes unnecessary mental anguish in persons who have already suffered trauma. The Legislature further finds that since medical science now recognizes that early diagnosis is a critical factor in the treatment of HIV infection, both the victim and the person charged with the offense benefit from prompt disclosure of test results. The Legislature finds that HIV test results can be disclosed to the victim of a sexual offense while confidentiality is protected in other respects (Florida, H.B. 1115, Chapter 90-210, 1990).

This statement reveals the flaws in reasoning discussed above. First, it does not matter if or when the alleged rapist is tested, the rape survivor still must be tested herself to be diagnosed and receive early treatment. Second, misleading a rape survivor into thinking that the alleged rapist's test result is critical to determining her own health status, when it is not, only exacerbates her mental anguish. Finally, in addition to the necessity for testing survivors for HIV, some medical experts recommend that survivors take a prophylactic dose of AZT

within 48 hours after the exposure (ACLU, 1991). Thus, testing an offender under the guise of facilitating early diagnosis and treatment for a survivor is both deceptive and futile. Yet, the Florida Legislature's flawed rationale is typical of the basis on which other states have enacted mandatory testing laws for convicted and/or alleged rapists.

HIV/STD COUNSELING FOR RAPE SURVIVORS NOT ADDRESSED

States claim that mandatory testing laws for convicted (and in some cases accused or charged rapists) are necessary to protect the rights of rape survivors who may have been exposed to HIV infection by the rape. Despite justifications that mandating testing for offenders is necessary to help rape survivors, state laws and policies actually do little for women who are raped. For example, of the 19 states that mandate HIV testing of offenders and disclose an offender's test results to a rape survivor, only ten states (Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Minnesota and Oklahoma) mandate HIV counseling for rape survivors upon disclosure of the offender's HIV test results.

California is presently the only state to legislate HIV counseling for rape survivors that is unrelated to disclosure of an offender's HIV test results. Under California's law, county health officers must establish counseling programs for sexual offense survivors who choose to be tested for HIV infection. In 1988, the California legislature directed the Department of

Health to develop a brochure about exposure to HIV infection for rape survivors that is a potential model for other states.

Minnesota does not provide for counseling but does require rape survivors to be notified about the risks of HIV exposure. Minnesota's 1990 survivor notification law requires hospitals to give written notice about all STDs to anyone receiving medical services in the hospital who reports or evidences a sexual assault. The law provides that when appropriate, the notice must be given to the parent or guardian of the survivor. The notice, which must be developed by the Commissioners of Public Safety and Corrections in consultation with sexual assault survivor advocates and health care professionals, must inform the survivor of: (1) the risk of contracting STDs as a result of sexual assault; (2) the symptoms of STDs; (3) recommendations for periodic STD testing where appropriate; (4) locations where testing is done and the extent of the confidentiality provided; and (5) other medically relevant information. Again, this written notice may be a model for other states.

Again, it is estimated that only 1 in 10 rapes are reported, and fewer than 40 percent of reported rapes result in charges against perpetrators. Thus, state laws that link assistance to survivors of rape to testing of a charged rapist fail to address the needs of the vast majority of rape survivors. Although state HIV/AIDS laws acknowledge the potential for a rape survivor to contract HIV infection from an infected rapist, these laws ignore the direct and immediate needs of the few women who do

successfully pursue prosecution. It is futile for a rape survivor to know that an HIV infected rapist may have exposed her to HIV infection if she cannot afford her own HIV counseling, testing, and treatment. Presently, no states pay for a rape survivor's HIV testing or counseling. Missouri's Department of Health will pay the costs of HIV testing for survivors if the convicted sex offender tests positive for HIV infection.

This law epitomizes the misdirected focus of state laws; rather than directly addressing the woman's medical, psychological, and financial needs, the law makes her needs consequent to and dependent upon the status of the man who has raped her. In legislators' rush to help relieve the "unnecessary mental anguish" of rape survivors, they have overlooked the mental anguish of the rape survivor who is HIV positive and has no access to health care. It will not reduce her anguish, fear and pain to know she is at risk of developing AIDS and is unable to afford treatment. Follow-up health care services for rape survivors which go beyond the emergency room examination must be funded.

