



# The Global Criminalisation Scan Report 2010

Documenting trends,  
presenting evidence



# Acknowledgements

On behalf of the Global Network of people living with HIV (GNP+), this document was written by Sally Cameron and Lucy Reynolds, with assistance and ongoing research and editorial support from Edwin Bernard, John Godwin and Moono Nyambe.

Thanks to the following GNP+ members of staff: Julian Hows, Christoforos Mallouris and Martin Stolk.

The report is based on information gathered during the implementation of the Global Criminalisation Scan by:

- The Asia-Pacific Network of people living with HIV/AIDS (APN+) who provided information for the Asia-Pacific Region;
- The Caribbean Network of people living with HIV/AIDS (CRN+), who provided information for the Caribbean;
- GNP+ North America (GNP+ NA ) who provided the data from Canada and the United States of America;
- The sub-regional networks of African People living with HIV/AIDS, in Central, East and West Africa, who provided data for Africa;
- Red Latino Americana de personas viviendo con VIH/SIDA (REDLA+) who provided data for Latin America; and
- Terrence Higgins Trust (UK) who provided the data for Europe and Central Asia.

GNP+ acknowledges the support of these partners and that of the individuals and organisations that completed the questionnaires and provided other information.

GNP+ acknowledges the strategic and programmatic support offered by the Programme Advisory Group: Deborah Glejser, Edwin Cameron, Matthew Weait, Priscilla Misihairabwi-Mushonga, Richard Elliott, Ruben E. Pecchio and Ted Gaudet.

Published by:

The Global Network of People Living with HIV (GNP+)

P.O. BOX 11726

1001 GS Amsterdam

The Netherlands

Website: [www.gnpplus.net](http://www.gnpplus.net)

E-mail: [infognp@gnpplus.net](mailto:infognp@gnpplus.net)

Some rights reserved: This document may be freely shared, copied, translated, reviewed and distributed, in part or in whole, but not for sale or use in conjunction with commercial purposes. Only authorised translation, adaptation and reprints may bear the emblems of GNP+. Enquiries should be addressed to GNP+, P.O. BOX 11726, 1001 GS, Amsterdam, The Netherlands, [infognp@gnpplus.net](mailto:infognp@gnpplus.net).

© July 2010. The Global Network of People Living with HIV (GNP+)

Design: Raffaele Teo ([arteo71@hotmail.com](mailto:arteo71@hotmail.com))

Suggested citation: GNP+. 2010 Global Criminalisation Scan Report

# Foreword

This report gives a global overview of the extent to which criminal and other laws have been used to prosecute people living with HIV for HIV transmission and exposure.

The full impact of these laws on the human rights of people living with HIV and on access to treatment, care and support has yet to be fully understood. However, the evidence presented here shows that there is no correlation between the HIV prevalence in a country and the willingness of countries to use criminal laws and other punitive measures to regulate transmission.

The report gives examples of instances where people living with HIV have expressed concerns about negative consequences that come from the overly broad use of laws in cases of transmission and exposure to HIV. We are encouraged by the conclusions of Anand Grover, the UN Special Rapporteur, on the right of everyone to enjoy the highest attainable standard of physical and mental health. His report calls for governments *'to immediately repeal laws criminalising the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalising intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases.'* (Grover 2010)

The Special Rapporteur's report is timely. The number of people prosecuted and convicted is growing. Western Europe and North America are the regions with the highest number of cumulative prosecutions against people living with HIV to date. In Africa, over 20 countries have introduced HIV-specific laws criminalising HIV exposure and transmission in the last 10 years. As the Special Rapporteur's report shows, these laws, *"increase stigma against people living with HIV and destroy the lives of those caught up in criminal trials: the accused, their families, and sometimes, those identified as victims"* (Grover, 2010).

However, it is not all doom and gloom. Change is possible. GNP+ and others welcome the legislative changes in Sierra Leone repealing a problematic section of that country's HIV law relating to vertical transmission. Local and international agencies and activists, including GNP+, were instrumental in advocating for these changes and providing the information to the country's lawmakers that enabled them to make this change. This is just one example of community advocacy highlighted in this report. I hope that this report promotes further activism from people living with HIV and others, and plays a vital part in mitigating the harms arising from a misinformed and misguided use of law.

This report highlights the urgent need for government reform and calls for the guided application of expert evidence and legal opinion to stem the swell of prosecutions and to counter the false premise of the perceived benefit of HIV-specific criminal laws.

## **Kevin Moody**

International Coordinator and CEO

Global Network of People living with HIV (GNP+)



# Contents

Acronyms	05
Executive Summary	06
Introduction	07
The Global Criminalisation Scan	08
Methodology	09
History	09
Results: Global Overview	11
Regional Overview	
Africa	13
Asia-Pacific	15
Caribbean	16
Europe-Central Asia	16
Latin America	18
North America	18
Discussion	
1. Transmission Risk	20
1.1 Sexual Exposure and Transmission Risk	21
1.2 Impacting transmission through sexual contact	22
1.3 Vertical Transmission Risk (mother to child: pregnancy, childbirth and breastfeeding)	24
1.4 Persistent Transmission Mythology (spitting, biting and scratching & phylogenetics)	26
2. Disclosure	28
2.1 Disclosure by those unaware of their HIV-positive status	28
2.2 Instances of miscommunication	30
2.3 Some people do not always disclose their HIV status	30
2.4 Disclosure triggering prosecution	31
3. Perpetuating Inequality	32
3.1 Protecting women	32
3.2 Migrant communities	35
3.3 MSM	36
3.4 Sex workers	37
3.5 Children	39
Conclusions	40
Recommendations	42
References	43



# Acronyms

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral therapy
<b>APN+</b>	Asia-Pacific Network of People Living with HIV
<b>CD4</b>	Cluster of differentiation 4 (CD4 count used to track and evaluate HIV progression, and considered in relation to initiation & efficacy of treatment)
<b>CRN+</b>	Caribbean Regional Network of People living with HIV
<b>FHI</b>	Family Health International
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPI</b>	Health Policy Initiative (USAID programme)
<b>ICW-Global</b>	International Community of Women with HIV/AIDS-Global
<b>IDU</b>	Injecting drug use
<b>MSM</b>	Men who have sex with men
<b>NAFOPHANU</b>	National Forum of PLHA Networks in Uganda
<b>NAP+</b>	Network of African People Living with HIV
<b>NGO</b>	Non-government organisation
<b>ODI</b>	Overseas Development Institute (UK based)
<b>PITC</b>	Provider-initiated testing and counselling
<b>PLHIV</b>	People living with HIV (including people with AIDS)
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>SADC</b>	Southern African Development Community
<b>STI</b>	Sexually transmissible infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Program
<b>USAID</b>	United States Agency for International Development
<b>USAID AWARE</b>	Action for West Africa Region on HIV/AIDS (USAID programme)
<b>VCT</b>	Voluntary counselling and testing
<b>VSO International</b>	Voluntary Service Overseas International



# Executive Summary

06

There is an increasing trend toward the application of criminal laws to HIV exposure and transmission. In some states, existing laws have recently been applied, and are being applied with increasing frequency. In others, new HIV-specific laws have been enacted or are being considered. This trend is highly problematic.

Criminal laws generally fail to reflect public health systems' considered response to HIV transmission. Prosecutions undermine HIV prevention efforts, undermine human rights protections, and exacerbate stigma against people living with HIV. They also fail to impact HIV transmission rates. Contrary to rhetoric about increasing equity, prosecutions exacerbate vulnerabilities of most at risk and other disadvantaged populations.

There are many examples of courts failing to apply or understand expert evidence on transmission risk. There are also significant failures of courts to critically examine whether an individual's actions constituted an appreciable risk of causing harm, particularly given emerging scientific evidence on transmission risk. Some new laws have introduced broad-ranging liability. Some also apply strict legal requirements at odds with their citizens' contemporary, cultural experience of living with HIV. Legal obligation has preceded social change, with the gap between social reality and legal requirement so vast, criminal laws are unlikely to leverage desired change. Instead, criminalisation is driving people away from services and further stigmatising HIV. In some instances, new HIV-specific laws will criminalise the actions of a significant proportion of the population.

Clear regional variations in HIV-related criminal laws and prosecutions are apparent. The United States of America (USA) bears the weight of archaic HIV laws that ascribe transmission risk to spitting, scratching and biting. North America leads the world in the number of HIV prosecutions to date. In Europe, the Scandinavian countries Sweden, Norway, Finland and Denmark represent four of the six jurisdictions with the highest rates of prosecution per capita of people living with HIV. Though few prosecutions have occurred to date, Africa is experiencing a roll-out of poorly drafted 'model laws' at odds with local experience of HIV epidemics. Systematic (or for that matter ad hoc) application of those laws would prove devastating.

Community advocacy is vital to communicate the urgent need for government reform and for the application of expert evidence and legal opinion to stem the swell of prosecutions and to counter the false premise of the perceived benefit of HIV-specific criminal laws.

**GNP+ reiterates the UN Special Rapporteur's<sup>1</sup> call for all states:**

to immediately repeal laws criminalizing the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalizing intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases. (Grover, 2010)

<sup>1</sup> Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover.

# Introduction

**“In situations apart from intentional transmission, criminal prosecution is not warranted.”**

(Policy Brief: Criminalization of HIV Transmission, UNAIDS 2008a)

In recent years, there has been a plethora of literature<sup>2</sup> chronicling and commenting on the trend towards prosecution of individuals for transmitting, or exposing others to, HIV. Information gathered through the Global Criminalisation Scan (the Scan) confirms that this global trend is accelerating. The Scan also confirms that several countries have recently introduced or are considering introducing HIV-specific laws criminalising HIV exposure and transmission. In many instances, people have been convicted in cases where HIV has not been transmitted. Some of those cases included little or no risk of transmission.

The appropriateness of the application of criminal law and other punitive measures to the HIV epidemic has been debated almost since the epidemic began. In general, HIV-specific laws, prosecution for ‘exposure’ without transmission, and prosecution for transmission without intent, have been rejected as counter-productive to HIV prevention efforts and in their capacity to undermine human rights and exacerbate stigma against people living with HIV. It is surprising then, that some 20 years after the first reported prosecutions; there has been no systematic study of the impact of HIV-related prosecutions to inform their continued use. The broad application of criminal laws to cases of HIV transmission and exposure, without regard to impact on individuals, or public health or human rights goals is a matter of considerable concern for GNP+ and for people living with HIV.

The drive to apply criminal laws to HIV exposure and transmission is no doubt motivated in part by a

desire to reduce the transmission of HIV; however, there is no evidence to show that laws that explicitly regulate the sexual conduct of people living with HIV significantly impact sexual conduct or moderate risk behaviours (Lazzarini 2002). All available evidence suggests such regulation is likely to have the contrary effect. Research also shows that most HIV is transmitted by the significant number of people who are unaware of their HIV-positive status,<sup>3</sup> and that most cases of HIV transmission occur through consensual sex, with the highest chance of transmission being during the early stages of HIV infection, when the viral load peaks (Wawar, 2005).

In a 2010 report, the UN Rapporteur on the Right to Health reviewed the global context of the HIV epidemic and the application of criminal law. Finding little if any benefit but the potential for alienation, stigmatization and fear, the Rapporteur concluded that HIV-specific criminal offences for non-malicious HIV transmission are inconsistent with state obligations to respect, protect and fulfil the human right to the highest attainable standard of health. The Report of the Special Rapporteur also found that the misuse of criminal law negatively impacts the right to health.

The Special Rapporteur’s conclusions echo the concerns expressed by people living with HIV. For example, participants at a recent technical consultation on ‘positive prevention’ expressed concern that criminal laws around HIV non disclosure, exposure and transmission may risk undermining public health by negatively im-

<sup>2</sup> Amongst others, see: *Criminalisation*. Reproductive Health Matters, volume 17 number 34, 2009, pages 119-170. UNAIDS. Policy Brief: Criminalisation of HIV transmission. Geneva: UNAIDS, 2006. *Verdict on a Virus*, public health, human rights and criminal law, IPPF: London, 2008.

<sup>3</sup> See, for example, A. Anand and others, Knowledge of HIV status, sexual risk behaviors and contraceptive need among people living with HIV in Kenya and Malawi, *AIDS*, vol. 23, No. 12 (July 2009), p. 1565.



pacting the uptake of HIV testing, raising unrealistic expectations of disclosure, and hindering access to HIV prevention, treatment and care services. By placing the burden of responsibility on people living with HIV, participants were concerned that these laws would undermine one of the key principles of Positive Health, Dignity and Prevention: namely, that preventing HIV transmission is a shared responsibility of all individuals regardless of HIV status (GNP+, 2009a). The UNAIDS Secretariat and UNDP have welcomed the Special Rapporteur's Report (UNAIDS, 2010).

'Ten Reasons to Oppose Criminalisation of HIV Exposure or Transmission' (OSI, 2008), endorsed by GNP+ (among others), clearly outlines a range of potential harms that arise from HIV-related prosecutions:

- Criminalising HIV transmission is only justified when individuals purposely or maliciously transmit HIV with the intent to harm others;
- Applying criminal law to HIV exposure or transmission does not reduce the spread of HIV;
- Applying criminal law to HIV exposure or transmission undermines HIV prevention efforts;
- Applying criminal law to HIV exposure or transmission promotes fear and stigma;
- Instead of providing justice to women, applying criminal law to HIV exposure or transmission endangers and further oppresses them;
- Laws criminalising HIV exposure and transmission are drafted and applied too broadly and often punish behaviour that is not blameworthy;
- Laws criminalising HIV exposure and transmission are often applied unfairly, selectively and ineffectively;
- Laws criminalising HIV exposure and transmission ignore the real challenges of HIV prevention;
- Rather than introducing laws criminalising HIV exposure and transmission, legislators must reform laws that stand in the way of HIV prevention and treatment;
- Human rights responses to HIV are most effective.

Findings from the Global Criminalisation Scan support those findings. It also reveals that advocacy efforts are being strengthened to mitigate potential and actual harms.

# The Global Criminalisation Scan

The Global Criminalisation Scan is an initiative of the Global Network of People Living with HIV (GNP+) and its partner. It aims:

- To collect and keep up to date information on national or state level laws criminalising the transmission of or exposure to HIV;
- To collect information on prosecutions and convictions of people for exposure to or transmission of HIV;
- To provide an easily accessible 'clearing-house' of resources, research, and initiatives on the subject;
- To provide a platform for advocacy initiatives.

The Global Criminalisation Scan seeks to assist advocacy efforts, particularly in those regions experiencing the current or impending application of criminal law to a broad range of instances of HIV transmission and exposure through consensual sex or mother to child (vertical) transmission. The Global Criminalisation Scan provides a repository of laws, case studies and other resources on the subject.

## Scope of the Report:

This report presents an overview of the findings of the Criminalisation Scan and considers the serious issues they raise in relation to transmission risk, disclosure, human rights and public health. The report focuses on sexual transmission of HIV rather than risks associated with medical or blood-borne transmission. The issue of criminal transmission of HIV through injecting drug use is not addressed in this report.

Next the report considers legislation and convictions for conduct which includes little or no risk of transmission (for example, spitting), as in some jurisdictions frequent prosecutions in those areas continue. The report also considers the likelihood of HIV-related prosecutions exacerbating disadvantage and the inequitable treatment of women, migrant communities, men who have sex with men and sex workers.

The report ends with a presentation of data on a country by country basis.

## Methodology

Most of the data were collected by GNP+'s partners on the Global Criminalisation Scan who provided data from their regions as follows:

- The Asia-Pacific Network of people living with HIV/AIDS (APN+), provided information for the Asia-Pacific Region;
- The Caribbean Network of people living with HIV/AIDS (CRN+), provided information for the Caribbean;
- GNP+ North America (GNP+ NA), provided the data from Canada and the United States of America;
- Network of African People living with HIV/AIDS (NAP+), through the Sub regional offices in Central, East and West Africa, provided data for Africa;
- Red Latino Americana de personas viviendo con VIH/SIDA (REDLA+) provided data for Latin America; and
- Terrence Higgins Trust (UK) provided the data for Europe and Central Asia.

