WORLD HEALTH ORGANIZATION
EUROPE

WHO technical consultation

in collaboration with the European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections

Copenhagen, 16 October 2006

Report of the WHO European Region Technical Consultation, in collaboration with the European AIDS Treatment Group (EATG) and AIDS Action Europe (AAE), on the criminalization of HIV and other sexually transmitted infections. Available at www.euro.who.int/aids

An extensive summary of the discussion at the consultation was prepared by the rapporteur, Richard Elliott of the Canadian HIV/AIDS Legal Network, and was circulated to participants for comment. Working from the draft summary and this further input, and based on internal discussions, WHO staff prepared this final condensed report.

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WHO technical consultation, in collaboration with the European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections

Executive summary

In October 2006, the World Health Organization Regional Office for Europe convened the first in a series of technical consultations on the criminalization of HIV and other sexually transmitted infections (STIs) transmission and exposure. The consultation brought together representatives of organizations of people living with HIV/AIDS, non-governmental technical experts from European Member States, WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS). They identified urgent needs for further collaborative action, including a WHO or United Nations position statement, by sharing experiences from select European countries. The key issues, challenges, policies and practices related to the criminalization of HIV and other STIs in Europe addressed were:

- the application of criminal law to situations involving unprotected sexual relations;
- the relationship between criminal law and the assumptions and principles underlying HIV/AIDS policy specifically and public health policy in general;
- the potential impact of the application of criminal law on the legal and social position of people living with HIV and on AIDS policy;
- policy action that is either desirable or necessary.

Public health needs and criminal law at variance
During the meeting it became clear that criminal law and public health programming are two separate systems of operation, addressing different structures and needs in society. Participants were concerned that HIV is being singled out for prosecutions in most jurisdictions that allow for that, and that the focus is on sexual transmission or exposure.

In criminal law, individuals are held responsible through penal sanctions for their actions that have been deemed to be unlawful. The emphasis is on individual responsibility for his/her deeds and the establishing of the moral culpability that underlies the claim for criminal culpability. For effective and convincing HIV/AIDS programming, it must be stressed that for all people there exists and remains a responsibility toward themselves and towards others to possibly minimize the risk of further transmission. This is crucial to safer sex campaigns, sexual health promotion campaigns and initiative as regards HIV and STI testing. Therefore, participants recommended that the potentially negative impact on public health and human rights of criminalization of so-called reckless and/or negligent transmission be carefully considered and that Member States consider the decriminalization of reckless/negligent transmission and exposure-cases (prosecutions and convictions of people living with HIV that engaged in unsafer sex without disclosing to their HIV-negative partners but where no HIV transmission occurred). Criminal law was viewed as a blunt instrument that can neither adequately capture the complexity of the contexts in which HIV transmission occurs nor deal effectively with matters such as the relative probability of transmission.

Additional issues considered in this consultation included:

1. Whether criminalization of HIV exposure and transmission may undermine public health and HIV prevention programmes by *inter alia* further stigmatizing and discriminating individuals and communities;
2. If all prosecutions for unsafer sex are stigmatizing *per se*, and whether prosecution of only sexual transmission (and not of transmission through unsafe injections or from mother to child) represents an unequal distribution of justice;
3. Targeted programming for people living with HIV, including advocacy of such programming, prevention interventions such as safer sex/risk reduction, personal empowerment and sexual health programmes;
4. If WHO can stress that prosecutions of exposure-only cases are contradictory to effective public health measures, and are in violation of the United Nations Declaration of Human Rights and/or the European Convention on Human Rights;
5. Consideration of whether criminal prosecutions for simple exposure to HIV and other STI cases should be stopped and that "reckless transmission" be deemed as being the object of public health and prevention programming;
6. In prosecution for actual transmission of HIV, it should be carefully and exhaustively considered if it was the suspect's direct, clear and wilful intention to transmit HIV, that reliable scientific evidence, such as genetic comparability of the virus and other, can be produced to prove the actual transmission from the defendant to the complainant; that a confession from the defendant should never be deemed to be enough indication of wilful intention as constructed later – either in prosecution proceedings before or during proceedings in court; if the virus was used as a weapon as such, and that the possibility that a third party was the actual carrier of the virus has been sufficiently excluded by in-depth investigations by the prosecuting authorities.

Further, epidemiological research in transmission in various populations, transmission rates per act, the role of highly active antiretroviral therapy (HAART) in reducing infectiousness as well as further sociological and psychological research toward the detrimental effects of criminal law on public health programming needs to be carried out. It was concluded that criminalization of HIV/STI transmission or exposure should be a last resort and only undertaken in a manner consistent with human rights conventions and laws, as outlined for example in instruments such as the *International Guidelines on HIV/AIDS and Human Rights*. Any instance of resort to criminalization represents a failure of prevention efforts, and participants highlighted the need for greater efforts on this front, including measures to overcome stigma and discrimination that undermine prevention.

WHO Europe plans to conduct further consultations on the criminalization of HIV and STIs with representative of Member Sates, civil society and other technical experts.

Introduction

On behalf of WHO Europe, Dr. Srdran Matic (Regional Adviser, HIV/AIDS and Sexually Transmitted Infections, WHO Europe) welcomed participants. By way of introduction, he noted that the UK Crown Prosecution Service is currently consulting on a draft policy to guide prosecutions related to the transmission of HIV and other sexually transmitted infections, in the wake of a number of such cases in the UK since 2003. This is thought to be the first such official prosecution policy of its kind. In addition, the continued criminalization of HIV transmission or exposure occurs against the backdrop of the current and ongoing debate, in which WHO plays a central part, about a shift in policy on HIV testing and counselling toward making testing more routine in health care settings. WHO Europe is committed to action for preventing and controlling HIV in accordance with ethical norms and human rights principles, both of which will inform its analysis of the question of criminalization of HIV transmission or exposure.

This technical consultation was an opportunity to take stock of the policies and practices in select member states (see Appendix 1) and to provide expert guidance and advice to WHO on this question. In the *International Guidelines on HIV/AIDS and Human Rights*, promulgated by the Office of the UN High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS),[1] Guideline 3 recommends that States review and reform public health laws to ensure that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations. In addition, Guideline 4 recommends that States review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups. Coercion, compulsion and restriction, through law, have historically been part of public health practice, but in too many cases such measures have been not only ineffective but also excessive; there have been many instances of the abuse of human rights in the name of public health. Health professionals and disciplines have also sometimes been implicated in such abuses.

There are, of course, circumstances in which rights such as those listed in the *International Covenant on Civil and Political Rights* may legitimately be restricted. However, arbitrary measures that fail to consider less intrusive measures may be abusive of human rights, in addition to constituting poor public health practice. As articulated, for example, in the "Siracusa Principles" adopted by the United Nations, limitations on civil and political rights must, at a minimum, satisfy at least five criteria to be justifiable:

- A limitation must be provided for and carried out in accordance with the law.
- The limitation must be aimed at a legitimate objective of general interest.
- The limitation must be strictly necessary in a democratic society to achieve that legitimate objective.
- The measures for achieving the objective must be the least intrusive possible, limiting the right(s) in question as little as possible.
- The limitation or restriction on rights must not be imposed in an arbitrary manner.[2]

[1] *HIV/AIDS and Human Rights: International Guidelines*. UN Doc. HR/PUB/98/1 (New York & Geneva: OHCHR & UNAIDS, 1998).

[2] UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights,* UN Doc.E/CN.4/1985/4, Annex (1985).