1991 Bills for Testing of Rapists

Mandatory HIV testing of convicted, and in some instances charged, rapists continues to dominate state legislatures in 1991. As of March 28, 1991, 27 states had introduced rapist testing bills, making it the most common HIV/AIDS legislative issue of the 1991 state legislative sessions. As with existing

laws, an examination of these bills reveals a hasty and misdirected focus on the relatively few rapists who are arrested and charged, rather than on rape survivors whose interest this legislation purports to protect. In most cases, these bills are variations on the basic federal requirement for mandatory testing of convicted rapists created by the Martin amendment.

For example, the legislative intent of Alaska's proposed law mandating testing for charged rapists notes that the purpose of the legislation is "to require that information that may be vital to victims ... be obtained and disclosed in an appropriate manner in order that precautions can be taken to preserve their health and the health of others or in order for these persons to be relieved from groundless fear of infection" (Alaska, House Bill Number 24, Introduced March 8, 1991). Yet the legislation does not provide or pay for a survivor's HIV testing or counseling.

Bills introduced in 16 states (Alaska, Arkansas, Delaware, Florida, Georgia, Hawaii, Iowa, Maryland, Montana, New Jersey, New York, Oklahoma, South Carolina, South Dakota, Washington, and Wisconsin) would mandate HIV testing for arrested sex offenders upon a court's finding that transmission of bodily fluids may have occurred or upon the request of a rape survivor. States are attempting to circumvent the constitutional problems raised by legislation mandating testing prior to conviction in several ways. Legislation in Delaware would allow individuals arrested for rapes to be tested for HIV "voluntarily." However, if defendants object to HIV testing a judge would decide whether or

not HIV testing will be performed. The judge would weigh the state's interest (the survivor's emotional need to know an alleged rapist's HIV status) against the alleged rapist's right to privacy.

It is not clear how judges would approach this balancing. It is possible that the survivor's sexual history and drug use history would be part of the evidence the judge would require to make his/her decision. Further, sexist stereotypes of "good" and "bad" women may enter the judge's decisionmaking as he/she decides whether the rape survivor is otherwise at risk for HIV; thus, not all rape survivors would be the beneficiaries of these laws. Indeed, one clue to how judges might approach the balancing of interests is found in Indiana's proposed legislation. Indiana would mandate HIV testing for individuals arrested for rape only if the rape survivor is pregnant as a result of the rape. In addition to viewing women primarily as incubators, this bill demonstrates that fetuses in Indiana garner more concern than women who have been raped. Again, women are viewed simply as vectors of HIV transmission to so-called "innocent victims."

HIV COUNSELING FOR RAPE SURVIVORS

Only six states (Alaska, Arkansas, Georgia, Kansas, Montana and South Carolina) propose a requirement that rape survivors receive HIV counseling upon disclosure of a tested rapist's test results. None of these states, however, define appropriate

counseling or pay for it. Kansas's health department will pay only for a survivor's counseling if the convicted rapist tests positive for HIV infection. Similarly, Montana's bill would arrange for post-test counseling only if the convicted person tests positive for HIV. Maryland's bill would require institutions or physicians treating rape survivors to inform them of anonymous HIV testing sites and HIV counseling centers. New Jersey's bill would require the Commissioner of Health to develop a testing program for rape survivors and a counseling program for survivors who test positive for HIV infection.

Looking at the Maryland bill, it seems to explicitly recognize the need for the survivor herself to be tested for HIV. Yet the bill still requires that the alleged rapist be tested prior to conviction, suggesting that the unspoken motivation may have more to do with punishing the alleged rapist than meeting the needs of the rape survivor. This would appear to violate the principle that an accused person is innocent until proven guilty. It is not hard to imagine that this punitive philosophy can be extended to arrested prostitutes and even pregnant women, who have not been arrested. It is critical that we do not allow HIV positive status to equal "guilty of criminal behavior."