The data provided by the partners were both qualitative and quantitative in nature and were mainly collected using the standard Global Criminalisation Scan questionnaire. The questionnaire was prepared in English by GNP+ Europe and Terrence Higgins Trust in 2005 and updated by GNP+ in 2009. It has been translated into local languages for some countries as required. Questionnaires were sent to networks of people living with HIV, HIV/AIDS service organisations, government departments (Ministries of Justice or Public Health or the equivalent), UN country representatives, government officials, and others working on the issues.

The questionnaire is divided into five sections:

- Section 1: About Criminalisation of HIV transmission - factual information about rates of convictions and prosecutions, where applicable.
- Section 2: The Law - information of the laws used, where applicable.
- Section 3: Who has been prosecuted? - Information about the people being prosecuted: gender, mode of transmission, nationality and occupation at the time of prosecution.
- Section 4: Other issues: The media, policy/ campaigns and advocacy.
- Section 5: The organisation completing the questionnaire - details of respondents and organisations working in this area.

Data were also collected by:

- Desk research of legal databases and government sites; and
- Literature review in English and French covering applicable law, academic and grey literature.

National laws have been checked through the Lexadin database at <http://www.lexadin.nl/wlg/>, and health statistics have been sourced through the World Health Organisation and UNAIDS websites, and from national authorities where not available via these United Nations organisations.

The analysis of the N'djamena model law by the Canadian HIV/AIDS Legal Network has been a key resource, as has the legal analysis of the problem by Justice Edwin Cameron. The extensive database of case law developments around the world maintained by Edwin Bernard has been an invaluable tool in the preparation of this report.

## History and chronology of data collection

In 2005, GNP+ Europe partnered with the Terrence Higgins Trust to conduct a rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights.<sup>4</sup> In 2008, this was followed by an expansion of this mapping exercise to include coun-

<sup>4</sup> GNP+ Europe and Terrence Higgins Trust, *Criminalization 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*, (London, 2005). Available at [www.gnpplus.net](http://www.gnpplus.net) (accessed on 12th July 2010)



tries in Asia-Pacific, Latin America and North America. These exercises were conducted in partnership with regional networks of people living with HIV.<sup>5</sup> In 2009 the mapping exercise was extended to Africa<sup>6</sup> and the Caribbean,<sup>7</sup> with data from these going online in December 2009.

Regional reports have been prepared for Europe and Central Asia, Africa and the Caribbean; information from these has been incorporated hereunder, together with data from country reports for Canada, the USA, Kenya, Nigeria and Zambia.

The GNP+ website at <http://criminalisation.gnpplus.net> serves as the platform for presenting the global evidence in an accessible form. It contains country-by-country information, regional and global analysis, and analysis of the main legal and ethical difficulties raised by criminalising HIV transmission and exposure.

### Data gathered

Responses were collected as follows:

Africa	Information collected from over 30 countries in the region, most of this comprising information on laws.
Asia-Pacific	Information collected from over 15 countries with in-depth information from Australia and New Zealand.
Caribbean	Information collected from at least 10 countries/territories
Europe and Central Asia	Information collected from over 40 countries in the original survey. Updates collected from most of the original countries surveyed.
Latin America	Information collected from at least 10 countries.
North America	In depth information collected from Canada and the United States of America (the two countries comprising the North America region).

There was, in general, a low response rate; however, some of those contacted replied that they could not

complete the questionnaire due to a lack of available domestic information.

Responses to the questionnaires varied in coverage and awareness, with high levels of knowledge in countries where there have been a number of prosecutions or where there has been public debate around criminalisation resulting from the introduction of new laws.

In Europe, data quality was good for countries with no prosecutions.

In some countries, including Switzerland and the USA, compiling information on prosecutions from the separate jurisdictions/states within the country proved especially challenging. Australia and Canada, both of which are further divided into judicial territories, had good information, largely due to the active involvement of organisations advocating on these issues (for example, the National Association of People living with HIV/AIDS (NAPWA) and the Canadian HIV/AIDS Legal Network respectively.)

<sup>5</sup> The Asia-Pacific Network of People Living with HIV (APN+), Grupo Genesis Panama and the Global Network of People living with HIV-North America respectively. Terrence Higgins Trust updated the 2005 data and included other countries from Europe and Central Asia.

<sup>6</sup> In partnership with the Network of African People living with HIV (NAP+)'s sub regional networks.

<sup>7</sup> In partnership with the Caribbean Regional Network of People living with HIV (CRN+).

# Results: Global Overview

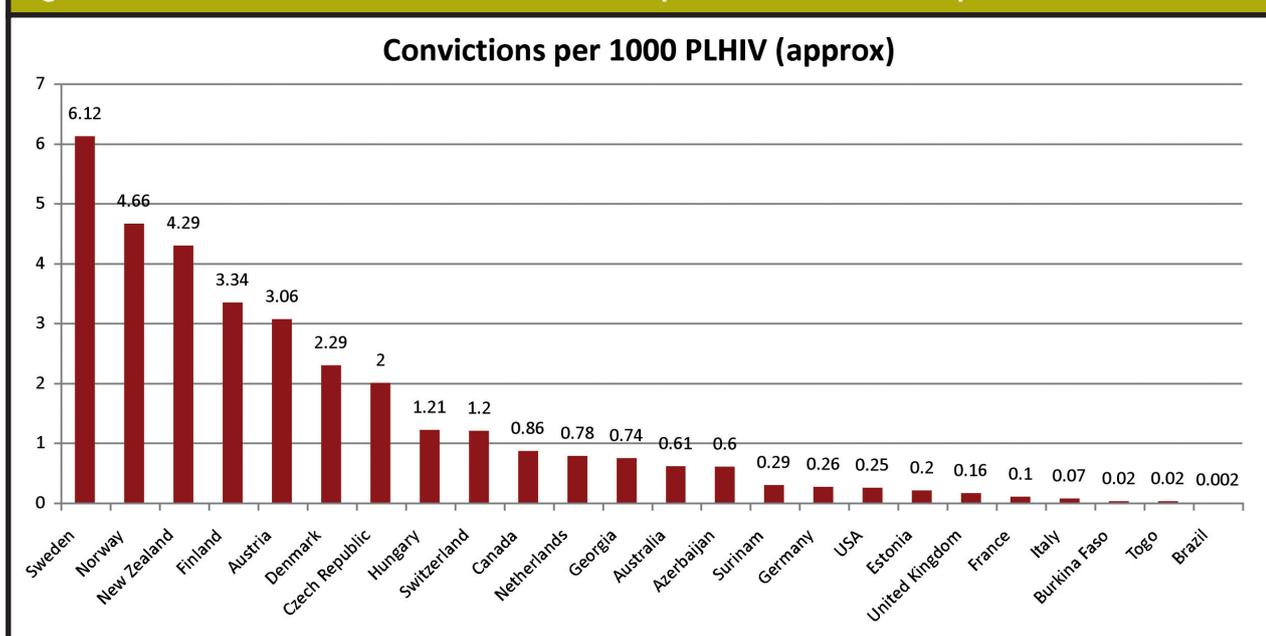
Data collected through the Global Criminalisation Scan provides a snapshot of the incidence of prosecutions for HIV exposure and transmission around the world. In some instances, people have been prosecuted under HIV-specific laws. In others, prosecutors have used general criminal laws, usually relating to nuisance or assault.

HIV-related prosecutions for exposure and transmission are distributed unevenly. Although most countries have not initiated HIV-related prosecutions, 60 countries and judicial territories have recorded convictions. Nearly as many have recently enacted or are considering enacting HIV-specific laws that have not yet been applied.

At least one HIV-related conviction has been recorded in Belarus, Bermuda, Cambodia, Cameroon, Cyprus, Ethiopia, Hungary, Malta, Singapore, Slovakia, Turkey and Zimbabwe. Other countries have prosecuted many more.

Considering prosecution data in epidemiological terms presents a different picture of the pervasiveness of HIV-related prosecutions. The following Criminalisation Index has been devised by ranking countries in terms of the number of prosecutions considered against the prevalence of HIV-infection in the general population.

**Figure 1. Criminalisation Index based on convictions per 1000 PLHIV and HIV prevalence**



**Table 1: Convictions by country**

Country	Estimated no of PLHIV <sup>8</sup>	Convictions <sup>9</sup>	Convictions per 1000 PLHIV (approx)
USA	1,200,000	Over 300	0.25
Canada	73,000	63	0.86
Sweden	6,200	38	6.12
Austria	9,800	30	3.06
Switzerland	25,000	30	1.2
France	140,000	15	0.10
Norway	3,000	14	4.66
Netherlands	18,000	14	0.78
Germany	53,000	14	0.26
United Kingdom	77,000	13	0.16
Denmark	4,800	11	2.29
Australia	18,000	11	0.61
Italy	150,000	10	0.07
Finland	2,400	8	3.34
New Zealand	1,400	6	4.29
Azerbaijan	7,800	5	0.6
Hungary	3,300	4	1.21
Czech Republic	1,500	3	2
Brazil	730,000	2	0.002
Georgia	2,700	2	0.74
Surinam	6,800	2	0.29
Estonia	9,900	2	0.20
Togo	130,000	2	0.02
Burkina Faso	130,000	2	0.02

<sup>8</sup> UNAIDS. AIDS epidemic update, November 2009.

<sup>9</sup> Global Criminalisation Scan website at <http://www.gnpplus.net/criminalisation/> (accessed on 12th July 2010). Current to December 2008 or 2009 (refer to website).

All of the top ranking 15 countries are European, except for Australia, Canada, and New Zealand (which are governed by British Commonwealth derived law), Azerbaijan (Caucasian) and USA.

The reality that prosecutions have become more likely in some environments with low HIV prevalence does not support the proposition that HIV-related prosecutions lower transmission rates.

In many instances, prosecutions have only recently commenced and have been applied against epidemics of some 25 years or more. In fact, there is no evidence to show that laws explicitly regulating sexual conduct of people living with HIV significantly impact sexual conduct or moderate risk behaviours (Lazzarini, 2002). To the contrary, most research to date suggests HIV-specific laws fail to impact disclosure and HIV risk practices. Moreover, many people (and in some settings, the majority of people) living with HIV are unaware of their positive status (Anand, 2009).

Punitive HIV-specific laws do, however, increase stigma against people living with HIV and destroy the lives of those caught up in criminal trials: the accused, their families, and sometimes, those identified as victims (Grover, 2010).

The greater incidence of prosecutions in countries with lower HIV-prevalence suggests instead that the operation of criminal law is at odds with the unfolding of national epidemics, and indeed, the international HIV pandemic. It fails to impact HIV prevalence, the many public health measures enacted to reduce HIV transmission risk, or to provide support and care to people living with HIV.

# Regional Overview

## 1 Africa

**Snapshot:** Many African countries have introduced specific legislation criminalising HIV exposure and transmission using a set of model laws (see Key Issues, below).

Eight prosecutions are known to have occurred, with details available for four. In Zimbabwe, a woman was convicted of 'deliberately transmitting' HIV, despite no transmission taking place. The law in Zimbabwe makes it a crime for anyone who realises 'that there is a real risk or possibility' that he or she might have HIV, to do 'anything' that the person 'realises involves a real risk or possibility of infecting another person with HIV'. The convicted woman was given a five year suspended sentence. Two other cases involving women were reported in Burkina Faso.

No country with HIV prevalence above 16% has convicted anyone of an HIV-related offence.

**Key Issues:** The creation of new legislation in Africa follows the US example of enactment of specific legislation criminalising HIV transmission and exposure. Many of the new West African laws derive from the USAID Action for West Africa Region on HIV/AIDS (AWARE) project, which was run by the US-based non-profit organisation Family Health International (FHI) from 2003 to 2008.



**Table 2: Laws criminalising HIV transmission/exposure introduced in Africa since 2000**

Country	Date of legislation	Based on N'djamena model law
Angola	2004	–
Benin	2006	AWARE
Burkina Faso	2008	AWARE
Burundi	2005	AWARE
Cameroon	2002 draft	Drafted Prior
Cape Verde	2007	AWARE
Central African Republic	2006	Not known
Chad	2007	AWARE
Congo-Kinshasa	2008	HPI
Côte d'Ivoire	Under consideration	Not known
Djibouti	2007	AWARE
Equatorial Guinea	2006	Not known
The Gambia	Draft	Not known
Guinea-Conakry	2005	AWARE
Guinea-Bissau	2007	AWARE
Liberia	2008	Not known
Kenya	2006	HPI
Madagascar	2005	Not known
Malawi	Still in Draft	Not known
Mali	2006	Not known
Mauritania	2007	Not known
Mozambique	2009	AWARE
Niger	2007	AWARE
Nigeria	Enugu state 2005 Lagos State 2007	No
Rwanda	2009 draft	HPI
Senegal	2010	AWARE
Sierra Leone	2007	AWARE
Tanzania	2008	HPI
Togo	2005	AWARE
Uganda	2009 draft	HPI
Zimbabwe	2004	No



In September 2004, FHI's AWARE project held a 'Regional Workshop to adopt a model law on STI/HIV/AIDS for West and Central Africa' in N'djamena, Chad. It was attended by a group of parliamentarians from across West Africa, who adopted the model law offered and created a plan to promote it across the region. The template agreed in N'djamena has now been adopted, with some local modifications, in many African countries.

USAID publications trumpet this legal initiative as a great success (USAID AWARE, 2005). While the motivation for the initiative was doubtless praiseworthy, and much of the content of the model law includes positive contributions to the protection of the human rights of people living with HIV, the model laws are highly problematic. Firstly, the legal provisions entrenching forward-thinking interventions to assist PLHIV and reduce the spread of HIV are not accompanied by budgets to render them more than a pleasing statement of intention (Sanon, 2009). Secondly, the laws criminalise HIV exposure and transmission in an unacceptably broad range of circumstances.

Unfortunately, the poor quality of the legal drafting has had serious consequences. Only Togolese law explicitly requires 'intent' as a condition for an offence. Pregnancy and lactation are either implicitly or explicitly criminalised (in all jurisdictions except Togo, Cote d'Ivoire and Mauritius). In Benin, Cape Verde, Democratic Republic of Congo, Kenya, Malawi, Mali, Niger, Tanzania, Togo and in the Ugandan draft legislation, the law provides that health care workers may disclose a patient's HIV-positive status to their sexual partners. In Burundi and Guinea, such disclosure is a requirement.

USAID is currently supporting the introduction of N'djamena model based laws in Cote d'Ivoire, the Gambia, Malawi, Rwanda and Uganda.

The model law ignores the fact that many women cannot choose to abstain from sex or insist on condom use, regardless of their HIV status. It ignores the likelihood the laws will increase stigma, alienate people living with HIV (driving them from services), and generate a lack of respect for law given it is completely at odds with cultural reality.

**Advocacy and Campaigns:** In most African countries, the new laws criminalising HIV exposure and transmission were introduced 'very quickly and with little consultation' (Canadian HIV/AIDS Legal Network), and in the absence of any local calls for their introduction. In several locations, local people have begun protesting against the more extreme provisions. In Sierra Leone, pressure from civil society resulted in the repeal of the law criminalising vertical HIV transmission in 2010. In Mozambique, the law requiring mandatory HIV testing of pregnant women has been repealed. And in Cameroon, the introduction of HIV-related criminal laws appears to have stalled. Protests are underway in Burkina Faso. Local civil society is resisting the new legislation in Cote-d'Ivoire, the Gambia and Malawi. In Mauritius, local legislators decided against criminalising HIV exposure and transmission on the basis that doing so would serve no preventive function and would work to the detriment of public health (Jurgens, 2008).

Zimbabwean law requires a person charged with engaging in sex work to be tested for HIV. If that person is diagnosed HIV-positive, the person can be prosecuted with deliberate transmission of HIV and sentenced for a maximum of 20 years (Section 79 of the Criminal Code). The constitutionality of this provision is currently being challenged in the High Court (ARASA workshop May 2010).