The rights to liberty and the principle of respect for autonomy are engaged by the criminalization of HIV/STI transmission or exposure. Guideline 12 of the *International Guidelines on HIV/AIDS and Human Rights* calls on States to cooperate through all relevant programmes and agencies of the United Nations system to share knowledge and experience concerning HIV-related human rights issues. WHO Europe has, therefore, initiated this process to inform a possible position on the issue of criminalization of HIV transmission or exposure, and to assist others within and outside the UN system in addressing this issue.

States and relevant United Nations agencies and programmes need to consider the impact of such policies on the response to HIV/AIDS and on people living with HIV, with reference to the (limited) evidence that is available and other appropriate policies that are or may be applicable, and to advocate for the adoption and implementation of appropriate policies, with reference to human rights concerns.

This report of the consultation includes the highlights of the presentations and presents recommendations to guide policy development on the issue of criminalization of HIV/STI transmission or exposure. Along with select background materials, the report is available at www.euro.who.int/aids and to Member States and other interested parties. It will also contribute to internal discussions within WHO Europe on the question of whether it will take an official position through its governing bodies. In any event, the outcomes of this meeting will guide WHO Europe in addressing this issue and organizing follow-up technical consultations.

The UN system and criminalization of HIV transmission/exposure

UNAIDS does not have an official position on criminalization, although in 2002 it produced a policy paper that outlined principles that should guide policy development in this area; identified a number of public policy considerations that should be taken into account; looked at alternatives to criminalization; discussed specific questions such as whether HIV-specific legislation is warranted and how far the criminal law should or should not go in criminalizing transmission or exposure; and made a number of recommendations to governments, police, prosecutors, judges and public health authorities.[3]

Concerned that information about criminal legislation and prosecutions was not readily available, and that the networking around such legal and human rights issues appeared to have ceased, UNAIDS pushed for the issue to be included in the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia.[4] This is reflected in part in Action 20 of the Dublin Declaration, which states: "Combat stigma and discrimination of people living with HIV/AIDS in Europe and Central Asia, including through a critical review and monitoring of existing legislation, policies and practices with the objective of promoting the effective enjoyment of all human rights for people living with HIV/AIDS and members of affected communities".

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[3] UNAIDS. Criminal Law, Public Health and HIV Transmission: A Policy Options Paper (Geneva, 2002), http://data.unaids.org/Publications/IRC-pub02/JC733-CriminalLaw_en.pdf.

[4] Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, February 2004, http://www.eu2004.ie.

In order to provide sound policy guidance to states in the light of an increasing number of criminal prosecutions and new legislative proposals and amendments, UNAIDS then collaborated with THT and GNP+ by providing partial funding for the rapid scan of laws and prosecutions in Europe.[5] Therefore, UNAIDS welcomed this initiative by WHO Europe and would like to see it go further, for example at the global level in the framework of the UNAIDS Global Reference Group on HIV/AIDS and Human Rights. As more prosecutions and legislative developments in this area are likely, it was further suggested that there is a need to establish some sort of "watchdog" system to monitor developments in the region.

Participants noted that it is already clear that some work is needed in particular areas (e.g., researching specific questions about the impact of criminalization and material to educate various actors within the justice system), which could be done without developing further policy statements. In addition, some work to guide policy on this issue has already been done, often at the national level such as the consultations on the draft UK Crown Prosecution Service (see Annex 1), and perhaps it is a question of ensuring that this does in fact get considered in the development of policies and practices.

Key issues discussed

1. How is "harm" understood in the context of criminal liability?

It was pointed out that the simple fact of transmitting HIV or another STI to a sexual partner or exposing another person to the risk of infection, cannot be considered on its own to be the wrongful infliction of a criminal harm. Rather, the harm arises in part because of the surrounding circumstances that negate the autonomy of the person infected, such as a lack of consent to the possibility of infection (e.g., as a result of deceit about the risk of infection). Interestingly enough, infection with HIV (and possibly other STIs in some jurisdictions) is defined as "(grievous/serious) bodily harm" in criminal law, whereas in other judicial/legislative contexts it is now represented as a chronic, manageable condition. However, because transmission in these cases is viewed through a "criminal law lens", it will inevitably be treated as a serious bodily harm.

Participants, however, emphasised that for many people in western Europe with a diagnosed HIV infection, effective treatment is available and such treatment ensures that they can live a full life. This is not to diminish the serious effects HIV can have, but it is important to realize that criminalization contributes to the way in which being HIV positive is understood, as a negative attribute of a person. Thus it contributes to stigma and discrimination. This again, can seriously hamper prevention and public health programming.

2. Should states enact HIV/STI-specific offences or, in appropriate cases, apply existing general offences?

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[5] Terrence Higgins Trust & Global Network of People Living with HIV. Criminalisation of HIV transmission in Europe: A rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights (2005), http://www.gnpplus.net/criminalisation/index.shtml.

The principle of *lex certa* requires that, before imposing punishment, the law must clearly delineate which conduct is prohibited; application of the law in violation of this principle risks contravening Article 7 of the *European Convention on the Protection of Human Rights and Fundamental Freedoms (ECHR)*. The Dutch Supreme Court, for example, has implicitly accepted this reasoning, stating that if the state is to pursue criminal prosecutions for HIV transmission or exposure, then the legislature should enact legislation that clearly states what is prohibited.[6] As a result of extensive dialogue with HIV sector organizations in advance of this ruling, the Ministers of Justice and Health recognized that embarking on such a legislative reform project would be undesirable (in part because of the stigmatizing impact). Therefore, they determined that, for legitimate public health reasons, they would accept the ruling of the Supreme Court that effectively circumscribes the possibility and scope of future prosecutions.

In general there are significant adverse impacts on the rule of law where people do not know the precise extent/scope/reach of the law. Thus, if states are going to criminalize transmission of HIV and other STIs this should not be subject to the vagaries of prosecution policy in the individual cases. It was also pointed out that, while an HIV-specific provision in criminal law is stigmatizing, it is the prosecutions themselves which are also stigmatizing, whatever their legal basis. Furthermore, the majority of prosecutions have happened in jurisdictions without such specific provisions, which have witnessed the ill-informed and also stigmatizing misuse of non-specific offences in the criminal law, which ought to be equally a cause for concern.

However, most participants argued for non HIV-specific legislation as to forestall debates over legislative proposals for criminalizing HIV transmission/exposure, which would be highly stigmatizing and counterproductive. WHO acknowledges both viewpoints.

Although HIV should ideally not be singled out for criminal prosecutions, neither is it desirable to expand the scope of the criminal law even further by targeting other STIs. Rather, the whole debate should be framed by public health considerations, not criminal law possibilities. This clearly establishes the need to narrow the scope of the debate and to gain consensus about the circumstances in which criminalization may be justified.

3. Should criminal law be limited to HIV/STI transmission or be extended to exposure?

There was a consensus among participants from European Union member states that, as a general proposition, the application of the criminal law should be limited to cases of actual HIV/STI transmission, and it is inappropriate and undesirable to extend the law to also criminalize HIV/STI exposure. There is considerable concern that the law would extend far too broadly if it were to criminalise all instances of exposure to a (known) HIV or STI infection – this would apply to hundreds of thousands of sexual encounters across Europe every year. It was also suggested by some participants that the per-act risk of transmitting HIV associated with various sexual acts was low enough that resort should not be had to the criminal law for simply instances of exposure, and that society's weapon of last resort should be reserved for those instances where actual harm has occurred. In particular, where precautions have been taken to the lower the risk of transmission even further (e.g., condom use and other safer sex measures), criminalizing the minimal risk that remains would be even

[6] "AA" [January 2005 judgement of Supreme Court of the Netherlands].

less justifiable, as well as counterproductively imposing criminal penalties even on those who follow public health advice regarding risk reduction. Finally, it was suggested that there is little evidence that criminalizing sexual exposure to HIV/STI has any public health benefit.