PAYING FOR A RAPE SURVIVOR'S HIV TESTING AND COUNSELING

Only New York's 1991 bill would offer unconditional payment for a survivor's HIV testing and counseling. By making payment contingent on whether a rapist tests positive or whether the rape

has been reported to the state, states reveal their indifference to the medical and psychological interests of rape survivors. For example, although New Hampshire's bill would pay the costs of HIV testing for a convicted rapist if he is indigent, the bill does not provide for payment for the HIV testing and counseling costs of indigent rape survivors.

New York's bill would amend existing law to include exposure to HIV within the definition of "out-of-pocket loss" for compensating rape survivors for the costs of testing, counseling, and prophylactic treatment prescribed by a physician. South Dakota's legislation would pay for voluntary HIV testing for rape survivors only if the alleged rape is reported to the state. While it is important that states pay for voluntary HIV testing for rape survivors, payment must not be contingent upon the survivor's entering the criminal justice system.

CRIMINAL RECORDS AND PROCEEDINGS

While Florida's bill would not allow a charged individual's test results to be admissible in a criminal proceeding, Iowa's and New Jersey's bills provide that a convicted rapist's positive test results become part of his criminal record. Iowa's legislation would allow this information to be considered in sentencing. In these proposed bills, it is obvious that HIV positive status is equated to "guilty of criminal behavior" and thus warrants additional punishment. Vermont's bill would allow the fact that a defendant is voluntarily tested for HIV infection

to be admissible in mitigation of sentence if the person is convicted of the offense. Vermont's bill is unique in actively encouraging plea bargaining but is not unusual in demonstrating how mandating HIV testing for rapists has the potential to harm rape survivors more than it helps them.

Recommendations for Survivor-Based Federal and State Policies

Laws that mandate HIV testing for alleged or convicted rapists under the guise of a survivor's right to know an offender's HIV status are unlikely to meet survivors' needs and will certainly lead to mandatory HIV testing of others -- particularly pregnant women. The Martin Amendment and state laws that mandate HIV testing for rapists should be repealed and replaced with laws that provide rape survivors with free voluntary HIV counseling, testing, and treatment. Such legislation should include the following provisions:

(1) Funding to provide free anonymous HIV testing and counseling to all rape survivors by trained staff of rape crisis centers and similar facilities. Funding also should be provided for training of rape crisis center staff and for preparation of appropriate written materials. Because of the potential for discrimination, testing must be performed anonymously to protect the survivor's privacy. Appropriate counseling would include, but not be limited to, the following: (a) accurate information to help a survivor

assess her risk of HIV infection; (b) information about prophylactic treatment; (c) education about applicable HIV confidentiality and discrimination laws; and (d) accurate information about the value of the rapist's test results for the survivor's health care decisions and choices. This information will help the survivor make an informed decision about plea bargaining and will empower her to fight for her rights and refuse to allow the accused rapist to bargain for a lesser charge or sentence in exchange for his test results.

(2) Funding to provide rape survivors with prophylactic AZT treatment when they lack insurance or when insurance will not cover this treatment. These costs may include a six week term of AZT if the survivor and her physician determine that this treatment is medically appropriate.

(3) Funding to develop model programs for the long-term care of survivors who initially test positive and negative for HIV. Counseling and health care intervention should be provided throughout the various stages of HIV infection for survivors who convert to HIV infection. Rape survivors should have access to clinical drug trials and to support services, such as child care and transportation, that may be needed so that they actually can participate.

(4) Provisions for free HIV counseling and testing services specifically targeted to low income women, women with disabilities, and women whose primary language is other than English.

(5) Financing training for: (a) rape crisis center and other counselors about HIV infection and the availability of appropriate public and private programs that provide counseling, treatment and support; (b) assistant U.S. attorneys and judges regarding the negligible value of test results of the alleged rapists and the societal value of bringing rapists to justice; and (c) physicians, social workers, psychologists, psychiatrists, law enforcement officials and all other individuals who may come into contact with rape survivors.

Conclusion

Although there may be a time when progress in medical technology and treatment for HIV infection may justify mandatory HIV testing for convicted rapists, that time has not yet come. As we have shown in this paper, laws that focus on alleged or convicted rapists rather than on rape survivors do not address the medical, legal, psychological, and financial needs of women who are raped.