## 2 Asia-Pacific

**Snapshot:** Numerous Asian countries specifically criminalise negligent or malicious acts likely to spread HIV (and other infectious disease): for example, Brunei Darussalam, Burma, India, Malaysia, Singapore, Sri Lanka and Vietnam. Singapore specifically criminalises risk behaviours (including low risk oral sex) by anyone who has reason to believe they have been exposed to a significant risk of transmission, unless the person discloses before sex, uses a condom, and has an HIV test. In 2006, China imposed the duty of disclosure to sexual partners, and established criminal liability for intentional transmission. Cambodia's 2002 law criminalises intentional transmission only. A new law criminalising HIV transmission is being considered in Indonesia.



Very few convictions for HIV-related exposure and transmission have been identified in countries in the Asia-Pacific region, with the exception of Australia (15) and New Zealand (7). The single prosecution in Singapore relates to an HIV-infected person performing oral sex: an act with little to no transmission risk. The only reported Cambodian case relates to a man convicted of raping his wife.

In Australia, some 28 people have been prosecuted for HIV-related exposure and transmission in seven of Australia's eight jurisdictions. At least four of those cases were dropped before the trial was concluded. Fifteen convictions have been recorded.

In New Zealand, there have been eleven prosecutions for HIV-related exposure and transmission offences (one of which related to a man willfully injecting his wife with HIV-infected blood). In 2005, a landmark case found HIV-positive people are not required to disclose their HIV-positive status to sexual partners if a condom is properly used. The case also found that due to the low transmission risk associated with oral sex, HIV-positive people are not required to disclose their HIV-positive status prior to oral sex.

**Key Issues:** Australian and New Zealand cases fail to reflect epidemiological data, with cases of heterosexual exposure/transmission and migrant African male accused, greatly over-represented. The rate of prosecutions appears to be increasing.

In Australia, advocacy is stymied by prosecutions being conducted across eight independent jurisdictions. The number of prosecutions combined with the resulting media coverage is undermining the National HIV Strategy, which is internationally recognised as highly successful in minimising the country's HIV burden. Ill-informed media coverage has been counterproductive to public health-based prevention strategies and to a supportive environment for providing care and treatment to PLHIV.

**Advocacy and Campaigns:** Both the National Association of People Living with HIV/AIDS (NAPWA) and the Australian Federation of AIDS Organisations (AFAO) have been active in increasing understanding about HIV-related prosecutions. AFAO has produced a discussion paper summarising key issues and identifying numerous areas for advocacy

(Groves, 2009). NAPWA produced a detailed report synthesising analysis by experts from grassroots, legal, medical, behavioural and social science fields (Cameron, 2009). The report was launched at Australia's Parliament House. In New Zealand, the New Zealand AIDS Foundation has been actively engaged in criminalisation debates, and the development of related education and policy.

### 3 Caribbean

**Snapshot:** Most countries in the Caribbean do not have HIV-specific legislation. There are, however, HIV-specific offences in Bahamas and Bermudan law. There is a law criminalising the malicious spreading of a communicable disease in the Republic of Cuba. A new law criminalising HIV transmission is under discussion in Trinidad and Tobago.

At least three prosecutions have been instigated in Suriname. In Bermuda, there have been five prosecutions resulting in three convictions. In one of the cases from 2008, a Bermuda man pled guilty to an exposure offence for failing to disclose his HIV-positive status to his girlfriend despite having unprotected sex on numerous occasions. He was sentenced to 10 years imprisonment.

**Key Issues:** Given no successful cases of prosecution for HIV exposure or transmission have been identified in any countries other than Bermuda and Suriname, the criminalisation of HIV is currently peripheral to the region's HIV response.

### 4 Europe and Central Asia

**Snapshot:** Several countries have HIV-specific laws: for example, Armenia, Azerbaijan, Czech Republic, Denmark, Georgia, Kazakhstan, Moldova, Montenegro, Poland, Romania, Serbia, Slovakia, and Uzbekistan. Several other countries have laws which relate specifically to the spread of disease (for example, Austria, Norway, and Switzerland). A number of new laws criminalising HIV exposure and transmission have recently been introduced in Eastern Europe and Central Asia, notably Turkmenistan (2001), Turkey (2005), Kyrgyz Republic (2005) and Moldova (2007). Albania is currently in the process of introducing a law criminalising HIV transmission.

There have been many prosecutions for HIV-related exposure and transmission in Europe, in countries with and those without HIV specific laws. Of the countries that provided data to the Global Criminalisation Scan, Sweden has the most prosecutions (at 53 cases) and has also undertaken the most cases in the world per capita of people living with HIV. Austria and Switzerland have both brought 30 cases each, and another seven western European countries have each convicted between 10 and 15 people.

**Key Issues:** Of those 84 cases where gender disaggregated data is available, 77 offenders were men, and seven were women. In numerous countries (for example, Norway and the UK), epidemiological data indicates most HIV transmission is between men. However, cases involving heterosexual exposure and transmission are over-represented in criminal prosecutions. Similarly, in numerous countries (for example, Denmark, Norway and the UK), men of African descent are over-represented as defendants (the accused).

A number of countries continue to apply vague or broadly targeted legislation. For example, in Austria, the law applies to anyone who negligently or intentionally commits an act which 'is likely to cause the danger' of spreading a transmissible disease, although more recently, legal arguments appear to include the risk of HIV transmission. The law in Norway denies a person's right to consent to a risk which might result in HIV transmission. Many jurisdictions criminalise exposure to HIV without assessment of risk.

**Advocacy and Campaigns:** Numerous European community agencies have developed active campaigns to reduce the number and impact of HIV-related criminal prosecutions.

In Sweden, HIV-Sweden has joined forces with the Swedish Association for Sexuality Education (RFSU) and the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) on a campaign to educate and inform politicians and other key decision-makers about the negative impact of current Swedish laws on the HIV response.

The campaign has also highlighted international debates on criminalisation.

Two years ago in Norway, the HIV Manifesto Group produced a four page manifesto which was distributed to all members of the Norwegian Parliament, media, and national and international organisations. The manifesto aimed to increase the public focus on HIV and criminalisation, and to get endorsements for change. The response was overwhelming, with the manifesto endorsed by a number of important Norwegian and international organisations and persons.

Recently, the manifesto's content was picked up and reiterated by the Norwegian Children and Youth Council, an umbrella for 73 children and youth organisations in Norway. The HIV Manifesto Group then established a website.<sup>10</sup> The Manifesto Group also arranged the publication of a hard-hitting, full page piece in a leading Norwegian newspaper by South African Supreme Court judge and HIV activist Edwin Cameron: 'Norway's exports of stigma'. It was translated and distributed globally.<sup>11</sup>

When the first prosecution occurred in England in 2003, community-based agencies were caught unawares because, although there had been a prosecution in Scotland, there had been consensus that English laws could not be applied to instances of HIV exposure and transmission. The application of a 19th century assault law was unexpected. Although HIV groups did not share the same views on prosecutions, organisations agreed to work on clarifying the law and its impact on people living with HIV.

Both the National AIDS Trust (NAT) and Terrence Higgins Trust (THT) approached the Crown Prosecution Service (CPS) and the UK Coalition of People with HIV surveyed people living with HIV. NAT called a round-table of groups and concerned experts, and with NAM, produced guidance on the use of phylogenetic analysis as 'proof' of transmission (Bernard, 2007) that greatly influenced the CPS guidelines. THT set up sector training sessions. Through a coalition with clinicians and others, organisations lobbied the CPS to agree to a public consultation on guidelines to clarify the kinds of cases that could

<sup>10</sup> at <http://solutio.no/Hivmanifest.html> (accessed on 12th July 2010)

<sup>11</sup> Available at [http://www.poz.com/articles/cameron\\_norway\\_hiv\\_criminalization\\_401\\_16670.shtml](http://www.poz.com/articles/cameron_norway_hiv_criminalization_401_16670.shtml) (accessed on 12th July 2010)



be prosecuted. CPS policy (CPS, 2008a) and prosecutorial guidelines (CPS, 2008b) were produced in 2008. Effort was put into building a strong legal defence team, so that expertise could be built up from case to case. The British HIV Association, working with the HIV community, developed guidelines for clinicians (Phillips, 2010). Community organisations began discussion with the Metropolitan Police (London's police force) and the Association of Chief Police Officers (ACPO). In 2007, police were persuaded to work with THT and a community panel on a report analysing police conduct of existing cases and drawing out good practice.<sup>12</sup> NAT then took this up with ACPO (and a community panel) which published their own guidance for police forces across England & Wales (ACPO, 2010). NAT are also working to try and improve the understanding of HIV by judges, while THT monitors investigations happening around the country.

## 5 Latin America

**Snapshot:** Numerous HIV-specific amendments to criminal laws have been enacted in South America, including those in: Belize, Bolivia, Columbia and El Salvador. New laws were introduced into Costa Rica (1998), Ecuador (2000), Honduras (1999), Panama (2000) and Paraguay (1991).

Despite some HIV-specific laws and capacity to prosecute under other existing laws, HIV-related prosecutions are known to have occurred only in Brazil, where two men were prosecuted in relation to heterosexual transmission. The first cases resulted in a 2.5 year sentence for assault (following appeals which reduced the original sentence). The second case involved a man charged with attempted murder for having unprotected sex without disclosure with three women, two of whom subsequently tested HIV-positive. The outcome of the case is pending.

**Key Issues:** There has recently been a suggestion that the Brazilian Ministry of Health may be preparing a public statement recommending that prosecutions for negligent or reckless HIV exposure or transmission cease. The statement would recommend that only intentional transmission should be prosecuted where both intent and transmission are proven.<sup>13</sup>

**Advocacy and Campaigns:** Given no specific case of prosecution for HIV exposure or transmission has been identified in any country other than Brazil, the criminalisation of HIV transmission is an emerging issue of concern in Latin America. At a recent meeting of the Latin-American regional consultation on HIV Legal Services and Rights (Mexico City, 26-27 April 2010), delegates recommended incorporation of the subject of legal services, HIV and human rights on the agenda of national, regional and international institutions and funding agencies. Criminalisation of HIV exposure and transmission was considered a major challenge and opportunity.

## 6 North America

**Snapshot:** Despite distinct legal systems, the two countries comprising North America (Canada and the USA), have convicted more people for HIV transmission or exposure than all other countries in the world put together.

Canada has generally applied national assault and sexual assault laws against cases of HIV exposure and transmission. The application of those laws is based on a Supreme Court ruling that failure to disclose HIV-positive status prior to sex vitiates consent to anal or vaginal sexual relations. Other criminal laws have also been applied, including the recent successful application of a murder charge.

Of Canada's 96 prosecutions, 45% were in Ontario (where some 39% of Canada's population resides), 14% were in Quebec, 13% in British Columbia, and the remaining 28% was spread across five of the remaining nine provinces. When ranked according to numbers of people living with HIV, the distribution of prosecutions is not as unevenly distributed as may first appear. Note: Newfoundland and Labrador's ranking results from a combination of only three prosecutions on a population of only 247 people living with HIV. Likewise, Nova Scotia convicted four people from a population of 743 (see figure 2 below).

In the USA, more than 400 people have been prosecuted for HIV exposure or transmission. At least 300 of these have resulted in convictions. Prosecutions have taken place in at least 39 states. 24 states have HIV-specific laws.

<sup>12</sup> Terrence Higgins Trust, *Policing Transmission*, 2008 found at [www.tht.org.uk/informationresources/publications/policyreports/policingtransmission950.pdf](http://www.tht.org.uk/informationresources/publications/policyreports/policingtransmission950.pdf) (accessed on 12th July 2010)

<sup>13</sup> See comments by Edwin J. Bernard at <http://criminalhivtransmission.blogspot.com/search/label/Brazil> (accessed on 12th July 2010)

**Key Issues:** Prosecutions continue despite many cases involving behaviours that include little or no transmission risk. In the USA, an alarming number of cases have resulted in conviction and weighty sentencing for spitting and biting despite scientific evidence that such behaviour cannot transmit HIV. Lazzarini et al found that 23% of US cases that had passed through the courts before 2001 were for spitting, biting, scratching or throwing body fluids. As a result of the ‘three strikes’ law, one HIV-positive man was sentenced to 35 years imprisonment for spitting at a police officer. The HIV-related laws in question were initially driven by the Ryan White Care Act 1990 (US federal legislation that required states to introduce laws criminalising exposure to HIV as a condition of federal funding).

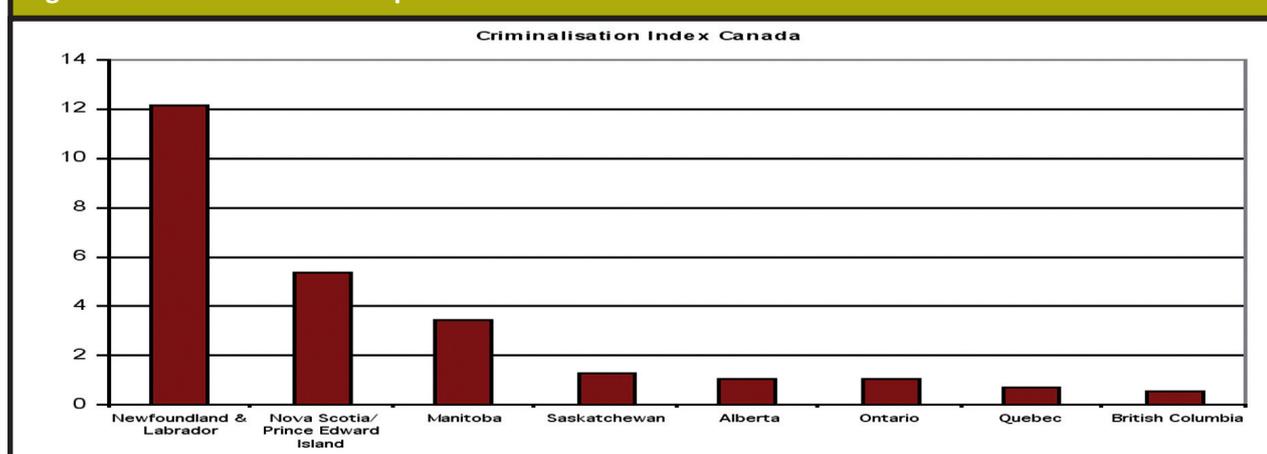
**Advocacy and Campaigns:** In the US, the Center for HIV Law & Policy (CHLP) has launched a three-year Anti-Criminalization project, a multi-pronged, collaborative plan to address the inappropriate use of criminal and civil law to specifically target the conduct of people with HIV for prosecution and punishment. The project challenges stigmatizing state laws and policies on the basis that the misuse of criminal and civil law to target consensual conduct of people with HIV undermines important public health goals. The project will launch and guide cross-disciplinary conversations and strategies to reframe the way HIV and transmission risk is conceptualised and discussed. It will also develop a consensus statement of principles on what constitutes appropriate use of the law in response to conduct which does, or is perceived to, pose the risk of HIV exposure or transmission. The primary goals of the project through

2010/11 are to secure the commitment of federal US officials to take clear and public steps to discourage HIV criminalization, and to provide the essential foundation for successful local advocacy efforts to repeal or curb the enforcement of state laws that impose punishment on the non-malicious conduct of people with HIV.

The Community HIV/AIDS Mobilization Project (CHAMP) initiated a sign-on letter campaign urging the Centers for Disease Control and Prevention (CDC) to adopt a proactive communications strategy to combat dangerously misleading information concerning the transmission and communicability of HIV currently being advanced as a result of criminal prosecutions of people living with HIV/AIDS in the United States.

In Canada, HIV agencies have worked in a variety of ways to impact the criminalisation of HIV. The HIV/AIDS Legal Network, Canadian AIDS Society and British Columbia Persons with AIDS Society have intervened in cases to introduce public policy arguments and thus attempt to contain the law, particularly around the definition of ‘significant risk’. The Coalition of Community Organizations Quebec Fight against AIDS (COCQ-SIDA) undertook fundraising and campaigning around the case of the woman convicted of HIV exposure after reporting an incidence of domestic violence. The Ontario Working Group on Criminal Law and HIV Exposure (CLHE) has produced a ‘Position Paper on the Criminalization of HIV Non-disclosure’, which includes calls for a comprehensive evaluation of the way Canada’s HIV-related criminal laws are being applied within

Figure 2 Canadian convictions per 1000 PLHIV



Ontario (where a disproportionate number of HIV prosecutions have occurred). A research study is being undertaken by the Ontario HIV Treatment Network and the University of Windsor to gather evidence on the impacts of criminalization.