However, it was also recognized that there might be some circumstances in which a person exposes another to the risk of infection with the purpose of causing infection, including possibly in a sexual context. It may be appropriate for the criminal law to apply in such a case where there is classically criminal intent.

4. Intentional transmission or exposure

4.1 Intentional transmission or exposure

There was a consensus among consultation participants that criminalization could be justified in cases of conduct that intentionally transmits HIV/STIs.

4.2 Reckless transmission of exposure

It was strongly suggested that the criminal law should be limited to only intentional contact and should not extend to criminalizing recklessness, whether considering situations of actual transmission or simply exposure. This has been the approach adopted in some jurisdictions.

One argument against criminalizing recklessness is that it exacerbates the disincentive to HIV testing: "A person who does not know his HIV positive status cannot, legally, be reckless because he cannot, logically, be aware of the risk of transmitting HIV to his partners(s)."[7]

However, if the law provides for criminal liability for merely reckless conduct, participants also made a number of important suggestions as to how this standard should be interpreted and applied if at all.

4.2.1. Knowledge of HIV infection as precondition

There was strong consensus that criminal liability for recklessness could only be imposed, whether for transmission or exposure, in the event that the defendant actually knew (or believed) that he or she is infected with HIV or another STI.[8] In other words, a person could not be considered to have acted with criminal recklessness in the absence of this positive knowledge. To extend the criminal law beyond those with diagnosed infection – for example,

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[7] M Weait & Y Azad. The criminalization of HIV transmission in England and Wales: questions of law and policy. *HIV/AIDS Policy & Law Review* 2005; 10(2): 1, 5–12, www.aidslaw.ca.

[8] One participant noted that there could be specific situations in which a sexually active young person has not yet been made aware of his or her HIV infection by parents or guardians. In such cases, evidently the young person himself or herself could not be held criminally liable for transmission or exposure because of the lack of requisite personal knowledge. However, it was also important not to impose vicarious criminal liability on the young person's parent or guardian; to extend the threat of criminal prosecution that far would risk unfairness to the parent or guardian who cannot necessarily monitor all sexual activity of the minor, would invite (further) policing of the lives and relationships of young people by parents and guardians upon pain of criminal penalty, and would represent an unacceptable infringement of the right to privacy of young people, their partners and their families. There was general agreement to this point.

to those who know they *may* be infected, or even further to those that it is felt *ought* to know they are or may be infected – would be cast the net of criminal law far too broadly. As has been pointed out, such a standard would mean that:

> people who had ever had unprotected sex with a person about whose HIV or sexually transmitted infection status they were uncertain, and who had determined their own freedom from infection prior to unprotected sex with a new partner, would – absent a defence – be criminally liable… This would have resulted in a significant extension of criminal liability, one from which it is but a small step towards basing liability on membership of a high-prevalence group – on the grounds that gay men, injecting drug users or people from sub-Saharan Africa ought to assume by virtue of these criteria alone that they are, or may be, HIV-positive.[9]

4.2.2. Level of risk of transmission

▪ *No criminalization in the absence of significant risk of transmission*

There was a strong consensus that criminal liability, including for recklessness, should never extend to conduct that carries no significant risk of transmission. As noted by UNAIDS:

> [e]xtending the criminal law to actions that pose no significant risk of transmission would:
> - trivialize the use of criminal sanctions;
> - impose harsh penalties disproportionate to any possible offence;
> - discriminate against the accused person on the basis of his or her HIV status, rather than focusing on his or her conduct;
> - not advance the primary objective of preventing HIV transmission; and
> - actually undermine HIV prevention efforts by perpetuating the misperception that the conduct in question must carry a significant risk of transmission because it has been targeted for criminal prosecution.[10]

It was noted that the available data for quantifying the per-act risk of HIV transmission is limited, and that this scientific assessment will continue to evolve.

▪ *Risk-reduction precautions negating recklessness (e.g., safer sex)*

There was also a strong consensus that the criminal law should not punish those persons who, even if they do not disclose their HIV/STI-positive status to a sexual partner, nonetheless act responsibly and in accord with standard public health advice by taking precautions to reduce the risk of transmission. Practising safer sex, including the use of a condom for penetrative anal or vaginal sex,[11] or engaging only in activities that carry a similarly low or even lower risk, should preclude a finding of recklessness on the part of the defendant.[12] On at least this

[9] M Weait & Y Azad, *supra* note 7 at 5–6.

[10] UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3 at 9.

[11] KK Holmes et al. Effectiveness of condoms in preventing sexually transmitted infections. *Bull WHO* 2004; 82(6): 454-461.

[12] Note that in its 2005 judgment in "AA", the Supreme Court of the Netherlands concluded that even the per-act risk of HIV transmission via unprotected sex was not significant enough to sustain a criminal prosecution for

significant point, criminal law policy can and should be consistent with public health efforts. It would be entirely counterproductive if the fact of having taken precautions such as using a condom were to be used evidence of the defendant's awareness of a risk of transmission, in order to convict him or her for recklessness.

In some cases, prosecutors and courts have recognised that criminalization in such circumstances is unwarranted. In a Canadian case, the prosecution acknowledged that unprotected oral sex is conduct that carries only a low risk of HIV transmission and would not be the basis for a prosecution.[13] The Supreme Court of the Netherlands has ruled, in a case involving unprotected anal and oral sex, that there was not a "substantial" risk of transmission, and therefore a prosecution for recklessness could not succeed.[14] Under New Zealand's criminal law, there is a duty to take "reasonable" precautions and care to avoid endangering human life. In a criminal prosecution involving unprotected oral sex and protected vaginal sex, the court observed that the risk of HIV transmission through oral intercourse without a condom "is so low it does not register as a risk" and that there is a "relatively low risk of transmission when a condom is used when vaginal intercourse takes place". Since the legal duty "is not to take failsafe precautions", but to use "reasonable" precautions and care, the court was satisfied that the defendant did take reasonable precautions and care, and acquitted him of the charge of criminal nuisance.[15]

▪ *Other factors lowering the risk of transmission so as to negate recklessness*

Available evidence indicates that viral load is the chief predictor of HIV transmission, such that a reduction in viral load through the use of highly-active antiretroviral therapy (HAART) may reduce transmission even in the absence of changes to risk behaviour.[16] Therefore, it was suggested that in the case of an HIV-positive person with a very low or undetectable viral load, the per-act risk of transmission is lowered considerably, such that unprotected sex should not be considered criminally reckless.

5. Should consent preclude criminal liability and what suffices to constitute consent?

▪ *Consent a complete bar to criminal liability*

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exposure. Similar logic could apply in concluding that the defendant who engages in such conduct is not criminally reckless, particularly where the risk has been lowered further through precautions (e.g. condom use).

[13] *R.* v. *Edwards*, 2001 NSSC 80 (Nova Scotia Supreme Court) at para. 6.

[14] "AA", *supra* note 6 at para. 3.5.

[15] *New Zealand Police* v. *Dalley*, District Court of Wellington, Court File No. CRI-2004-085-009168, 4 October 2005 (per S.E. Thomas J.).

[16] TC Quinn et al. Viral load and heterosexual transmission of human immunodeficiency virus type 1: Rakai Project Study Group. *N Engl J Med* 2000; 342: 921-9; GD Sanders et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *N Engl J Med* 2005; 352: 570-85.