Numerous workshops, conferences, public forums and training sessions have been held for front-line workers and HIV-positive people, to inform people and increase public debate. There are continuing efforts to better inform HIV service organisations throughout Canada of their rights and obligations as a means to address the anxiety and confusion that exists around HIV criminalisation among people living with HIV, front-line workers and counsellors. The Canadian HIV/AIDS Legal Network and partner organisations, including GNP+, AIDES and Groupe sida Genève, are involved in producing materials in English and French<sup>14</sup> for defence counsel and AIDS service organisations (including suggesting medical experts, public health arguments, etc.) to assist in the development and delivery of good defence cases, which will hopefully narrow the scope of the application of the law.

# Discussion

## 1 Transmission Risk<sup>15</sup>

**Key message: People continue to be convicted of crimes relating to HIV exposure and transmission without regard to the risk of transmission associated with their actions. Courts and legislators have failed to analyse and take account of scientific evidence related to risk behaviours. In some instances, people have been convicted despite their actions including no risk of HIV transmission.**

It is now accepted science that HIV is a virus that cannot live outside a host. Unlike tuberculosis, swine flu or measles it cannot survive in air. HIV may be found in blood, breast milk, semen, and vaginal, cervical and rectal secretions. It is sometimes present in saliva or tears, but the amount of HIV is so low that it is generally not infectious. HIV is not present in sweat, urine or faeces. HIV cannot be transmitted through touch or by mosquitoes.

HIV may be transmitted from one person to another through:

- blood transfusion with contaminated blood,
- by using contaminated syringes, needles or other sharp instruments,
- unprotected penetrative sex,
- from an infected mother to her child during pregnancy, childbirth and breastfeeding.

There is a high risk of HIV transmission from HIV-contaminated blood and blood products (around

<sup>14</sup>AIDES, the Canadian HIV/AIDS Legal Network, GNP+ and Groupe sida Genève. *Responding to the criminalization of HIV transmission or exposure: Resources for lawyers and advocates.*

<sup>15</sup>Readers are referred to Bernard, EJ ' HIV and the Criminal Law ' (NAM, 2010) for more detailed information on current HIV transmission data, particularly as it impacts criminal trials.

95%) as HIV remains stable in blood at the temperature at which blood and individual blood components are stored, and transfusion facilitates a larger viral dose per exposure than for other routes (WHO, 2010).<sup>16</sup> The HIV-transmission risk associated with injecting drug use stems from the use of shared needles, because at the start of every intravenous injection, blood is introduced into the needle and syringe, and that blood may then be injected directly into the bloodstream of another person if the needle/syringe is shared.<sup>17</sup>

This report, however, addresses the criminalisation of HIV exposure and transmission through sexual activity and mother/child transmission. The following section summarizes medical and scientific evidence on HIV transmission risk related to sexual acts and transmission from mother to child, and considers that risk as it impacts criminal offences for HIV exposure and transmission.

## 1.1 Sexual Exposure and Transmission<sup>18</sup>

**Key message: HIV transmission during sex is not automatic. The risk of harm associated with unprotected sex is radically lower than the risk of harm from an assault with a weapon. Many have been prosecuted and jailed for HIV exposure despite their being little or no risk of transmission, or the level of risk not being thoroughly considered under standards of criminal law.**

HIV transmission during unprotected penetrative sex is not automatic. Transmission risk varies according to numerous intersecting factors including the type of sexual activity, the amount of HIV in a person's bodily fluid, the presence of abrasions or sexually transmitted infections, and whether or not a man's penis has been circumcised.

- **Unprotected oral sex:** Risk of transmission from an insertive partner to a receptive partner during fellatio (penis-mouth sex) is estimated as ranging from a risk of zero to a risk of one in 2500. Researchers suggest the throat is less susceptible than genital and anal tissue, that saliva actually inhibits HIV, and that digestive enzymes in a person stomach may destroy HIV. Risk for the insertive partner in fellatio is so low to it is impossible to calculate a risk.

### Oral sex conviction (Singapore)

In 2008, an HIV-positive Singapore man was jailed for a year for performing oral sex on a male HIV-negative sixteen year old (sixteen is Singapore's legal age of consent). The accused pleaded guilty to a charge of exposing the teenager to HIV without first informing him of the risk. Ironically, the risk might be described as 'miniscule' or 'absent'.

- **Unprotected vaginal intercourse:** Risk of HIV transmission from a man to a woman during a single instance of vaginal intercourse has been calculated at between one chance in 1250 and one chance in 333. Risk of transmission from a woman to a man during a single instance of vaginal intercourse is estimated at between one chance in 2500 and one chance in 263 (Boily, 2009).
- **Unprotected anal intercourse:** Risk of HIV transmission from an HIV-positive insertive partner is estimated at between one chance in 122 (Vittinghoff, 1999) and one chance in 70, (Jin, 2010) with risk lower if the insertive partner does not ejaculate: one chance in 154. Risk is understood to be similar whether

<sup>16</sup>There have been many individual and class actions against politicians and public officials in relation to contaminated blood products, although many of these have been civil claims for damages. There have also been a limited number of prosecutions of individuals for donating HIV-infected blood, including a 1985 Canadian conviction for 'common nuisance' (RSC 1985 - R v Thornton), and a number of cases in Singapore where people unaware of their HIV infection have been prosecuted for failing to disclose risk activities prior to blood donation.

<sup>17</sup>Prosecutions for consensual use of non-sterile injecting equipment without disclosure of HIV-positive status are unknown. In rare cases, individuals have been convicted for using syringes filled with (actual or alleged) HIV-infected blood as weapons during acts that are already illegal, for example, robbery. There have been a very small number of cases in which people have intentionally injected others with HIV. (See, for example: Anonymous. *Father Is Guilty in H.I.V. Case*. New York Times, December 6, 1998; Bernard EJ. *Four Dutch men accused of 'premeditated' criminal HIV transmission via rape and injection*. Aidsmap.com, June 1, 2007; van der Stoep L. *Eight years' prison for HIV infection*. Sunday Star Times, Feb 7, 2010.) Additionally, medical workers have been prosecuted for allegedly infecting others through the use of non-sterile injecting equipment, including a case in Kazacstan (See: Kaiser Network. *Doctors in Kazakhstan on Trial for Medical Malpractice Following HIV Outbreak Among Children Who Received Blood Transfusions*. March 20, 2007 and Associated Press. *21 convicted in Kazakh AIDS case*. June 27, 2007) and the infamous Libyan case (See: BBC. *HIV medics released to Bulgaria*. July 24, 2007).

<sup>18</sup>The following estimates are averages.



or not the receptive partner is a man or a woman (Boily, 2009). Risk of transmission from a male receptive partner to a circumcised insertive partner is estimated at one chance in 909, and to an uncircumcised receptive partner it is one chance in 161.

### Rejection of 'significant' risk associated with anal sex (Canada)<sup>19</sup>

In May 2010, a judge in British Columbia found an HIV-positive man not guilty of aggravated sexual assault (which specifically related to failing to disclose his HIV status prior to sex) based on the evidence that the sexual encounters in question did not represent a 'significant risk of serious bodily harm': the legal threshold set out by the Supreme Court of Canada for triggering a duty to disclose known HIV-positive status.

The accused was exclusively the receptive partner during three instances of anal sex. The prosecution's medical expert estimated the risk of transmission per act at four in 10,000, with a cumulative risk of 12 in 10,000 over the three occasions. In addition, the judge found that HIV infection may now be considered a chronic, manageable condition in Canada: relevant in her view because, as the severity of the possible harm decreases, the risk of harm must increase in order to warrant criminal prosecution.

This judgment reinforces the basic point that not every risk is a 'significant' risk, and illustrates the importance of ensuring that courts consider carefully all available scientific evidence. While critical of the accused's conduct, which she described as unethical, the judge observed: 'Not every unethical or reprehensible act engages the heavy hand of the law'.

## 1.2 Impacting transmission through sexual contact

Transmission risk through sexual contact is also significantly impacted by:

- **Correct condom use** – HIV cannot pass through condoms. Research on the correct use of condoms has revealed a small risk of

condom slippage or breakage, which then impacts HIV transmission risk. Epidemiological evidence on the reliability of condoms shows transmission risk is reduced by some 85%, however that risk must be understood as operating in conjunction with the established risk of particular behaviours (see above), so that correct condom use reduces the risk of HIV transmission to a point that is almost unquantifiable (National Institute of Allergy and Infectious Diseases, 2001).

### Condom Use as Reasonable Precaution (New Zealand)

In 2005, a New Zealand case provided a landmark decision on the centrality of condom use as an HIV prevention tool. The accused was charged with endangering a female sexual partner's health by exposing her to HIV (i.e. HIV was not transmitted). The accused had used a condom during vaginal sex with a woman but had not informed her that he was HIV-positive. The judge considered an earlier case which had found that reasonable precautions and reasonable care require condom use. The judge then drew on scientific and medical evidence to determine whether the use of a condom was 'sufficient to constitute reasonable precautions against and reasonable care to avoid the transmission of the HIV virus'. The judge found the accused not guilty as he had taken reasonable precautions ('failsafe' precautions were not required) to prevent HIV transmission.<sup>20</sup>

### Liability for condom breakage (Canada)

In 2009, an HIV-positive woman pleaded guilty to two counts of sexual assault related solely to having had sex without disclosing her HIV status. The woman used condoms during two instances of sexual intercourse on a single occasion. During the second instance, a condom ripped. The woman then informed her partner that she was HIV-positive, and told him of the availability of post-exposure prophylaxis (PEP). The man did not contract HIV. The woman has been sentenced to two years' house arrest followed by three years probation, and will be registered as a sex offender for life.

<sup>19</sup> From Canadian HIV/AIDS Legal Network. Vancouver HIV Case Highlights Again the Need for Clear Guidelines on Criminal Prosecutions. Toronto, 11 May 2010 at <http://aidslaw.ca/publications/interfaces/downloadFile.php?ref=1642> (accessed on 12th July 2010)

<sup>20</sup> *New Zealand Police v. Dalley*, District Court of Wellington, Court File No. CRI-2004-085-009168, 4 October 2005.

Questions remain about the appropriate legal response to a person who aims to prevent HIV transmission by using condoms, but experiences slippage or breakage of that condom. This question is even more compelling when both partners have contributed to the condom being positioned or the HIV-negative partner is solely responsible for having put on the condom (see example above).

- **Viral load** – Viral load describes the amount of HIV in a person’s body, with high viral load describing a high level of HIV. People experience high viral load soon after infection. Viral load then decreases and may plateau for some time but if untreated will start to rise again, triggering increased health problems and finally AIDS. Treatment aims to keep viral load low: a possibility extending many years, if not decades, for those with access to effective treatments.

Low viral load is associated with decreased risk of HIV transmission<sup>21</sup> (Wawer, 2005; Das-Douglas, 2010; Montaner, 2010). Undetectable viral load describes the presence of HIV that is so reduced it can no longer be measured by scientific tests. Researchers are now suggesting that undetectable viral load may reduce the risk of transmission via unprotected sex to levels comparable to condom use by persons with higher viral load (Vernazza, 2008).

The Swiss Consensus Statement generated significant worldwide discussion with its assertion that a person who has had an undetectable viral load for at least six months and who has no sexually transmissible infection cannot transmit HIV through vaginal sex if they consistently adhere to antiretroviral therapy and their viral load is evaluated regularly. Most HIV-related agencies responded by stating that there remained a lack of evidence to support that position and by reiterating the importance of safe sex practice. In response to a strong backlash, the authors of the Statement clarified that their statement had been a vehicle to inform the Swiss criminal law system (Cameron, 2009):

**“We wanted to stop where somebody was on a fully suppressive HAART, for instance, if they wanted to have a child, literally it’s**

**a crime to have sex without condoms even if you’re under fully protective HAART and your partner knows about the HIV infection and the risk.” (Vernazza, 2008)**

The actions of the Swiss authors have to some extent been vindicated (see case below).

#### Low Viral Load and Transmission Risk (Switzerland)

In 2009, in the first ruling of its kind in the world, the Geneva Court of Justice quashed an 18-month prison sentence of a man convicted of HIV exposure.<sup>22</sup> The Court of Justice accepted expert testimony from Professor Hirschel (one of the Swiss statement authors) that the risk of sexual HIV transmission during unprotected sex on successful treatment is 1 in 100,000 (Bernard, 2009). That decision was upheld by the Federal Court, although the Federal Court decision does not explicitly address viral load.

#### Low Viral Load and Transmission Risk (Canada)

In a Canadian case<sup>23</sup> on exposure which occurred a few months after the publication of ‘the Swiss statement’, the defence failed in its argument that the accused may not have been infectious at the time of the alleged exposure offences. The judge stating that the combination of an undetectable viral load and the use of a condom would have reduced the risk below what would be considered a significant risk of serious bodily harm. The judge noted that neither the CDC nor WHO/UNAIDS agreed with the Swiss Statement, and that the crimes of the accused took place prior to there being any public statement on the effect of treatment on transmission.

The uproar over the ‘Swiss statement’, and the political response to it, marks an uneasy divide between HIV strategy priorities as they apply to public health measures versus criminal law:

- The public health perspective is that it is dangerous if individuals interpret the Statement to mean that low viral load gives them licence to engage in unprotected sex. Risk behaviours may translate into increased incidence of new infections when risk-taking is multiplied at population

<sup>21</sup> See: WHO. Antiretroviral therapy for HIV prevention at: <http://www.who.int/hiv/topics/artforprevention/en/index.html> (accessed on 12th July 2010)

<sup>22</sup> A copy of that decision (in French, with official translation into English) is available at [http://www.edwinjbernard.com/pdfs/Accused%20S\\_Swiss%20Decision\\_EN-FR-affidavit.pdf](http://www.edwinjbernard.com/pdfs/Accused%20S_Swiss%20Decision_EN-FR-affidavit.pdf) (accessed on 12th July 2010)

<sup>23</sup> R. v. Mabior, Court of Queen’s Bench of Manitoba, MBQB 201, July 15 2008.



level (although arguably this perspective is shifting as interest grows in ‘treatment as prevention’ debates).

- The criminal justice perspective is that criminal law must consider an individual’s understanding that low viral load minimises risk, if that is a person’s rationale for engaging in unprotected sex. The issue is crucial in assessing the accused person’s intent and applying the widely held criminal law principle of *mens rea* (loosely translated as ‘guilty mind’). *Mens rea* must generally be proved to establish that a person is guilty of a criminal offence.

Viral load is set to become an issue of increasing importance in relation to criminal trials. This will have different implications in countries where viral load of people receiving antiretroviral therapy is regularly monitored and data is thus accessible, as compared to low- and middle-income settings where viral load testing is not routinely conducted or is simply unavailable. Many countries now face the possibility of criminal prosecutions without the ability for the prosecution or defence to obtain relevant scientific evidence.

- **Presence of sexually transmissible infections (STIs)** – STIs are implicated in HIV transmission in a number of ways. Presence of an STI may trigger higher levels of HIV in genital fluids and may cause inflammation and ulceration of genital organs, both of which increase transmission risk. Presence of an STI also increases vulnerability to transmission. A number of studies have found the presence of genital herpes doubles the probability of a person becoming HIV infected through sexual exposure (Wald, 2002), but vulnerability is also increased by the presence of chlamydia, gonorrhoea or syphilis.
- **Male circumcision** – Two studies conducted in 2007 found clear evidence that circumcision reduced HIV transmission risk: Circumcised men were 50% to 65% less likely than uncircumcised men to become infected with HIV through unprotected vaginal intercourse (Bailey, 2007; Gray, 2007).

### 1.3 Vertical Transmission Risk (mother to child: pregnancy, childbirth and breastfeeding)

**Key message:** Criminalisation of vertical HIV transmission marks all HIV-positive pregnant women as potential offenders, but this is particularly the case for those most disadvantaged by poverty, lack of education, absence of health resources and gender inequality. It fails to question why women may not take all measures to avoid vertical transmission, including the appalling trade-offs facing HIV-positive mothers in many resource-poor contexts: risk of HIV infection versus risk of fatal diarrhoeal infection from unsanitary bottle feeding, and the many risks associated with disclosure in an environment where HIV is highly stigmatised: risk of violence, loss of home and livelihood. For those HIV-positive people living in situations where in-vitro fertilisation and embryo implantation is unavailable or unaffordable (that is, most HIV-positive young people) the criminalisation of vertical HIV transmission impinges on their human right to marry and found a family.

In 2008, around 430,000 children under 15 became infected with HIV, in most instances, through mother-to-child transmission. Some 90% of those infections occurred in Africa (UNAIDS, 2009a).

HIV-positive people have a right to have children. In resource rich settings, use of antiretroviral therapy in pregnancy, elective Caesarean section and avoidance of breastfeeding can reduce transmission risk to 1 to 2%. Without intervention, risk of transmission from HIV-positive mother to child is some 20 to 25%, with likelihood of transmission correlating to maternal viral load (WHO, 2009a). Vertical transmission risk is divided approximately equally between pregnancy, delivery and breastfeeding.

Unfortunately, interventions are unavailable to many, exacerbated by the lack of accessible HIV testing. In 2008, UNAIDS estimated worldwide coverage of Prevention of Mother to Child Transmission (PMTCT) interventions at about one-third, with some regions clearly doing better than others:

**Table 3: PMTCT coverage relative to numbers of affected pregnancies<sup>24</sup>**

Region	% coverage relative to need
West Africa	11%
East and Southern Africa	43%
East, South, and South-East Asia	22%
Europe and Central Asia	71%

Prosecutions for vertical HIV transmission are rare. (GNP+, 2009) Charges are known to have been brought in Sweden, the USA and Canada against women who did not disclose their HIV status or take antiretrovirals when instructed, and who consequently transmitted HIV to their child (Sanon, 2009).

#### Vertical Transmission Case (US)

In 2008, an HIV-positive American woman pleaded guilty to the felony of child neglect for not taking steps to decrease the risk of transmitting HIV to her son. She faced up to 15 years in prison, but made a plea bargain which reduced the sentence to two years probation with conditions including undertaking employment and participation in parenting classes.

The woman had previously had a child and had taken all steps to prevent vertical HIV transmission. In this instance, she testified that she failed to seek medical care for her son because she did not want her new partner (her son's father) to know her HIV status.

The current raft of laws being implemented across West Africa have the potential to criminalise HIV-positive women whose children become infected with HIV. Laws in Burkina Faso, Guinea,

Guinea-Bissau, Kenya, Malawi, Mali, Niger, Tanzania and Zimbabwe could be applied to vertical transmission.

#### Community Advocacy (Sierra Leone)

Local and international agencies and activists, including GNP+, have successfully lobbied for the repeal of a problematic section of Sierra Leone's HIV law relating to vertical transmission. Article 21 stated an HIV-positive person must:

- 'take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of a pregnant woman, the foetus';
- not knowingly or recklessly place another person ('and in the case of a pregnant woman, the foetus') at risk of becoming infected with HIV, unless that person knew of the fact and voluntarily accepted the risk of being infected.

The law was repealed in mid-2010.

UNAIDS argues that criminalising mother-to-child transmission is inappropriate because:

- everyone has the right to have children, including women living with HIV;
- when pregnant women are counselled about the benefits of antiretroviral therapy, almost all agree to being tested and receiving treatment;
- in the rare cases where pregnant women may be reluctant to undergo HIV testing or treatment, it is usually because they fear that their HIV-positive status will become known and they will face violence, discrimination or abandonment;
- forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for mother-to-child transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent; and
- HIV-positive mothers often have no safer options than to breastfeed, because they lack breast-milk substitutes or clean water to prepare formula (UNAIDS, 2008b).

<sup>24</sup>Source: WHO, UNAIDS, UNICEF, Towards universal access: scaling up priority HIV/AIDS interventions in the health sector – Progress report 2008 [www.who.int/hiv/mediacentre/universal\\_access\\_progress\\_report\\_en.pdf](http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf) (accessed on 12th July 2010)



## 1.4 Persistent Transmission Mythology (spitting, biting, scratching & the limits of phylogenetic analysis )

**Key message: The role of HIV mythology in constructing transmission risk must be addressed. Individuals who are unaware of HIV transmission routes must not be prosecuted. Judges and decision makers must be fully informed of contemporary HIV transmission and disease progression data before making judgements in prosecution cases.**

Myths regarding the means by which HIV may be transmitted continues to hamper HIV prevention efforts. Myths include notions that HIV can be

transmitted through mosquito bites, through casual contact (like touching), and through spitting and scratching. Emerging myths misrepresent scientific capacity to demonstrate date and direction of HIV transmission. These myths negatively impact individuals caught up in the criminal justice system, sometimes with dire consequences.

### Spitting, biting, scratching

By far, the greatest number of prosecutions for low/no risk activity have occurred in the USA. Lazzarini et al's 2001 review of US case law found 23% of HIV-related prosecutions prior to 2001 were for spitting, biting, scratching or throwing body fluids, with only 67% of those involving other behaviours that included the possibility transmission.

**Table 4: Recent US convictions for spitting, biting, scratching, and throwing bodily fluids**

USA	
Florida	Biting police officer
Georgia	Biting police officer Spitting at another woman
New Hampshire	Spitting at police officer
Indiana	Threw urine and faeces on nurse's shoes
Kentucky	Biting shop assistant
Michigan	Charged for biting neighbour
New Mexico	Spitting at police officer
Ohio	Spitting
Pennsylvania	Spitting at fellow prisoner
South Carolina	Biting neighbour
Tennessee	Spitting blood at police officer
Texas	Spitting at police officer
Vermont	Spitting at police officer



## Prosecutions for spitting and biting (USA)

In 2006, an HIV-positive man in Texas was sentenced to 35 years in prison for spitting into the eye and open mouth of a police officer during an arrest for being drunk and disorderly. The jury held the man's saliva could be considered a 'deadly weapon'. The 'three strikes' rule impacted the heavy sentence received.

In 2008, an HIV-positive woman in Georgia was sentenced to three years in prison for spitting in another woman's face after pleading guilty to aggravated assault.

In 2008, an HIV-positive man was charged with aggravated robbery after putting a \$4.79 package of sausage in his pants and walking past the cash register without paying. A security guard then confronted the accused, who kicked and punched the guard. During the scuffle, the man bit the guard twice, puncturing his skin.

After almost three decades of research and surveillance, saliva 'has never been shown to result in transmission of HIV' (Centers for Disease Control and Prevention, 2008). Even at the most basic level, the US CDC's website precludes the possibility of HIV transmission through saliva if a person is spat on, scratched or bitten and the bite does not break the skin. The CDC states there is a remote risk of transmission by human bite, but all documented cases where transmission has occurred included severe trauma with extensive tissue damage and the presence of blood.<sup>25</sup> Despite that, CDC representatives and other experts have given testimony in court during which they have failed to preclude the possibility of HIV transmission during biting.

The US is not alone. Numerous jurisdictions have convicted persons for HIV exposure relating to spitting, biting, scratching or throwing bodily fluids. In Australia in 2008, an HIV-positive man struggled and bit a police officer during an arrest for public drunkenness. The man was charged with serious assault to which he pleaded guilty. Despite the bite not breaking the police officer's skin, the judge handed down a 12 month sentence, stating 'When I first became a judge ... it was unheard of for any-

one to bite or spit on a police officer but in recent years I have had to deal with many, many cases. ... There are now diseases in the community which are spread like this'. Numerous charges have also been laid in Canada.

## Community Advocacy (US)

Activists in the US (and further abroad) have actively campaigned for the Centers for Disease Control and Prevention (CDC) to take a more active role in decreasing the number of prosecutions based on risk of HIV transmission through saliva. In 2008, the HIV Prevention Justice Alliance coordinated more than 200 agencies and many more individuals to sign up to a letter asking the CDC to:

- effectively re-position itself as the primary resource for accurate information about the transmission of HIV;
- work in close collaboration with state health departments and legal and policy advocates nationwide to address the poor HIV information for those working in the criminal justice and court systems;
- develop a rapid communication response to combat scientifically unfounded prosecutorial and judicial responses to incidents of supposed HIV exposure.

The CDC responded by making a number of commitments to increase their impact in this area. Unfortunately, no action was taken. In January 2010, the HIV Prevention Justice Alliance wrote again to the CDC. In April 2010, the Director of the CDC committed to undertake a number of concrete steps to ensure the CDC's role in communicating accurate advice about HIV transmission risk.<sup>26</sup>

## Limits of phylogenetic analysis

Phylogenetic analysis describes a complex scientific process used in molecular epidemiology where specialists analyse the genetic code of individual strains of HIV. By undertaking HIV gene sequencing, specialists are able to identify small differences and establish whether two samples may be genetically related. The process is particularly challenging as HIV is constantly 'evolving'.

The introduction of phylogenetic testing into criminal trials was initially heralded as a triumph for

<sup>25</sup> <http://www.cdc.gov/hiv/resources/qa/transmission.htm> (accessed on 12th July 2010)

<sup>26</sup> A full copy of the CDC letter is available at [http://media.champnetwork.org/2010/05-May/CDC\\_Response\\_2010-04-16.pdf](http://media.champnetwork.org/2010/05-May/CDC_Response_2010-04-16.pdf) (accessed on 12th July 2010)



prosecutors who stated they could ‘prove’ that a specific person had infected another because they shared the same ‘strain’ of HIV. Despite the sophisticated science required, phylogenetic analysis is very limited. Phylogenetics uses computational tools to create a hypothetical diagram (known as a phylogenetic tree) representing links between people’s HIV strain but not a ‘match’. Using the most sophisticated techniques available, phylogenetic analysis can exclude a connection between two people if analysis shows their HIV is too different. It cannot prove transmission occurred directly between two individuals, and cannot establish direction of transmission (i.e. who infected who).

#### Application of Phylogenetic Analysis (London)

In 2006, a man was acquitted of transmitting HIV to his male partner,<sup>27</sup> after the judge directed the jury to find him not guilty in light of evidence given by an expert virologist. The defence case successfully argued that it was impossible to prove whether or not the man had passed HIV to his partner because the complainant had a clear history of unprotected sex with others without regularly testing for HIV. This was the first UK prosecution for HIV transmission to reach a not guilty verdict. It is particularly important because it challenged the erroneous belief that virological evidence could provide a level of proof similar to DNA or fingerprint evidence: changing the way phylogenetic analysis is understood.

#### Community Advocacy (UK)

Since identifying the misuse of phylogenetic analysis during trials or as a mechanism to prompt a guilty plea (precluding cross examination of the ‘evidence’), UK non-government agencies NAM and the National AIDS Trust have worked to increase understanding of the applicability of phylogenetic analysis. Those efforts include the commissioning of a briefing paper entitled *HIV Forensics: The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission* (Bernard, 2007) The paper is primarily aimed at virologists and other potential expert witnesses as well as people working in the criminal justice system, but may also be useful for those supporting HIV-positive individuals as either potential complainants or defendants.

Even if viral strains are similar, it may be that both parties were infected with a similar viral strain by a person or persons from the same transmission network (i.e. individuals who have had sex partners in common, whether or not they are aware of that possibility).

## 2 Disclosure

**Key message: Most criminal laws penalise an HIV-positive person’s failure to disclose their HIV-positive status without regard to the reasons why a person might not disclose and the reality that not all HIV-positive persons will disclose their HIV-positive status in all relevant contexts: before every new sexual encounter, before sharing injecting equipment, and before engaging with all health care providers. Some laws criminalise HIV exposure or transmission despite a person disclosing their HIV-positive status prior to the risk event in question.**

**Focussing on disclosure enables a false sense of security among people who believe themselves HIV-negative, some of whom are and some of whom are not.**

Many of the African laws based on the model law require disclosure of HIV status to sexual partners: Benin, Cape Verde, Chad, Central African Republic, Democratic of Congo, Guinea Bissau, Mali, Niger, Tanzania and Togo, and disclosure will also be required under Malawi and Uganda’s proposed new laws. In some instances, penalties are not imposed, however, up to a year’s incarceration is mandated in the Central African Republic. Most other jurisdictions around the world either specifically require disclosure of HIV-status prior to a risk incident or it is available as a defence.

### 2.1 Disclosure by those unaware of their HIV-positive status

Numerous studies have shown that significant numbers of people are unaware they are HIV-infected. Those people may not consider the possibility of HIV infection or may wrongly advise that they are HIV-negative when engaging with health professionals or

<sup>27</sup> R v Collins (Unreported 9 August 2006)

engaging in risk behaviours. The issue is particularly significant given elevated risk of transmitting HIV (due to high viral load) during the brief period following HIV infection, and people's willingness to forgo condom use if they believe both partners to be HIV-negative.

In 2008, the Australian National Centre in HIV Epidemiology and Clinical Research undertook scientific modelling based on surveillance data and estimated that 30% of new HIV infections among MSM in Australia occur as a result of transmission from the estimated 9% of MSM who are unaware that they are HIV-positive (Wilson, 2008). The National Centre in HIV Social Research's E-male study found using a condom with casual sexual partners is *less* likely following disclosure (Rawstorne, 2009). Similarly, US research showed people who are aware of their HIV status engage far less in unprotected penetrative sex (Marks, 2006).<sup>28</sup> Fraser et al.'s analysis of Dutch and Zambian cohort data also suggested some 30% of transmissions were by people unaware of their HIV-positive status. Canada's Public Health Agency estimated that at the end of 2008, 26% of people living with HIV were unaware they were HIV infected. Estimates of those unaware of their HIV-positive status in sub-Saharan Africa are 80%-90%.

The issue of people's capacity to disclose is arguably linked to diagnosis, which is linked to testing. In many developed countries, there is high uptake of HIV testing, facilitated by rigorous confidentiality protections and the accessibility of antiretroviral therapy. That is not the case in all regions, particularly in low- and middle-income settings. Some people are unable to access testing due to a lack of testing facilities. Others, including those who understand HIV transmission routes, may be unwilling to access HIV testing because they are aware of the catastrophic personal consequences that disclosure of such information may trigger. That issue has taken on a new imperative given many African states have introduced laws stating that if a patient does not disclose to a partner post-diagnosis, healthcare workers are permitted to breach patient confidentiality, even against the will of the patient. Kenyan law (*HIV and AIDS Prevention and Control Act 2006*) indemnifies health care workers against any legal redress, while in Guinea and Burundi health care workers are legally required to make such disclosure. Mandated disclosure without regard to a person's individual situation and without appropriate social support can be disastrous:

**“Last month, one pregnant woman tested HIV-positive in this antenatal clinic. This week she came back and told us that she has been thrown out of her husband's house - divorced, desperate and alone with no relative to turn to or any support for herself or her unborn child. We haven't been prepared or trained to deal with this.”** (Kenya, nurse's conversation with researchers, in Welbourn, 2008)

Numerous analysts have argued that the potential for criminal liability is a disincentive to be HIV tested, particularly in environments where positive diagnosis does not facilitate clear benefits, such as the provision of treatment and care. In the UK, the Sigma Research study found many interviewees expressed the view that criminalisation would discourage testing (Dodds, 2009). Ironically, criminal laws may hold HIV-positive people who have not been tested liable for exposure or transmission. In other instances, liability before formal diagnosis is enshrined in law.

Zimbabwean law (Criminal Law Codification and Reform Act 2004) contains provisions that specifically allows for prosecution without HIV testing:

79 (1) Any person who

(a) knowing that he or she is infected with HIV; or

(b) realising that there is a **real risk or possibility** that he or she is infected with HIV;

intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realises involves a **real risk or possibility** of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person, and shall be liable to imprisonment for a period not exceeding twenty years.

It is unclear what a 'real risk' or 'real possibility' might mean in practice. Certainly, a 'possibility' might be defined very broadly compared to definitional terms such as 'probability' or 'likelihood'. Moreover, the section is misleadingly titled 'De-

<sup>28</sup> Summary: <http://www.aidsmap.com/en/news/50971C85-3F46-4C5D-9941-035ECED21686.asp?type=preview> (accessed on 12th July 2010)

liberate transmission of HIV' despite it applying to transmission and exposure.