As recommended previously by UNAIDS and the OHCHR, if criminal law is applied to HIV transmission, it must be ensured that the question of consent is clearly addressed in law.[17] There was strong consensus among consultation participants that there is no justification for criminal prosecution for HIV/STI transmission or exposure in cases where there was consent on the part of the sexual partner of the person with HIV/STI (or an honest belief by the defendant in the partner's consent, following standard criminal law doctrine). To do so is an unjustifiable invasion of privacy and autonomy of both parties, and is to apply the criminal law to situations in which there is no harm that can give rise to the legitimate use of society's most serious weapon of last resort.[18]

▪ *Defining 'consent': general or specific?*

The more difficult question is what should constitute consent that precludes criminal liability for HIV/STI transmission or exposure.[19] Does a general agreement to engage in sex, particularly unprotected sex, with all the attendant risks, suffice? Or, in order to be legally valid and preclude a criminal charge for transmission or exposure, must a person's consent to sex, particularly if unprotected, be specifically informed by the knowledge that his or her partner has HIV or another STI. The latter standard would effectively obligate disclosure in most circumstances.

There was consensus that general consent to engage in sex with a partner whose HIV/STI status is unknown should be considered in law to amount to consent to possible exposure to HIV/STI, precluding criminal liability in cases of non-disclosure. Participants noted that, in accordance with standard criminal law doctrine, the application of criminal sanctions should be a measure of last resort. In addition, there is a generalized responsibility for HIV/STI prevention, a message that is at the heart of public health policy, which criminal law policy should respect. Finally, there is widespread awareness that unprotected sex carries a risk of a range of consequences, from HIV to other STIs to pregnancy in some cases. It would be unwarranted to criminalize "the individual who transmits HIV where those who have been infected are, despite non-disclosure, well aware of the potential harm to which they may be subjecting themselves by agreeing to have sex that carries the risk of transmission."[20] Furthermore, a person:

> does not need to know the HIV status of the sexual partner in order to make meaningful choices. He or she may choose not to engage in sexual acts so as to avoid

[17] *International Guidelines on HIV/AIDS and Human Rights*, *supra* note 1, Guideline 4; UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3.

[18] Courts have recognised the importance of respecting autonomy. For example, in the *Dica* case, the Court of Appeal for England and Wales recognised that if it were legally impossible to consent to risk-taking in consensual sex, the law would unjustifiably infringe upon personal autonomy, and ruled that interference to such a degree may only be made by Parliament through conscious enactment: *R* v. *Dica*, [2004] 3 All ER 593 at para. 52 (EWCA). See also: M Weait. Criminal Law and the Sexual Transmission of HIV: *R* v *Dica*, (2004) 68(1) *Modern Law Review* 121-134. The Court of Appeal also accepted this basic proposition in the subsequent case of *R* v. *Konzani*, [2005] EWCA Crim 706.

[19] The THT/GNP+ rapid scan (*supra* note 5) did not gather information on how this question of consent has been addressed so far in European jurisdictions.

[20] Weait & Azad, *supra* note 7 at 9.

> the higher degree of risk such acts would pose, may choose to take preventive measures to lower the risk to a level they find acceptable (e.g., condom use), or may choose to engage in unprotected sex, aware that a risk of HIV transmission may exist.[21]

Given this, to deny the defence of consent "would be tantamount to saying that the person infected bears no responsibility for their own sexual and physical health."[22] For these reasons, participants agreed that general consent to sex with a partner of unknown serostatus should preclude criminal liability of that partner.

▪ *Deceit versus non-disclosure*

Some participants drew a distinction between active deceit about one's HIV/STI-positive status and simple non-disclosure. They suggested that active deceit undermines the autonomy of the sexual partner who seeks to act, albeit imperfectly, to minimize his or her risk by basing his or her conduct on the information about the person's HIV status that has been (untruthfully) provided. This would, therefore, be conduct that could legitimately attract criminal penalty.[23] There was not the opportunity to discuss this point further or to reach any consensus as to whether a distinction with legal consequences should be drawn between deceit and mere non-disclosure, and in what circumstances. It has been noted, however, that:

> Instances where persons know that they are HIV-positive but do not disclose may be less a matter of a conscious effort to deceive, as the application of the criminal law suggests, and more a matter of denial, lack of self-efficacy to disclose, or concerns over potential repercussions of disclosure… Situation factors working against disclosure include engaging in sex in environments that implicitly discourage verbal communication between partners…, engaging in sex as a means to procure money or drugs, or engaged in sex with persons with whom an individual has not developed rapport. All of these factors reduce the reliability of relying on disclosure to determine if a prospective partner has HIV.[24]

▪ *Relevance of circumstances of the complainant*

It is critical that a putative defendant's individual circumstances, such as age and understanding of the nature of infection and of risk, be taken into account when deciding whether to prosecute. It is not in the public interest to prosecute those HIV positive people who are young, mentally ill, vulnerable (for social, cultural or other reasons), or ignorant.

▪ *Is there recklessness when circumstances hindering disclosure or taking of precautions?*

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[21] UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3 at 10.

[22] M Weait. Criminal Law and the Sexual Transmission of HIV: *R* v *Dica*, (2005) 68(1) *Modern Law Review* 121 at 128.

[23] E.g., Terrence Higgins Trust. Criminal Prosecution of HIV Transmission: A THT Policy Statement (April 2006), www.tht.org.uk; Executive Committee on Aids Policy & Criminal Law, 'Detention or prevention?': A report on the impact of the use of criminal law on public health and the position of people living with HIV (The Netherlands, 1 March 2004), http://www.aidsfonds.nl.

[24] C. Galletly & SD Pinkerton. Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV. *AIDS Behav* 2006; 10: 451–461.

It has been recognized that:

> Imposing criminal sanctions for conduct that transmits HIV or risks transmission would be unjust in circumstances where the HIV-positive person's options to avoid that harm, or risk of harm, either by disclosing to a partner and/or by taking precautions to reduce the risk of transmission, are limited. This is an issue that is of particular relevance to HIV-positive women.[25]

This unfairness would be particularly great in those cases where the person living with HIV is at risk of criminal prosecution for exposing or infecting his or her sexual partner when it is precisely the circumstances of the relationship with that partner – such as fear of violence upon disclosure of HIV status or the suggestion of safer sex – that impedes measures to prevent or reduce the risk of HIV transmission.

However, it remains to be seen whether prosecutors and courts share this recognition that disclosing HIV-positive status and/or taking precautions such as condom use may be particularly difficult in some circumstances, and will temper the application of criminal law accordingly. Occasionally it has been recognised that an appreciation of context is required: "the nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented."[26]

Depending on the law of the jurisdiction, one way in which prosecutors and courts could take a contextual approach to criminalization would be to determine that in some circumstances there is no recklessness on the part of the person who does not disclose HIV infection to a sexual partner or take precautions such as condom use where she or he honestly believes there is a risk of certain adverse consequences. This should certainly include an honest belief in the risk of physical violence, but should likely extend to include certain other serious adverse consequences.

- *Prosecution bears the burden of proving the absence of consent*

Finally, however "consent" may be defined in the law of a jurisdiction, it was agreed that it should be clear in the law that HIV/STI transmission or exposure may only constitute a criminal offence in the absence of consent on the part of the complainant – that is, the absence of consent is a requisite element of the offence. Consequently, the onus is on the prosecution to prove the absence of consent on the part of the complainant; the burden of proving consent does not lie on the defendant. There needs to be a clear understanding of this important point on the part of police, prosecutors, the defence bar, and courts (both judges and juries).