### Liability if aware of a risk that may be HIV-positive (Canada)<sup>29</sup>

In September 2003, the Supreme Court considered the possible liability of an HIV-positive person who infects someone before being tested for HIV. The accused had unprotected sex with his female partner on numerous occasions during an 18 month relationship. Although the case did not hinge on this point, the court found that a person could be convicted of 'attempted aggravated assault' and 'common nuisance' if they are aware of a risk they may be HIV-positive but they do not disclose that risk to their prospective sexual partners. No such charges have been laid in Canada to date.

There have also been numerous cases that have hinged on accused's testimony that they had erroneously believed themselves to have tested negative for HIV.<sup>30</sup>

### Testing (Canada)<sup>31</sup>

In 2009, a man was found guilty of four counts of aggravated sexual assault for having unprotected sex with four women between 2001 and 2005. Throughout his trial, the accused vigorously denied knowing he was HIV-positive until late 2004. He testified that he had had six negative HIV tests in Zimbabwe, and also medical tests to facilitate his migration to Canada, believing they included an HIV test. They did not. A few months after arriving in Canada in 2001, the accused was tested for STDs and HIV. The clinic phoned him and the accused testified the caller had said his results were 'fine' but he needed to come in for counselling. He testified that he understood 'fine' to mean he did not have HIV. Although, the accused had tested positive for HIV, the clinic did not give him that information over the phone, and he didn't go back for counselling so never picked up his positive result. The accused testified that from the time he learned he was HIV-positive, either the women knew he was HIV-positive and/or they practiced safe sex. The Judge found beyond a reasonable doubt that the accused knew he was HIV-positive at the time of the risk behaviours and sentenced him to ten years less three days in prison.<sup>32</sup>

## 2.2 Instances of miscommunication

The term 'serosorting' has gained usage amongst gay men and other men who have sex with men (MSM) to describe the process whereby men engage in unprotected anal intercourse and other sexual acts only with men they believe to be of the same HIV-status as themselves. Some men (occasionally, sometimes or frequently) practice forms of non-verbal HIV-status disclosure. Researchers and HIV advocates have described instances of miscommunication (including instances when an HIV-positive person believes an HIV-negative person has communicated their HIV-positive status - and vice-versa) as 'seroguessing' (Zablotska, 2009). In numerous locations, HIV health promotion campaigns aimed at MSM have been developed to specifically address serosorting practice.

If such a practice is well established and understood in particular communities, it is important that legislation and the legal process are able to take account of such practices. The issue of 'community norms' (i.e. practices within a particular community) may be relevant to an accused's state of mind, particularly if he believes he has indirectly communicated his HIV-positive status and that his partner has done the same.

## 2.3 Some people do not always disclose their HIV status

The prosecutions of a few individuals for HIV exposure or transmission is unacceptably arbitrary and ignores the reality that, regardless of ethical considerations about what people living with HIV should and should not do, not all people will disclose their HIV-positive status before every risk event or relevant interaction with a health care provider. People may fail to disclose for a range of reasons including:

- the use of risk reduction strategies, such as the use of condoms;
- the belief that having a low viral load equates to low or no transmission risk;
- the belief that a behaviour, such as oral or insertive sex, contains no risk;
- fear of rejection, which may include sexual rejection but also a sudden end to a long-term or a developing relationship;

<sup>29</sup> Canadian HIV/AIDS Legal Network, 'Notice Re: Supreme Court of Canada Decision in R v. Williams', in AIDS Law, 21/06/2006 at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=22> (accessed on 12th July 2010)

<sup>30</sup> Mzitee and lamkhong (R v lamkhong (2009) ONCA 478.

<sup>31</sup> R v Mzite (Bernard, E. J. (2009) from <http://criminalhivtransmission.blogspot.com/2009/03/canada-yet-another-african-migrant.html> (accessed on 12th July 2010)

<sup>32</sup> See <http://www.timescolonist.com/Health/Mzite+gets+year+sentence+sexual+assault/1450941/story.html>

- fear of violence, ostracism and abandonment; or
- loss of privacy, because once disclosed, even in a very specific context, a person loses control over who may learn they are HIV-positive and particularly, how people may respond. Information about individuals' HIV-positive status can and does travel. Notably, the Australian Research Centre in Sex, Health and Society's *HIV Futures 6* reports that 51% of HIV-positive respondents (from all Australian states and territories) are aware of their HIV status being disclosed to a third party (or parties) without their permission. In some cases, such as the 15-year old Kenyan boy (born with HIV) murdered by his uncle in 2007 (Muiruri, 2007), or the five Ugandan women killed by their husbands in 2008 (see above), disclosing to family members can be fatal.

The reality that information about a person's HIV-positive status does travel is borne out in the numerous cases triggered by a third party informing a 'victim' or the police of a person's HIV status.

#### Exposure prosecution following disclosure by third party (Canada)

In 2008, an HIV-positive woman was acquitted of aggravated sexual assault after a judge rejected the testimony of a man who claimed she'd exposed him to HIV. The man had bragged to a waitress about the 'wild sex' he had had with the accused. The waitress had recognised the woman and told the man she was HIV-positive. She then reported the woman to 'Crime Stoppers'. The police issued a Canada-wide warrant for her arrest. In court, the judge found the man's testimony lacked credibility: giving different versions of his sexual exploits, with his demeanour showing a braggart or bravado attitude. The woman testified that she was well aware of the risks of unprotected sex, having contracted the virus from her late husband while she was in her teens. She said she had been dating the man but flatly denied ever having sex with him. The woman's name and photo was given substantial media coverage.

#### Exposure prosecution following disclosure by third party (Zimbabwe)

In 2008, a 26 year old HIV-positive woman pleaded guilty to 'deliberate transmission of HIV' for having unprotected sex with her partner without informing him of her HIV status. Reportedly, 'the man's brother, who had got wind from their cousin that she was HIV-positive, later, informed the complainant'.<sup>33</sup> The accused's boyfriend took the stand and asked that the case not proceed. The woman was given a five year suspended sentence attribute to the fact she did not transmit HIV.

## 2.4 Disclosure triggering prosecution

In a number of unfortunate incidents, a person's disclosure of their HIV status has triggered their prosecution. Cases include the Canadian case (outlined at 1.2) in which a woman informed her partner of her HIV status after recognising that a condom had split, and the case involving a mental health condition described below.<sup>34</sup>

#### Disclosure triggering prosecution (Canada)

In Canada in 2008,<sup>35</sup> a young man with a diagnosed mental illness (schizoid-affective disorder), met a 55 year old gay man in an internet chat room, and later had two unprotected sexual encounters. The young man did not inform the man he was HIV-positive. He testified that he had believed he had sweated out the virus, but had moments of clarity. Some hours after the second sexual encounter, he realised he had had sex without disclosing his status, and phoned the man to inform him of his HIV-positive status.

Despite the judge recognising the young man had a mental illness affecting his judgment and had genuinely expressed his remorse, the judge sentenced him to eight months jail (with additional conditions). The 'victim' remains HIV-negative.

Recognising that not all people living with HIV disclose before every risk event is not an argument

<sup>33</sup> Zimbabwe: HIV-positive Woman's Case Postponed Again, 2 April 2008 at <http://criminalhivtransmission.blogspot.com/search/label/Zimbabwe> (accessed on 12th July 2010)

<sup>34</sup> Another case is the 2009 prosecution of a man for failure to disclose his HIV status under NSW's *Public Health Act 1991* (Australia). The man noticed a condom had failed and notified his partner of his HIV status, also contacting her later by phone to ensure she was aware of the availability of PEP.

<sup>35</sup> R v Handy (Unreported 27 March 2008) See Bernard, E. J. (2008) at <http://criminalhivtransmission.blogspot.com/search?q=handy> (accessed on 12th July 2010) and Canadian HIV/AIDS Legal Network (2008a)



against disclosure. Instead it recognises the reality of science surrounding transmission risk and the lived reality of the many thousands of people living with HIV, and argues that disclosure is ill-conceived as core HIV prevention policy. The potential to maximise disclosure is most likely in an enabling environment. That environment is undermined by the potential for criminal prosecution. The Australian HIV Futures 6 (Grierson J et al, 2006) found that 42.4% of those surveyed reported being worried about disclosing their HIV status to sexual partners 'because of the current legal situation'.

There is no evidence that prosecution or incarceration increases the likelihood of an individual disclosing HIV-positive status prior to sex. In fact, in at least two instances (Sweden and New Zealand), an individual has been charged with failing to disclose HIV status following a prior conviction.

#### Prosecution for HIV offence following incarceration (Sweden)

In 2009, a 20 year old man, previously sentenced to two years in prison for exposing seven women to HIV (having unprotected sex without disclosing his HIV-positive status) was charged with committing a new offence while 'on conditional release', and then convicted and sentenced to a further jail term.

Arguably, the individual and the public would have been better served by a rigorous public health intervention.

### 3 Perpetuating Inequality

**"In jurisdictions where HIV transmissions have been prosecuted, of the very few cases that are prosecuted out of the many infections that occur each year, the majority have been noted to involve defendants in vulnerable social and economic positions."**

Anand Grover , UN Special Rapporteur, 2010

#### 3.1 Protecting Women

**"Applying criminal law to HIV exposure or transmission does nothing to address the epidemic of gender-based violence or the deep economic, social, and political in-**

**equalities that are at the root of women's and girls' disproportionate vulnerability to HIV. On the contrary, ... criminalization is likely to heighten the risk of violence and abuse women face; strengthen prevailing gendered inequalities in healthcare and family settings; further promote fear and stigma; increase women's risks and vulnerabilities to HIV and to HIV-related rights violations; and have other negative outcomes for women."**

J. Kehler, M Clayton, T Crone,  
ATHENA Network, 2009

Much of the early rhetoric surrounding the introduction of African laws criminalising HIV exposure and transmission positioned those laws as providing 'protection' for women and thus as enablers of greater gender equality. Instead, there is no evidence to suggest that criminal laws will benefit women, particularly in those environments where women are marginalised by gender, associated poverty and lack of independence. In fact, it is difficult to imagine how criminal laws might benefit women in cultures where most women lack access to justice because they lack the educational, economic and social support to take a case to police and push it through the legal system. Police are not necessarily 'interested', and judges are not necessarily inclined to recognise the severity of crimes (particularly sexual violence) perpetrated against women.

#### Women as victims

In Africa, the model law has been touted as a response to the significant problem of men in committed relationships becoming infected through infidelity and not disclosing to their spouses, and of older sexually active men infecting young women (who may be particularly vulnerable if sexual acts involve even small injury to their developing bodies). Certainly, in many instances notions of 'mutual responsibility' do not fit various African contexts. HIV-negative women who are fearful of becoming infected by their husbands may be intimidated by physical threat, actual assault, economic duress, or familial and social pressure. Many understand that a marriage contract removes a woman's capacity to consent or refuse sex with her husband. In some instances, that right is more than a social expectation: it is enshrined in law.

Power and economic imbalances between men and women may also make it hard for women to initiate condom use. Condoms may carry an association of female infidelity, or the implication that male misbehaviour is resented. Unprotected sex may be considered a sign of love (e.g. Chinkonde study in Malawi, 2009), while insistence on condom use is a high-risk strategy for women who will be destitute if they leave or are abandoned, or are at risk of marital violence if they stay with their husbands.

The question remains as to the effectiveness of a 'criminal justice' model in furthering gender equality and the rights of individual women. Little has been done to understand the trial experience of female victim/witnesses, but anecdotal evidence from Australia and New Zealand suggests that for many, the experience is anything but empowering. Some women have specifically stated that the results of the criminal trial were not what they wanted. That is, the problem was not that the accused got a lower sentence than they desired but that the outcome was completely different; for example, a partner was jailed and a family destroyed, or despite the woman having her identity suppressed by the court, her and her children's identities were easily ascertainable by people in their community through publication of a former partner's name, address and photo. Information technology has substantially impacted victim's privacy. For example, a single, quick internet search from almost anywhere in the world provides the full name and other identifying details of a woman tourist to a Mediterranean island who successfully pushed for prosecution of a former sexual partner some thirteen years ago. That information will likely remain accessible online for some time to come.

### Women as perpetrators

Numerous women have been prosecuted for HIV exposure or transmission in high-income countries, including many women in the USA and Canada, four in Denmark, one in Finland, and two in the UK. In some instances, press coverage has been sensationalist and arguably sexist (for example, the UK woman was described as a 'man eater' and 'pure evil'. It was alleged she had had 'dozens' of boyfriends, but after extensive police investigations and a media alert, she was charged in relation to one<sup>36</sup>). At least one woman has been charged when seeking police

assistance in relation to an incidence of domestic violence (see below).

### HIV Exposure Conviction while Domestic Violence Ignored (Canada)

In 2003<sup>37</sup> a woman in her early 40s met a man who was to become her partner. When they first began a sexual relationship she did not tell him she was HIV-positive but she testified that she had insisted he use condoms. He testified they engaged in unprotected sex at least once. When the woman revealed her HIV status, her partner accepted it and they continued their relationship for some five years.

After some time, the relationship deteriorated, and the woman's partner was arrested on various assault charges after attacking her and her son in their home. Following the domestic violence investigation, the man went to police and alleged the woman had kept her HIV status 'hidden'. He was not HIV infected.

The man was apparently given an unconditional discharge with no criminal record for his assault against the woman and her son. The woman was found guilty of aggravated assault (for HIV exposure only) and given a one year suspended sentence to be served in the community.

### Community Advocacy

The Coalition of Community Organizations Quebec Fight against AIDS (COCQ-SIDA) undertook significant fundraising and campaigning around the above domestic violence-related case.

Women frequently face a range of difficult decisions regarding disclosure of their HIV-positive status. An HIV-positive woman who does not want to risk transmission but fears violence, economic deprivation or other punishment from her male partner, faces a frightening choice: disclose to protect his health or keep the secret in order to avoid abandonment without alternative livelihood, denial of contact with her children, injury or even death. In many contexts, the threat is anything but hypothetical.

<sup>36</sup> R v Porter (Unreported 19 June 2006)

<sup>37</sup> R c DC [2008] QCCQ 629 See <http://criminalhivtransmission.blogspot.com/2008/05/canada-montreal-domestic-violence.html> (accessed on 12th July 2010)



Table 5: Disclosure rates and consequences for women living with HIV tested during PMTCT

Country, author & year	Sample	Disclosure rate	Fears expressed by participants	Negative or dangerous outcomes
<b>Burkina Faso</b> , Issiaka et al, 2001	79	31.6% after an average of 8 months	Rejection or abandonment 71% Being considered unfaithful 24%	4% reported dispute without violence
<b>Kenya (Mombasa)</b> , Gaillard et al, 2000	331	32% after 2 months 75% of those who had not disclosed by then said they intended never to do so	Domestic violence	3.5% physically assaulted 3.5% chased out of the house by partner 10.5% of partners did not believe the results
<b>Kenya (Nairobi)</b> , Farquhar et al, 2000	104	65%	Blame 54% Physical assault and abandonment 19%	Not collected
<b>Thailand</b> , Bennetts et al, 1999	129	44%	Shaming family	28% separated from partner or partner died
<b>Tanzania (Dar es Salaam)</b> , Antelman et al, 2001	1078	22% within 2 months 40% within 4 to 6 months	Losing confidentiality 32% Social isolation 14% Not wanting to worry others 17% Conflict with partner 15% Just being afraid 11%	Not collected
<b>Tanzania (Dar es Salaam)</b> , Kilewo et al, 2001	1050	17% within 16 months after diagnosis	Stigma 46% Divorce 46% Violence 16%	15% of partners reacted violently

Events in Uganda are instructive. In ActionAid Uganda's survey of 465 women, 100 women (21.5%) said they experienced domestic violence as a result of disclosing their status (Kielburger, 2009). According to the International HIV/AIDS Alliance, five Ugandan women were murdered in 2008 by their husbands after disclosing their serostatus, and thousands suffered abuse or eviction (Kielburger, 2009).

A number of analysts have also raised the possibility that in some settings women will be disproportionately affected by HIV-related criminal laws mandating disclosure because more women than men access provider-initiated testing and counsel-

ling (PITC). That may mean more women than men are aware of their HIV-positive status but without the social and other supports to disclose to their sexual partners. Further, antenatal testing of pregnant women in environments where voluntary testing take-up is minimal means that pregnant women are usually tested before their male partners, who may confuse finding out about the disease first with being infected first. According to the Director of the AIDS and Rights Alliance for Southern Africa, 'in Africa most of those who know their status will be female, because most testing occurs at prenatal health care sites. The result is that most of those who will be prosecuted will be among these women

who it might be said know or ought to know their status' (Kehler, 2009).

Real efforts to increase gender equity in many African settings would include efforts to educate community and increase prosecution and appropriate sentencing of men for crimes of domestic assault and sexual assault. Such efforts would no doubt also impact women's vulnerability to HIV transmission.

### Women as bad mothers

As noted above, numerous jurisdiction's criminal laws may be applied to cases of vertical HIV transmission. Malawi's draft targets pregnant women. Concurrently, there is no effort to address the role of fathers in effective parenting and care for the health and safety of their children.

The potential criminalisation of vertical HIV transmission coexists with the unfortunate reality that:

**"where the right to access to appropriate health services (such as comprehensive prevention of mother-to-child transmission services and safe breastfeeding alternatives) is not ensured, women are simply unable to take necessary precautions to prevent transmission, which could place them at risk of criminal liability."**

(Anand Grover, 2010)

In 2008, only 45% of pregnant women living with HIV in sub-Saharan Africa and some 25% in South and East Asia had access to prevention of mother-to-child transmission services (World Health Organisation, 2010).

### Community Advocacy (New Zealand)

Media coverage of the first criminal prosecution for HIV transmission in 1995 included significant focus on the accused as a 'Kenyan migrant'. The case threatened strategic policy development, including the proposition that mandatory testing be applied to women who became pregnant after sex with men from Africa, Asia or the US. Community agencies and key stakeholders articulated the potential damage of such a practice and effectively lobbied to ensure those demands were not implemented.

## 3.2 Migrant communities

A significantly disproportionate number of prosecutions in high-income countries (including the UK, New Zealand, Australia and Canada) have been of heterosexual migrant men. The reasons have not been fully investigated and analysed, however, analysts have suggested reasons may include heterosexual populations' failure to adopt the 'mutual responsibility' ethos embedded in safer sex messages, the tendency for women to more readily identify as victims in heterosexual relations, and men's propensity to manipulate heterosexist power dynamics in their interests. It also seems likely that complex cultural factors, xenophobia, and class and race based assumptions have impacted how those individuals come to be charged and the ways their cases are conducted (Cameron, 2009).

### African man convicted of exposure (Australia)

A young man arrived from the Sudan in July 2006, and was diagnosed HIV-positive three months later. The health department became aware the man was engaging in unsafe sex and served him with a public health order requiring him to use condoms, disclose his HIV status and attend counselling, but he did not do so. Police were alerted to his behaviour and their investigations revealed he had had unprotected sex with a number of women. He was arrested and detained at a psychiatric hospital for a period of time. Medical records indicated he had difficulty accepting his condition and the fact it could not be cured. A psychologist's report showed he was likely suffering from post-traumatic stress disorder, having witnessed the deaths of his family before fleeing as a refugee. After a few months, the man was transferred to a suburban home where he was monitored by staff and under video surveillance 24 hours a day, pending his trial.

The man was convicted of two counts of 'reckless conduct endangering life' for exposing a female sexual partner to HIV. Taking into account the health care the defendant had received, the judge imposed a suspended 2 year jail term. He was put on a strict community-based order and required to undergo treatment and counselling, and abstain from alcohol. These conditions would have been possible under a public health order, making questionable the significant cost and heavy-handedness of the criminal law intervention.



In many instances, community and media responses have been anything but helpful. Media consistently raise migrants' countries of origin with racist overtones, and frequently uses inflammatory headlines.

Media coverage concerning criminalisation makes the stigma associated with having HIV far worse. African people living with HIV in particular are concerned about the impact of these prosecutions on their own lives, especially those who see gender and racial bias in the criminal prosecution system and the media (Dodds et al. 2004a).

In a number of unfortunate instances, criminal charges against individual migrants have been caught up in anti-immigration debates. In a few instances, conviction has also triggered the likelihood of deportation at the completion of a person's prison term (for example, in Canada and Sweden).

#### Deportation post conviction (Canada)

In 1995, a Thai woman came to Canada from Hong Kong on a work visa to perform at a strip club. She began a relationship with a man in 1996 and they married the following year. The woman had previously tested positive for HIV in Hong Kong, but testified that she had believed she was HIV-negative because she had mistakenly understood she had been HIV tested in Canada for immigration purposes and those tests showed she was not HIV-positive. In fact, those tests did not screen for HIV as the woman entered Canada seven years before the HIV screening of immigrants was introduced (in 2002). The woman received no HIV treatment until she learned she had AIDS in 2004, at which time she told her husband of her diagnoses. The woman was convicted of aggravated assault and criminal negligence causing bodily harm for failing to disclose her HIV-positive status to her husband and was sentenced to two years jail. The sentence made it likely that despite being a 'landed immigrant', she would be deported. The woman successfully appealed her sentence, with the judge reducing her sentence by a day, which meant she could legally appeal her deportation order (with decision pending at March 2010).

(Canadian HIV/AIDS Legal Network, 2009)

#### Community Advocacy

**UK:** In October 2004, the National AIDS Trust and Terrence Higgins Trust wrote to UK Crown Prosecution Service and the Chair of the Commission for Racial Equality regarding the inequitable distribution of prosecutions against men from migrant communities. The issue was then raised at the Crown Prosecution Service's Working Group on the Transmission of Serious Disease, and formally included in the *Equality and Diversity Impact Assessment Report (2007)*. Finally, recognition of the issue was entrenched in the Crown Prosecution Service's Policy Statement on guidance for prosecutions: 'We will be mindful of any indications that there is a disproportionate impact on any particular group of individuals that we may prosecute'.

**Australia:** Concerns raised by HIV service providers prompted funding of the Regional Victoria Project. The aim of the project was to assist the Victorian Sudanese community to improve HIV awareness and to deal with issues related to the discrimination and distress they experienced when a Sudanese man was charged with knowingly transmitting HIV in 2007. The project included information about legal rights and media skills as well as HIV prevention and testing information.

### 3.3 Men who have sex with men (MSM) and transgender people

The criminalisation of same-sex conduct, sexual orientation and gender identity significantly impacts HIV prevention efforts. Consensual same-sex conduct is a criminal offence in about 80 countries (Ottooson, 2009). Some countries criminalise cross-dressing (e.g. Afghanistan, Malaysia, Samoa) and many countries deny basic citizenship rights to transgender people.

A number of states have recently decriminalised same sex conduct, including Nepal (2007) and Fiji (2010). The High Court of Delhi found in 2009 that the *Indian Penal Code* provisions criminalising consensual sex between adult men are unconstitutional.

In 2009, a member of the Ugandan parliament introduced a bill which proposed the death penalty for

people living with HIV who engage in homosexual activity. A lesser penalty was proposed for those engaging in homosexual activities who do not have HIV. After international condemnation and threats from donors to discontinue development assistance, the Government of Uganda indicated that it would not support the Bill in 2010.

In 2010, Rwanda rejected plans to criminalise homosexual practices, or the encouragement or sensitization of people to same-sex sexual practices: Minister of Justice, Tharcisse Karugarama, stating 'sexual orientation is a private matter and each individual has his or her own orientation – this is not a State matter at all' (Musoni, 2010).

In almost all countries, HIV disproportionately affects men who have sex with men.<sup>38</sup> For example, 15% of new HIV infections in Kenya (where sodomy is an offence punishable by 14 years imprisonment) were transmitted through male-to-male sex in 2007. After this research was published in 2010, the Kenya Medical Research Institute (one of the organisations that conducted the research) was attacked by violent mobs: angry that the Institute provides HIV services to MSM.<sup>39</sup> In support of the protests, religious leaders from the Council of Imams and the National Council of Churches criticized the government for 'providing counselling services to these criminals' and demanded that the Kenya Medical Research Institute office that had been providing HIV services to MSM be shut down.<sup>40</sup>

Criminalisation of same sex practices, the associated fear of prosecution, high levels of stigma associated with homosexuality, and violence directed at MSM and transgender people have been significant factors in preventing MSM and transgender people from accessing health services, testing and treatment (Grover, 2010).

There is growing recognition that the denial of human rights relating to sexual orientation and gender identity significantly impedes the scaling-up of HIV responses targeting MSM, with consequences for the whole population. In 1997, the *International Guidelines on HIV/AIDS and Human Rights* recommended

that sodomy laws be repealed and other protective legal and policy measures be put in place (UNAIDS, 2006). In 2006, UN member states endorsed the UN *Political Declaration on HIV/AIDS*, agreeing to remove legal barriers to effective HIV responses, including writing domestic laws to protect vulnerable populations. In 2009, the UN's Economic and Social Council passed a resolution on HIV/AIDS, specifically calling for action on MSM issues. It 'welcome[d] the promulgation of the UNAIDS *Action Framework: Universal Access for Men who have Sex with Men and Transgender People*, ... and call[ed] on UNAIDS ... to address the political, social, legal and economic barriers to universal access' (ECOSOC, 2009)

Laws criminalising same-sex acts make disclosure of HIV-positive status highly problematic, as that disclosure will frequently include disclosure of illegal risk behaviours. That issue may then be compounded by the reality that disclosure of same-sex behaviours frequently includes disclosure of acts that are socially unacceptable. In some instances, such disclosure also requires disclosure of infidelity. Issues around disclosure in punitive legal environments then intersect with laws criminalising exposure and transmission of HIV. Some African HIV-based legislation (notably that of Egypt, Senegal and Uganda) specifically targets gay men. Persecuting gay men undermines public health management strategies. Arguably, however, it is at its most problematic when targeting HIV education and treatment. The Penal Codes of Kenya, Rwanda, Burundi and Tanzania, bar gay men from access to treatment (Michael, 2009): a particularly retrograde measure given the high transmission risk associated with anal sex and the effectiveness of antiretroviral therapies in reducing infectivity. In 2009, nine gay Senegalese HIV educators were prosecuted and given eight-year sentences (Treatment Action Campaign, 2009).

### 3.4 Sex Workers

Considering sex workers as a heterogeneous population group is a convenient mechanism for international advocacy or epidemiological purposes, however, the term 'sex worker' encompasses broadly diverse people in many different circumstances (UNAIDS, 2008).<sup>41</sup>

<sup>38</sup>UNAIDS, "Report on the global AIDS epidemic 2008: executive summary" (Geneva, 2008), p. 30.

<sup>39</sup>Research: Kenya in denial over homosexuals *Saturday Nation* 23 December 2009 <http://www.nation.co.ke/News/-/1056/830496/-/item/0/-/w2jpnq/-/index.html> (accessed on 12th July 2010)

<sup>40</sup>Human Rights Watch Kenya: *Halt anti-gay campaign, protect health workers*, 17 February 2010. <http://www.hrw.org/en/news/2010/02/17/kenya-halt-anti-gay-campaign> (accessed on 12th July 2010)

<sup>41</sup>For the purposes of this report, the term 'sex worker' does not apply to children or to people who are forced to work in the sex industry. Given growing interest in human trafficking, it is important to note that many people migrate for work, including those who work in the commercial sex industry. Conversely, the sexual exploitation of children and trafficking of adults into any industry merits criminal prohibition.



Research conducted in 2005 identified at least 25 types of sex work demarcated by worksite, mode of soliciting clients, and sexual practices (Harcourt, 2005). In fact, many who undertake sex work ‘may not consciously define those activities as income generating’ (UNAIDS, 2002). The Commission on AIDS in the Pacific considers unprotected commercial and transactional sex a major source of HIV vulnerability within the Pacific, as the purchasing of sex is common in some countries and some population groups. However, much less visible but more widespread, is unorganized, transactional sex: namely sex exchanged for food, clothing or other resources, or for a ‘good time’ or the attentions of a ‘boyfriend’. Studies in Papua New Guinea have found some women partly or fully support themselves and their families by selling sex but do not identify themselves as sex workers (UNGASS 2008).

The intersection of sex work regulation and HIV prevention has long been recognised, with ‘evidence-informed measures to address sex work ... an integral component of an effective, comprehensive response to HIV’ (UNAIDS, 2009b). Unfortunately, many states continue to regulate sex work based on beliefs or supposition about what may ‘protect’ or ‘be good for’ the population, without regard to evidence about what constitutes effective sex industry regulation.

Sex workers are impacted by laws regulating sex work activity and potentially by laws criminalising HIV exposure and transmission. General laws that may at first seem unrelated to HIV prevention (e.g., those regulating the sale or purchase of sexual services, the type of sex work, location, conditions of registration, etc) have a direct impact on effective public health promotion. Many states criminalise the selling or buying of sexual services, despite there being no evidence that prohibition can be successfully implemented<sup>42</sup> and that it increases violence, often perpetrated by those in positions of authority: ‘an unfortunate corollary of criminalisation’ (Grover, 2010). Criminalisation undermines access to health (and other) services, and the establishment of open and honest therapeutic relationships to minimise HIV transmission risk and maximise ongoing treatment.

In most instances, states have criminalised the sale of sexual services, although some also criminalise the purchase of sexual services. Since 1999, Swe-

den has taken the radical approach of criminalising only the purchase of sexual services (as a means to protect women and also ‘society’). Despite that action, the Swedish National Board of Health and Welfare found no significant change in the amount of sex work being undertaken between 1999 and 2004 (2004). Swedish sex workers have criticised the legislation, saying it has increased disadvantage and exposure to risk by forcing them to go underground (Lund, 2007) and to travel to neighbouring countries to work (Sambo, 2001).

**“As with other criminalized practices, the sex-work sector invariably restructures itself so that those involved may evade punishment. In doing so, access to health services is impeded and occupational risk increases.” (Grover, 2010)**

The International Guidelines on HIV/AIDS and Human Rights state that:

**With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients. (2006)**

‘Decriminalisation’ refers to the removal of sex industry related criminal laws, with regulation falling under the gamut of public health and local government planning regulations.<sup>43</sup> Decriminalisation has been shown to deliver significant public health (and other) benefits, particularly when combined with resourcing of sex work based organisations to deliver peer-led education. In New Zealand, decriminalisation has led to sex workers being more willing to disclose their occupation to health workers and to carry condoms, and to refuse particular clients and practices and negotiate safer sex (Jordan, 2005; Prostitution Law Reform Committee, 2008).

Sex workers may also be impacted by laws criminalising HIV exposure and transmission, either in their working or their private lives. Some people who

<sup>42</sup> Except with brief exceptions in totalitarian settings such as under the Taliban in Afghanistan and during the Cultural Revolution in China. See Harcourt C, Egger S, Donovan B (2005). *Sex Work and the Law. Sexual Health, 2*, CSIRO Publishing, Australia.

<sup>43</sup> Abuses such as sexual assault or trafficking continue to be covered by criminal law.

undertake sex work are HIV-positive. They may or may not have been infected through their work, and their HIV infection may or may not have been diagnosed. UNAIDS suggests sex workers who become infected with HIV may be doubly stigmatised (2002). HIV-related stigma compounded by sex work-related stigma, represents a significant barrier to HIV-positive sex workers access to medical and psychosocial care and support services, yet we know the greatest potential to prevent HIV transmission is within an enabling environment. Support services must be delivered in an environment that enables sex workers living with HIV to be open about their sex work so that options around safe sex practice can be fully explored and understood. Studies indicate 'that sex workers are among those most likely to respond positively to prevention programmes relating to HIV' (UNAIDS, 2002).

### Community Advocacy (Australia)

Australia is among the few countries where the incidence of HIV among sex workers is low. Despite sophisticated surveillance mechanisms identifying more than 28,000 diagnoses of HIV infection since 1983 (NCHECR, 2009), no recorded case and only a handful of suspected cases of HIV transmission have been identified in an Australian sex work setting. Although prevalence of other sexually transmissible infections among sex workers is comparable to the general population, very few sex workers are HIV-positive (Donovan 2009). Australia's success in maintaining such a low incidence of HIV transmission in sex work settings has been attributed to the strong involvement of sex workers in both advocacy and the development and delivery of prevention programs, generally funded by state health departments. Sex worker organisations and sex workers have been successful in implementing routine condom use within the Australian sex industry.