6. Public interest considerations: impact of criminalization on public health

It has been suggested by proponents of criminalizing transmission and/or exposure that the criminal law can serve HIV/STI prevention objectives, and in some cases such claims have

[25] UNAIDS, *supra* note 3 at 26.

[26] *R.* v. *Cuerrier* [1998 Judgment of the Supreme Court of Canada] 2 S.C.R. 371.

been accepted with little questioning by government policy-makers, prosecutors and courts.[27] But UNAIDS and the Inter-Parliamentary Union have observed overall that the existence of criminal prohibitions on HIV transmission or exposure "has little impact on the spread of the virus, given that the vast majority of cases of transmission occur at a time when the infected person is unaware of his or her own infection. Such laws divert attention and resources from measures which do make a difference in curbing the epidemic…"[28] Furthermore, there is, no scientific data supporting the claim that criminal prosecution, or the threat thereof, has any appreciable effect in encouraging disclosure to sexual partners by people living with HIV/STI or deterring sexual conduct that risks transmission. In fact, there is some limited evidence that the law has no appreciable effect.[29]

However, there is evidence that, following diagnosis, a significant proportion of people living with HIV do act in ways to reduce the risk of transmission to sexual partners.[30] In addition, evidence suggests that one factor strongly associated with such behaviour change is having received good-quality voluntary counselling and testing; hence the importance of ensuring access to such services, and to other support services that can assist in addressing underlying factors that may contribute to risk behaviours.[31] The available evidence also suggests, therefore, that before policies of criminalization are pursued, careful consideration must be given to the possible adverse consequences of deterring testing or impeding access to services that can support risk reduction.

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[27] Consider, e.g., the following statement from the Supreme Court of Canada in its first ruling on the question of criminal liability for HIV transmission: "If ever there was a place for the deterrence provided by criminal sanctions it is present in these circumstances. It may well have the desired effect of ensuring that there is disclosure of the risk and that appropriate precautions are taken...": *R.* v. *Cuerrier*, *supra* note 26.

[28] UNAIDS & Inter-Parliamentary Union. *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (Geneva: UNAIDS/IPU, 1999) at 50.

[29] Burris et al. have reported the results of a study that attempted to determine whether the criminal law regarding HIV transmission/exposure has any empirical effect on risk behaviour and disclosure. Based on data gathered from 500 participants in 2 jurisdictions in the United States with different criminal laws regarding HIV transmission/exposure, the authors conclude that: "Our data do not support the proposition that passing a law prohibiting unsafe sex or requiring disclosure of infection has a normative effect, for the simple reason that the overwhelming majority of people in our study already believed that it was wrong to expose others to the virus, and right to disclose infection to their sexual partners." They caution: "Given concerns about possible negative effects of criminal law, such as stigmatization or reluctance to cooperate with health authorities, our findings suggest caution in deploying criminal law as a behavior change intervention for seropositives." See: S Burris et al., "Do Criminal Laws Effect HIV Risk Behavior? An Empirical Trial". 1st Annual Conference on Empirical Legal Studies Paper Available at SSRN: (forthcoming 2007), draft online: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=913323.

[30] G Marks et al. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. *JAIDS* 2005; 39: 446-52.

[31] See, generally, UNAIDS. The Impact of Voluntary Counselling and Testing: A global review of the benefits and challenges (Geneva: UNAIDS, 2001), and studies cited therein; LS Weinhardt et al. Effects of counseling and testing on sexual risk behavior: A meta-analytic review of published research, 1985-1997. *Am J Public Health* 1999; 89: 1297-1405.

7. Establishing the causal link: proving infection by the defendant

Consultation participants noted that in recent years, prosecutors handling cases of HIV transmission increasingly have resorted to scientific evidence such as phylogenetic testing in attempting to prove the defendant was the source of the complainant's infection and to rule out other possible sources of infection. However, it has become apparent that such technical evidence, and its limitations, have not been well understood by police, prosecutors, the defence bar, courts or the media, nor is it necessarily well understood by people living with HIV or HIV sector organizations. In some cases, this evidence is being misused, with overstated claims as to its conclusiveness in "proving" beyond a reasonable doubt the guilt of the defendant. It was noted that in a recent prosecution in the UK, for the first time a prosecution collapsed because the defence produced a virologist as an expert witness who outlined the limits of the phylogenetic testing performed by the prosecution. In Denmark, a case has been launched recently in which the prosecution relies heavily on phylogenetic testing evidence in its claim that the defendant is responsible for infecting three sexual partners.

There is, therefore, an urgent need to produce accurate information, in a language and format that is accessible to those without virological scientific expertise, on the use of scientific evidence such as phylogenetic testing in criminal prosecutions for HIV/STI transmission. Consultation participants strongly recommended that WHO, among others, take up this task and make such information widely available. There is also a need to address the improper use of such evidence in prosecutions (see below).

8. Conduct of police investigations and prosecutions

UNAIDS has recommended that "States establish guidelines for prosecutors to prevent inappropriate criminal prosecutions and to guide prosecutorial conduct during proceedings, so as to avoid publicity that may prejudice a trial, breach the confidentiality of the accused's HIV status, expose the accused to stigma and discrimination before having been convicted of any offence, and undermine public health efforts by contributing to widespread misconceptions about how HIV may be transmitted."[32] Participants were unanimous in their concern over actual or potential misconduct by police and prosecutors in the criminalization of HIV/STI transmission. Various examples were been cited over the course of the day's discussion. The job of police is to fairly and impartially investigate allegations of criminal offences; the duty of the prosecutor is not to secure a conviction *per se*, but to act in the public interest and to assist the court in ensuring justice is done and seen to be done. In the light of these concerns, participants agreed on a number of points that should inform policy and practice:

- *Prosecution policy:* It is advisable that there be a policy, developed in consultation with groups of people living with HIV and HIV/STI sector organizations as well as public health experts and the health ministry, to guide prosecutorial decision-making. Recognizing that criminalization should be a last resort, such a policy should take the approach of refraining from prosecution unless certain conditions, specified in the policy,

[32] UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3 at 40.

are satisfied.[33] Among other things, the policy should clearly state that there is no criminal offence unless the prosecution can prove the absence of consent on the part of the complainant.

- *Complainant as precondition:* It should be required that there be an actual complainant wishing to press charges in order to launch a police investigation or proceed with a prosecution. Policies governing police and prosecutorial conduct should state clearly that cases will not proceed in the absence of such a complainant.

- *Use of scientific evidence:* Policies governing prosecutors must require that prosecutors seek independent advice from qualified medical experts regarding the risks of HIV/STI transmission in the circumstances of a given case before making a determination to proceed with a prosecution for transmission or exposure. Similarly, prosecutors must consult with qualified medical experts regarding the use of the scientific evidence that may be used for the purpose of demonstrating a defendant is the source of a complainant's infection (e.g. phylogenetic testing of HIV/testing of RNA levels), and must not mislead the defendant or his/her legal representatives, the media and general public, or the court regarding the reliability of this evidence. In addition, a policy statement should direct that the prosecution may not proceed on the basis of a guilty plea obtained solely on the basis of such evidence regarding the route of transmission, in the absence of further corroboration to support the guilt of the defendant. Similarly, a practice direction to courts should prohibit a court from accepting a guilty plea, or entering a conviction, solely on the basis of such evidence, absent further evidence to corroborate the defendant's guilt.

- *Solicitation of complaints:* Policies governing police conduct should prohibit the release of information about a person suspected or accused of HIV/STI transmission or exposure, either to the media or directly to the public, that is aimed at soliciting additional complaints. Such solicitation is particularly inappropriate when a complaint that has been received does not itself provide reasonable grounds to believe any offence has been committed.

- *Public commentary on a particular prosecution:* Policies governing police and prosecutors must clearly prohibit police officers or prosecuting authorities from making public comments about the defendant that are intended, or can reasonably be foreseen, to prejudice the right to a fair trial. This includes statements that: misstate known facts regarding HIV/STI transmission or disease; exaggerate or misrepresent the evidence known to police and prosecutors; exaggerate or misrepresent an offence with which the defendant has been charged; or appeal to or provoke racist, sexist, homophobic or other stereotypes or prejudices in relation to either the defendant or the complainant. Policies governing police should also prohibit any member of the investigating police force from publicly calling for prosecutors to proceed with a prosecution in a particular case, and should prohibit police officers from commenting publicly on a case once the decision has been made by prosecuting authorities to proceed with the matter before the courts.

In addition, consultation participants endorsed the following recommendations by UNAIDS:

[33] E.g., see the recommendation to this effect in Executive Committee on Aids Policy & Criminal Law, 'Detention or prevention?', *supra* note 23.

> States must ensure clear policies and protocols ensuring that the conduct of legal proceedings is not tainted by misinformation about HIV/AIDS and bias towards people living with HIV/AIDS, so as not to prejudice the right to a fair trial and perpetuate misconceptions about HIV/AIDS. HIV-positive defendants in criminal or public health proceedings should be treated the same as any other defendant, and "[n]o unusual safety or security precautions should be employed", such as gloves, masks or restraints, or permitting counsel or court personnel to stand back from an HIV-positive defendant [simply on account of his or her serostatus]. Discriminatory courtroom proceedings also include prejudicial and inflammatory questioning and, in the case of trials by jury, courts should have and use the power to hear proposed evidence outside the presence of the jury and make preliminary rulings as to whether such evidence is admissible.[34]

> "People living with HIV/AIDS should be authorized to demand that their identity and privacy be protected in legal proceedings in which information on these matters will be raised." States should ensure that laws and policies governing the conduct of legal proceedings include provisions for courts to protect the confidentiality of the accused by ordering the use of a pseudonym for proceedings, sealing the court record of proceedings, permitting proceedings *in camera*, imposing a publication ban on details that would identify the accused, and imposing prohibitions on court personnel from disclosing information ordered to be kept confidential.[35]

Consultation participants noted that, as is often already the case in many jurisdictions, provisions for ordering the use of pseudonyms should be applicable for both defendants and complainants, both of whom may have a significant interest in avoiding HIV/STI-related stigma and discrimination as a result of public attention to prosecutions, including often sensational media coverage.

9. Privacy rights: confidentiality of communications with service-providers

Consultation participants endorsed the recommendation by UNAIDS that:

> So as to minimize the potentially detrimental impact on access to counseling and support services which assist in avoiding risky behaviour, details of the accused person's communications to a health-care professional, spiritual adviser or other counselor should be legally inadmissible in a prosecution for a criminal or public health offence.[36]

They also recommended that WHO undertake a more in-depth analysis of this issue so as to provide guidance to States in ensuring this protection for the privacy of health information, consistent with the need to support overall public health efforts to prevent the spread of HIV and other STIs, and with protections for the right to privacy in international legal instruments.

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[34] UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3 at 41, with reference to: American Bar Association. Policy on AIDS and the Criminal Justice System (1989).

[35] Ibid., with reference to: *International Guidelines*, *supra* note 1, Guideline 5.

[36] UNAIDS. Criminal Law, Public Health and HIV Transmission, *supra* note 3 at 41.

10. Other conclusions and recommendations

In addition to their conclusions and recommendations regarding specific questions of the appropriate or inappropriate use of the criminal law, consultation participants identified a number of other initiatives that are needed to respond to the public health and human rights concerns raised by criminal prosecutions for HIV/STI transmission or exposure.

▪ *Human rights assessment of criminal prosecutions or coercive public health measures*

The survey undertaken by THT/GNP+ "confirmed that there is a need for further research into the potential human rights violations present in some aspect of criminal enforcement and judicial systems in relation to HIV". For example, the penalty imposed may include deportation of a convicted defendant to a country where there is little or no access to effective HIV/AIDS treatment, a practice that has been questioned by the European Court of Human Rights.[37] In other cases, persons living with HIV have been subject to lengthy detention and forced isolation (under quasi-criminal public health legislation) without justification; the European Court of Human Rights has ruled unanimously in at least one case that the state had violated Article 5 of the *ECHR* which guarantees the rights to liberty and security of the person.[38]

▪ Monitoring criminal prosecutions and legislative/policy developments

A number of HIV sector organizations have had to respond in some way to criminal prosecutions or legislative/policy developments criminalizing HIV/STI transmission or exposure. As noted. As noted in the THT/GNP+ survey,

> the extent of this involvement ranged from keeping a watch on events to active support for those being prosecuted or for their lawyers. Some organizations were also campaigning to change or shape their national laws on criminalization of HIV transmission. There was, however, often a sense that organizations had been overtaken by events… [I]t was noticeable that in a number of countries there was no easily located source of community or NGO expertise on HIV and the law. [… There is] a need to encourage better data surveillance and collection on prosecutions and use of this area of the law…. As we gain in understanding of how the use of the criminal law impacts upon people with HIV and upon public health, it will be important to formulate ways of empowering national and local groups which seek to debate this issue and work on it. Greater access to information, to others working on the issue within their country or region, and to core documents will all be part of supporting this greater capacity. It is vital that people with HIV, those most at risk of transmission, those who provide treatment and care, and those involved in sexual health promotion are all enabled to help shape future jurisprudence which respects human rights and furthers public health.[39]

[37] *D.* v. *United Kingdom* (1997), 24 EHRR 425.

[38] *Enhorn* v. *Sweden*, Judgment, European Court of Human Rights, Application no. 56529/00, January 2005.

[39] THT & GNP+, Criminalization of HIV transmission in Europe, *supra* note 5.

WHO and UNAIDS could play a role, in collaboration with NGOs, in monitoring criminal prosecutions and related legislative/policy developments, as well as in ensuring this information, and the analysis of this information, is made available to groups working on these issues.

▪ *Engagement with media*

As noted in the THT/GNP+ rapid scan:

> Respondents identified the media as being a prominent accompaniment of most prosecutions, particularly during trials, and especially during the first successful prosecution of an HIV transmission case within a country. In most cases, the popular press appeared to 'sensationalize' the cases, often depicting those convicted as being a threat to the population. Media, and media-shaped negative public viewpoints, were cited by a number of respondents as a key factor in criminal prosecutions and their public impact.[40]

Given that stigma and discrimination undermine effective public health responses to HIV/STIs, consultation participants noted the need for a closer examination of the role of the media, and media coverage of prosecutions or other legal developments related to HIV/STI transmission, in contributing to HIV-related stigma or providing (mis)information to the general public about HIV/STI transmission. In addition, groups of people living with HIV and HIV sector organizations need to engage more pro-actively with the media to encourage accurate, non-stigmatizing reporting of prosecutions. This could include developing information kits about HIV/STIs and the criminal law, or other educational efforts, that explaining basic facts and concepts, identify examples of poor reporting, and suggest ways in which such stories can be covered, if at all, in ways that avoid or minimize the stigmatizing effect. In some cases, resort should be had to industry complaints mechanisms for inaccurate or egregious reporting if there is reason to believe such mechanisms are effective.

▪ *Educate actors in the criminal justice system*

Consultation participants repeatedly identified the need for HIV sector organizations and groups of people living with HIV to educate actors in the criminal justice system – prosecutors, the defence bar, and judges – about HIV and other STIs. Again, organizations such as WHO and UNAIDS can play an important role in supporting these efforts, by bringing its scientific expertise and authority in public health to bear and in producing materials that address specific questions about HIV and STIs that arise in the context of contemplating, pursuing, defending against, or adjudicating criminal prosecutions. These materials could also be useful in educating the broader public and leading to more informed debate about the appropriate application of criminal law in the context of HIV/STI transmission or exposure.

▪ *HIV prevention efforts, for general public and for people living with HIV*

Consultation participants strongly agreed that, in the face of criminalization, there was an even greater need for renewed HIV prevention messages for the broader sexually active

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[40] THT & GNP+. Criminalization of HIV transmission in Europe, *supra* note *5*.

public, including reinforcing the key notion of shared responsibility for risk reduction. It was also noted that "prevention for positives" public health efforts, which focus on people living with HIV, need to be undertaken in ways that do not undermine the broader public health message that all persons have a responsibility for prevention and that do not contribute to further stigmatization and criminalization of people living with HIV.

- *Alternatives to criminal prosecutions*

Finally, it was suggested that HIV sector organizations and groups of people living with HIV will have an ongoing role in supporting people living with HIV in dealing with the question of criminalization, which will include both complainants and defendants, potential and actual. These organizations need to be in a position to: (i) assist people living with HIV in understanding the state of the law in their jurisdiction as it relates to HIV transmission or exposure and by supporting them in avoiding conduct that is or may be criminalized; (ii) assist complainants in making informed decisions about whether to resort to criminal charges (e.g., by providing information about what the process of a criminal prosecution will entail); and (iii) assist defendants in finding competent legal representation and by providing information about HIV, scientific evidence, and legal arguments and public policy considerations that need to be considered in conducting a defence. HIV sector organizations may also wish to look at facilitating alternatives to criminal prosecution for those who are aggrieved by a past sexual partner from whom they believe they contracted HIV, such as alternative dispute resolution mechanisms.

Conclusions and next steps

Participants recommended that the criminalization of HIV/STI transmission should be a last resort and only undertaken in a manner consistent with States' human rights obligations, as outlined for example in instruments such as the *International Guidelines on HIV/AIDS and Human Rights*. Any instance of resort to criminalization was seen as a failure of prevention efforts, further highlighting the need for greater efforts on this front, including measures to overcome stigma and discrimination that undermine prevention. WHO Europe plans to conduct additional consultations on the criminalization of HIV and STIs with representatives of Member Sates, civil society and other technical experts and was encouraged to consider developing a position statement on this issue.

ANNEX 1. Criminalization of HIV/STIs: Select country summaries

United Kingdom

The draft UK Crown Prosecution Service (CPS) policy extends beyond HIV to include other STIs (including hepatitis C, which is primarily a bloodborne infection and is rarely sexually transmitted), but is clearly being driven by the prosecutions which have occurred to date in the UK, all of which have been against persons living with HIV. Since 2003, there have been 10 prosecutions under the *Offences Against the Person Act, 1861*. Eight of these cases have been based on alleged transmission in heterosexual relationships, while two prosecutions have arisen from alleged sexual transmission between men; that the majority of the prosecutions in the UK have been for heterosexual relations (and predominantly HIV-positive men accused of transmission to female partners) seems similar to the pattern observed in other jurisdictions. Nine of the prosecutions have resulted in convictions, some following guilty pleas. All those convicted received custodial sentences, ranging between 2½ to 4½ years. Four of the defendants have been migrant men (3 of African origin, one from Portugal), four have been white British men, and two have been white British women. In some cases, reporting has focused as much on the immigration status of the person accused as on the potential and actual harm caused, a situation which has been seen in some other countries as well.[41] Recently, one of the ten prosecutions has resulted in an acquittal. For the first time, an expert virologist challenged the prosecution's use of phylogenetic testing in an attempt to prove the defendant was the source of the complainant's infection, leading to the collapse of the prosecution's case.

The cases to date have highlighted the poor understanding of HIV by the courts and have often been marked by objectionable police practices (e.g., trawling through the sexual history of people living with HIV in an effort to uncover infected would-be complainants, and public solicitation of additional complainants, in some cases even without any evidence of an offence known to UK law having been committed). Under the law of the United Kingdom (notwithstanding minor differences in formulation between Scottish law and that in force in England and Wales) as it currently stands:

- the accused must know he or she is HIV-positive;
- the accused must engage in conduct carrying a risk of transmission;
- the accused must understand the risk of transmission associated with that conduct;
- actual transmission of HIV must occur as a result of the defendant's conduct; there is no crime of exposure; and
- the consent of the defendant's sexual partner to the risk of infection may be raised as a defence, but consent cannot be inferred from a general understanding or awareness of HIV. Rather, consent can only arise as a defence if the defendant has disclosed or, in some other way, the complainant is aware of the defendant's HIV infection.

[41] Terrence Higgins Trust & Global Network of People Living with HIV. Criminalization of HIV transmission in Europe, su*pra* note 5. For research in the UK documenting concern about stigmatization and selective prosecution of migrants, see: C Dodds et al. Outsider status, stigma and discrimination experienced by gay men and African people with HIV. Sigma Research, December 2004, www.sigmaresearch.org.uk.

Non-governmental organizations in the UK have raised a number of arguments against such criminal prosecutions, including the following:[42] *stigmatisation of HIV/AIDS and people living with HIV*, the *undermining of other HIV prevention efforts, that it is disconnected from the social realities of sexual encounters, such as widespread knowledge of HIV risk and safer sex messages as a result of public education efforts, and invasions of privacy.*

The British HIV Association (BHIVA) has recently undertaken a consultation on the implications of criminalization of HIV/STIs for clinicians, in an effort to supplement more generic guidance on professional ethics from the General Medical Council.[43]

The Netherlands

In the Netherlands prosecutions of cases of HIV exposure occurred between 2001 and 2005, the year when they were effectively ended by a ruling of the Dutch Supreme Court. This court specifically mentioned public health interests as a general reason to limit prosecutions of risk behaviours by people living with HIV to situations where "extraordinary, risk-exacerbating conditions" were at stake. According to the ruling of the Supreme Court: the outcome of prosecutions in general would be wholly undesirable. The Supreme Court also commented that current legislation did not suffice to sustain warrant prosecutions in part because it did not provide sufficiently clear direction on advance of the conduct is criminally prohibited – the *lex certa* principle as laid down in Section 7 of the European Convention on Human Rights. As a result of dialogue between HIV organizations and the Health and Justice Departments as of 2002, the Dutch government decided not to introduce legislation that would enable prosecutions. However, it remains uncertain how the law will deal with transmission cases. The Dutch Supreme Court will likely issue a ruling on a transmission case in late 2006 or early 2007.

Sweden

As of the end of 2005, there have been a total of 7099 cases of HIV infection reported in Sweden and there have been a disproportionate number of criminal prosecutions vis-à-vis the rest of Europe.[44] In 2004, Sweden enacted a new *Communicable Disease Act* (2004: 168), which, like previous legislation, includes provisions granting authority to public health authorities to intervene in the event a person is spreading, or is suspected of spreading, a communicable disease.

In particular that Chapter 4 of that Act imposes an obligation on a person to inform sexual partners about infection with a disease listed in the Act (which includes HIV), as well as a prohibition on sharing needles if HIV-positive. Chapter 5 allows for compulsory isolation of a person with a listed communicable disease if, in the circumstances of an individual case, (i)

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[42] For further discussion, see e.g.: National AIDS Trust. Criminal Prosecution of HIV Transmission: NAT Policy Update (August 2006), www.nat.org.uk; Terrence Higgins Trust. Criminal Prosecution of HIV Transmission, *supra* note 23; M Weait & Y Azad. The criminalization of HIV transmission in England and Wales, *supra* note 7.

[43] J Anderson et al. "HIV transmission, the law and the work of the clinical team: A briefing paper" (British HIV Association, 2006), www.bhiva.org.

[44] THT & GNP+. Criminalization of HIV transmission in Europe, *supra* note 5.

the public health authority concludes that a person is not ready to follow measures necessary to reduce the risk of transmission of the disease, or (ii) there is reason to believe the person is not following the rules of behaviour that have been prescribed by the public health authority. Upon diagnosis with a communicable disease, the person in question must sign a document indicating that he or she understand the rules of behaviour that have been prescribed. The medical health officer (a physician) at the county level has the authority to order compulsory isolation, which decision is also within the bailiwick of the county administrative court. Up until 1998, there have been 65 cases of compulsory isolation (62 of whom were PLWHA between the age of 20–49). The average time for isolation was 6-9 months; however, there have been 12 cases in which isolation was imposed for more than 2 years; in one such case, a person living with HIV who had severe drug dependence was isolated for 7½ years. Aside from persons who use injection drugs and/or have other mental health issues, other men who have been the subject of compulsory isolation orders have been almost entirely those who have immigrated to Sweden from outside Europe.

As for Swedish criminal law, the *Penal Code* (1962: 700) includes the offences of assault and gross assault, as well as prohibiting attempts to commit these two offences (see Chapters 3 and 23 of the *Code* in particular). These have been the basis for most of the criminal prosecutions to date in Sweden.

In April 2004, the Supreme Court issued an important ruling on a defendant's appeal from his conviction for gross assault for unprotected sex without disclosure (to one partner out of ten known partners) and reduced the sentence of four years of imprisonment to one year (imposed even though the partner was not infected). The Supreme Court substituted a conviction on the lesser charge of "creating danger for another" and reduced the sentence correspondingly.

It was recommended that there be further work with the mass media to address their reporting on such cases; enhanced HIV/STI awareness campaigns to raise the level of basic knowledge about HIV/STI risks and responsibilities in the general public; the ongoing need to fight HIV-related stigma and discrimination; and the need to educate actors in the justice system (police, defence lawyers, prosecutors and judges) about HIV.

Germany

There is no law specifically addressing sexual transmission of HIV or another STI. Rather, transmission, through sex or other means, can be prosecuted as the offence of "causing dangerous bodily harm"; if the complainant is simply exposed to the risk of infection, without actual transmission, this can be prosecuted as attempting to cause grievous bodily harm.

German law is not clear-cut when it comes to the issue of disclosure, but it was suggested that if a person living with HIV takes precautions to reduce the risk (e.g., using a condom), then this may prevent prosecution. On a related point, there is, for example, no legal obligation on the part of someone who is injured to disclose his or her HIV-positive status to someone attending them.

Hungary

While under the Hungarian Penal Code other STIs could in theory be the basis of criminal prosecutions, there do not seem to have been any cases other than for alleged HIV exposure.

The HCLU knows of only 3 prosecutions so far (dating to 1994, 1999 and 2000), but none of them have resulted in convictions. There is a clear need for training of and dialogue with police, prosecutors, and judges, including to educate them about HIV/STIs. If guidelines are developed (e.g., by WHO or at the national level), then it will be important to answer the concerns of people who are HIV-negative and are afraid of becoming "victims" of infection.

A few years ago, the HCLU published a book on HIV/AIDS and human rights in Hungary which includes a chapter on criminal law.[45] HCLU's analysis is that murder or manslaughter charges under the *Penal Code* would not be applicable, because the causal and temporal link between HIV infection and death would be too weak to sustain conviction on these offences. According to HCLU, as it now stands, actual infection, not mere exposure to the risk of infection, would be required in order for a criminal conviction: *recklessly causing bodily harm* can result in criminal liability.

Denmark

The Danish *Penal Code* includes a provision that imposes a penalty of up to 8 years' imprisonment on any person who, for the purpose of gain or wantonly or recklessly endangers the life or physical ability of others, or who wantonly brings about the danger of infecting someone with a fatal and incurable disease (s. 252).[46] To date, there have been 19 criminal prosecutions, the majority of them related to HIV exposure rather than transmission; 8 cases so far have resulted in convictions. The first prosecution related to HIV was brought in 1993. However, the Danish Supreme Court found the defendant not guilty because this section did not provide a clear legal basis for conviction. Other subsequent prosecutions failed for the same reason. In response, in 2001, the Danish government issued an order that lists only HIV/AIDS as the sole disease covered by this provision.[47] Since then, some prosecutions have failed for other reasons.

In September 2006, a young gay man has been charged for allegedly infecting 3 other young men; he has pleaded not guilty. When the case was first presented, the front page of some tabloid newspapers carried a picture of the defendant at a youth event at HIV Denmark, putting the organization in a difficult position as it tries to provide support to all people living with HIV/AIDS. In this case, the prosecution plans to rely heavily on the use of HIV-RNA testing in trying to prove the defendant infected the three complainants. This is the case to date that most squarely raises the issue of criminal liability for actual transmission, and raises directly the question of reliability of such scientific evidence.

[45] Hungarian Civil Liberties Union. *HIV/AIDS and Human Rights in Hungary* (Budapest: HCLU, 2004).

[46] Summary based on unofficial translation provided by HIV Denmark.

[47] Government Order nr. 547 of 15 June 2001.

ANNEX 2. Programme

Monday, 16 October	**CH-1,** WHO Regional Office for Europe, Scherfigsvej 8, Copenhagen
10.30–11.00	Registration and coffee
11.00–11.30	Introduction and Welcome *Dr Srdan Matic*, Regional Adviser, Sexually Transmitted Infections, HIV/AIDS Programme, WHO Regional Office for Europe; *Nikos Dedes,* European AIDS Treatment Group,
11.30–12.00	United Kingdom Policy Proposal: *Mr Yusef Azad,* National AIDS Trust (NAT)/AIDS Action Europe, *Charles Gore*, Hepatitis C Trust, *Nicola Rowan*, Mainliners
12.00–12.30	Criminalization of HIV/STIs: Country examples – Netherlands *Ronald Brands*, Amsterdam Task Force; Sweden, *Andreas Berglof* HIV-Sverige
12.30–13.30	Lunch (WHO Canteen)
13.30–14.30	Country examples (continued) – Germany: *Ingo van Thiel*, German Liver Health Association and *Ulrich Marcos*, Robert Koch Institute; Hungary: *Eszter Csernus*, Hungarian Civil Liberties Union; Denmark: *Henrik Arildsen*, HIV Danmark
14.30–15.00	Criminalization of HIV/STIs: UNAIDS position, *Henning Mikkelsen*, UNAIDS
15.00–15.15	Coffee break
15.15 – 17.00	Discussion to identify and agree key issues (Moderator: *Richard Elliott*, Canadian HIV/AIDS Legal Network)
17.00–17.45	Wrap-up and next steps: *Srdan Matic* and *Jeffrey Lazarus*, WHO Regional Office for Europe

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ANNEX 4. List of background material

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