In 2008, Scarlet Alliance, the Australian Sex Workers Association, carried out a needs assessment among sex workers living with HIV in Australia (Matthews, 2008). That research gave voice to sex workers living with HIV and highlighted the levels of institutionalised marginalisation and stigmatisation they experience. It also highlighted the need for sex work and HIV based agencies to integrate the issue into policy analysis and service delivery.<sup>44</sup>

## 3.5 Children

Criminalisation of HIV transmission will not protect children. Issues relating to mothers and infants are outlined above (at 1.2 and 3.1), although perhaps here it is useful to ask specifically, what good comes from prosecuting mothers on behalf of their infants, particularly if conviction results in the mother being removed from her infant while incarcerated? Children may be adversely affected by criminal offences for HIV-transmission in many ways. Ironically, these laws co-exist with laws which forbid children access to HIV education (in Guinea and Mali) (Eba, 2008), and the AWARE-N'djamena model allows parents a right to opt-out of HIV education for their children. Lack of information enables the propagation of misinformation in relation to HIV risk. It is concerning that such opt-out mechanisms may also have a gendered impact: with a perceived need to 'protect' teenage girls from 'unseemly' information about sexual acts.

There are many children from families affected by HIV, and many also HIV-positive. Those children frequently have very few life choices. On Kenya's coast, for example, teenage girls orphaned or with parents unable to work as a result of AIDS, provide commercial sexual services to tourists (Niles, 2008). The prosecution of HIV-positive children for engaging in risk activities as a matter of survival, is unacceptable.

### Prosecution of women for acts committed as a minor (Azerbaijan)<sup>45</sup>

In 2008, an 18 year old woman was convicted under Article 140 of the *Criminal Code* for 'deliberately infecting a person with HIV'. Press reported she had infected more than 100 men: an allegation that has not been verified.

UNICEF Azerbaijan Country office has alleged the woman was diagnosed with HIV as a minor, and was a juvenile at the time offences were alleged to have occurred. Moreover, UNICEF states she is a 'victim of human trafficking, prostitution and pornography', and thus should not be treated as a criminal. No information is available regarding how the girl became infected with HIV and whether any attention has been turned to the men who had commercial sexual intercourse with a girl.

<sup>44</sup> For further information see Jeffreys E, Matthews K, Thomas A (2010) 'HIV Criminalisation and Sex Work in Australia', *Reproductive Health Matters* 18 (35).

<sup>45</sup> Links to articles on [http://www.gnppplus.net/criminalisation/index.php?option=com\\_content&task=view&id=113&Itemid=42](http://www.gnppplus.net/criminalisation/index.php?option=com_content&task=view&id=113&Itemid=42) (accessed on 12th July 2010)

# Conclusions

40

UNAIDS has urged governments:

**to limit criminalisation to cases of intentional transmission i.e. where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it. In other instances, the application of criminal law should be rejected by legislators, prosecutors and judges. (UNAIDS Policy Brief, 2008)**

That position is gaining increasing support from international and domestic agencies highly experienced in delivering HIV prevention efforts over almost three decades. The rollout of HIV-specific criminal laws, the application of existing laws to HIV transmission risk and disclosure, and the increasing numbers of HIV-related criminal cases undermines HIV prevention efforts, increases stigma against people living with HIV and their families, and destroys the lives of those involved in criminal trials.

Most recently, the UN Special Rapporteur (Anand Grover) has reiterated the recommendations of UNAIDS by calling on states:

**to immediately repeal laws criminalising the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalizing intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases. (Grover, 2010)**

Drafting HIV-specific criminal laws is problematic not only because it associates HIV with possible

criminality, but also because in some instances it overrides the broad tenets of criminal law. In many US states and in sub-Saharan Africa, for example, HIV-specific offences have been constructed to negate considerations of mens rea (guilty state of mind) or a requirement that the act include an appreciable risk of harm.

HIV-specific laws and prosecutions under general laws appear to have filled a gap where an effective public health response has 'failed'. One could argue that this is a failure of governments, particularly those involved in administering public health and communicable disease responses and the government experts in HIV strategy. Granted, the legal process often precludes health officials intervening in specific cases. However, the spectre of increasing HIV-related prosecutions requires more than case-specific interventions. Health departments must leverage structural reform. They are the primary internal agencies dealing with HIV, and they do so using a public health (as opposed to a law and order) framework. Health departments understand the rationale and the demonstrated successes of a supportive public health response. Police are not experts in HIV transmission. In fact, HIV transmission is absolutely peripheral to the majority of police departments, particularly at local level. Health departments must step-up, under the auspices of their governments, to communicate to police and justice departments the harms of prosecution for HIV exposure and unintentional HIV transmission. Police and justice departments must meet them half way. Police and justice officials should draft guidelines which clearly and narrowly define the appropriate application of criminal law. In locations where counselling, support and public health proc-

esses exist to work with people whose behaviour puts others at risk, systems should be developed to enable police to refer complainants and those who are alleged to be placing others at risk into supportive and rigorous public health processes.

HIV community agencies and organisations of people living with HIV must be allowed to participate in debates about appropriate strategies to address HIV, and in the construction of legislation and policy to effect change. Unfortunately, the GIPA principle (Greater Involvement of People living with HIV/AIDS) has been noticeably absent from legislative and policy development processes relating to HIV and the criminal law. Yet, people living with HIV understand the dynamics surrounding transmission, which has vital potential for problem-solving to reduce transmission rates. It is particularly important that this understanding be local. In developing new law, or revising existing law, a comprehensive consultative process is needed to ensure the legal framework is responsive to the values, customs and priorities of each country.

Criminalisation of HIV exposure and unintentional transmission presents a series of disastrous possibilities. If people may be convicted prior to testing, people may be held criminally liable in relation to a fact of which they were unaware. If people may only be convicted post testing, those laws will discourage people from being tested. That increases the likelihood of people engaging in risk behaviours and limits pregnant women's access to formal antenatal care. That, in turn precludes people from accessing treatment, impacting the risk of each risk episode and increasing vertical transmission risk.

Criminal penalties for failure to disclose HIV-positive status prior to a risk behaviour, or in interactions with health care providers, immediately criminalises the actions of many. Behavioural research across the world indicates that not all HIV-positive people will disclose their HIV status before every single risk episode. Data from Africa confirms that mandatory disclosure laws are completely out of touch with the lived reality of HIV-positive people. A great deal of work needs to be done to change societal values before criminalising significant proportions of the population. It also ignores the enormous social consequence such disclosure can trigger, particularly for women. Mandating health care workers breaching of confidentiality provisions will drive people away from HIV testing.

While it is encouraging that the leadership of many high-prevalence countries continue to grapple with means to reduce HIV transmission, HIV-specific criminal laws are counterproductive. The lack of action to minimise prosecutions by other governments is concerning: perhaps the result of a sense of complacency as HIV is increasingly considered less of a 'crisis'. Certainly, comparatively few prosecutions occurred in the first two decades of the HIV epidemic.



# Recommendations

Significant actions must be undertaken to curb this unfolding criminal law focus that presents disastrous consequences for HIV prevention efforts:

- (i) Criminal laws should not be HIV-specific and prosecutions must be restricted to exceptional cases of malicious and deliberate transmission by a person who knows their HIV-positive status.
- (ii) If laws regarding HIV transmission remain on the statute books, they should encourage the practice of safer sex by providing the use of reasonable measures to prevent HIV transmission (for example, condom use or a consistently undetectable viral load) as a defence to criminal liability. Scientific understandings of infection risk must be taken into account in assessing whether behaviour carries an appreciable risk of harm.
- (iii) Informed consent following disclosure should always be available as defence to criminal liability for HIV transmission. Disclosure should not be specifically mandated by criminalising failure to disclose. Courts must take account of anticipated repercussions when considering why an accused failed to disclose their HIV-status. All evidence suggests disclosure is most likely to occur in an enabling environment. Laws should provide people living with HIV and most-at-risk populations, such as MSM and sex workers, with protection from discrimination, violence and hate crimes, rather than criminalising people living with HIV.
- (iv) Voluntary counselling and testing should be available, accessible, discreet, confidential, and free of charge, but not compulsory. Mandatory testing is likely to push vulnerable people underground and to create a black market for HIV-negative certificates. Increasing availability of anonymous HIV testing must be considered. Where provider initiated counselling and testing approaches are implemented, it is extremely important that the person being tested is fully informed about the legal and social consequences of an HIV diagnosis as well as the health implications. That advice should include the availability of support and legal protections should the person face violence or discrimination after diagnosis.
- (v) Laws should entrench health care workers' obligation to maintain confidentiality. Contrary requirements will drive people away from health care services, which will reduce access to HIV testing and treatments, thereby increasing HIV transmission risk.
- (vi) Criminal law advocates aiming to protect women should focus their efforts on the application of law to instances of domestic violence and sexual assault. Rape should be punishable, whether or not it occurs in marriage. Equal access to property ownership, inheritance and fair financial settlements after separation or divorce are also essential to decreasing the risk of HIV transmission to women, and increasing the capacity of women to disclose HIV-positive status.
- (vii) Comprehensive, frank, evidence-based education about HIV transmission risks and the benefits and disadvantages of treatment should be provided to the whole population from puberty, and ideally before. Knowledge of HIV transmission risk would allow young people the opportunity to develop safe habits from the commencement of their sex lives, and would facilitate greater defence from sexual predators.
- (viii) Networks of people living with HIV should be resourced and supported to grapple with the complexity of HIV-related legislation and its consequences. Networks of people living with HIV and advocates against criminalisation must be proactive to prevent the introduction of punitive laws and oppose the application of existing criminal laws to cases of HIV exposure and transmission, except in narrowly defined circumstances of malicious intent.
- (ix) Journalists and other media personnel should be educated on all aspects of HIV and its regulation by the criminal law in order to reduce the proliferation of sensationalist and misleading press promoting the benefits of HIV-related prosecutions.



# References

ACPO. (2010). *Investigation Guidance relating to the criminal transmission of HIV*. UK: Association of Chief Police Officers.

Anand, A., Bunnell, R.E., Diaz, T., Jacobs, K., Kamoto, K., Marum, L.H., (...) Solehdin, N. (2009, July). *Knowledge of HIV status, sexual risk behaviours and contraceptive need among people living with HIV in Kenya and Malawi*. *AIDS*, 23 (12).

Australasian Society for HIV Medicine. (2010, March). *Guide to Australian HIV Laws and Policies for Healthcare Professionals*. Retrieved from <http://www.ashm.org.au/HIVLegal/>

Bailey, R.C., Moses, S., Parker, C.B., Agot, K., Maclean, I., Krieger, J. N., (...) Ndinya-Achola, J.O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet*, 369 (9562), 643-56.

Berger, P.B. (2009). Prosecuting for knowingly transmitting HIV is warranted. *CMAJ*, 180 (13).

Bernard, E., Azad, Y., Geretti, A.M., Van Damme, A.M., Weait, M. J. (2007). HIV Forensics: The Use of Phylogenetic Analysis as Evidence in Criminal Investigation of HIV Transmission. *National AIDS Manual Briefing Papers*.

Bernard, E.J. (2010). *HIV and the Criminal Law*. London: NAM.

Boily, M.C., Baggaley, R. F., Wang, L., Masse, B., White, R.G., Hayes, R.J. and Alary, M. (2009). Heterosexual risk of HIV-1 infection per sexual act: a systematic review and meta-analysis of observational studies. *Lancet Infectious Diseases*, 9 (2), 118-29.

Burris, S., Beletsky, L., Burlison, A., Case, P., Lazzarini, Z. (2007). Do Criminal Laws Influence HIV Risk Behaviour? An Empirical Trial. *Arizona State Law Journal*, 39 (467), 467-519.

Cameron, S. and Rule, J. (eds) (2009). *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality*. Australia: NAPWA.

Cameron, E. (2009, June 9). The criminalisation of HIV Transmission and exposure. *HIV and criminal law in Sweden*. World Trade Centre Stockholm.

Canadian HIV/AIDS Legal Network. (2009). Thai woman's deportation postponed until resolution of her criminal appeal. *HIV/AIDS POLICY & LAW REVIEW*, 14 (1).

Canadian HIV/AIDS Legal Network. (2010). *Criminalization of HIV Exposure: Canada*. Report prepared for the Global Network of People Living with HIV. Amsterdam: GNP+.

Center for Disease Control and Prevention. (2008). Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV. Retrieved from <http://www.cdc.gov/hiv/resources/qa/qa37.htm>

Chinkonde, J.R., Sundby, J., Martinson, F. (2009). The prevention of mother-to-child HIV transmission programme in Lilongwe, Malawi: why do so many women drop out? *Reproductive Health Matters*, 17 (33), 143-151.

Christian Aid. (2010, February). *Brief Position paper on Malawi Draft HIV Bill*.

Cooper, R.G. and Reid, P.D. (2007). Sexually transmitted disease/HIV health-care policy and service provision in Britain. *International Journal of STD & AIDS*, 18 (10), 655-661.

CPS. (2008a). *Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection*. London.

CPS. (2008b). *Legal guidance: Intentional Or Reckless Sexual Transmission Of Infection*. London.

Criminal Law Codification and Reform Act (2004). Chapter 9:23 at Division D.

Csete, J., Pearshouse, R. and Symington, A. (2009). Vertical HIV transmission should be excluded from criminal prosecution. *Reproductive Health Matters*, 17 (34), 154-162.



- Das-Douglas, M. et al (2010). Abstract 33: Decreases in community viral load are associated with a reduction in new HIV diagnoses in San Francisco. *Seventeenth Conference on Retroviruses and Opportunistic Infections*. San Francisco.
- Davidson, R. (1994). Venereal Disease, Sexual Morality and Public Health in Interwar Scotland. *Journal of the History of Sexuality*. 5 (2)
- District Court of Wellington. (2005, October 4). New Zealand Police v. Dalley, Court File No. CRI-2004-085-009168.
- Dodds, C. (2005). *Grievous Harm*. London: Sigma Research.
- Dodds, C., Weatherburn, P., Bourne, A., Hammond, G., Weait, M., Hickson, F., (...) Jessup, K. (2009). Sexually charged: the views of gay and bisexual men on criminal prosecutions for sexual transmission. London: Sigma Research.
- Dodds, C., Keogh, P. (2006). Criminal prosecutions for HIV transmission: people living with HIV respond. *International Journal of STD & AIDS*, 17 (5).
- Donovan, B., O'Connor, J.L., Harcourt, C., Wand, H., Egger, S., Schneider, K. (...), Bates, J.L. (2009, June/July). Law and Sexual Health (LASH) Project poster from the International Society for STD Research in London, National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, University of Melbourne, Fremantle Sexual Health Centre, Melbourne Sexual Health Centre, Sydney Sexual Health Centre, Urban Realists Planning and Health Consultants, Australia.
- Eba, P. (2008). One size punishes all...a critical appraisal of the criminalisation of HIV transmission. South Africa: AIDS Legal Network.
- ECOSOC. (2009, July 24). Economic and Social Council Resolution E/2009/L.23.
- Family Health International/USAID Action for West Africa Region (AWARE). (2008). Disseminating and Replicating Best Practices in West Africa: Strengthening West Africa's Response to the HIV/AIDS Epidemic.
- Fraser, C., Hollingsworth, T., Chapman, R., de Wolf, F., Hanage, W. (2007, October 22). Variation in HIV-1 set-point viral load: epidemiological analysis and an evolutionary hypothesis. *Proc Natl Acad Sci USA*. 30;104 (44):17441-6.
- Futures Group. <http://www.futuresgroup.com/technical-services/policy-and-advocacy/>
- Galletly, C.L. and Dickson-Gomez, J. (2009). HIV seropositive status disclosure to prospective sex partners and criminal laws that require it: perspectives of persons living with HIV. *International Journal of STD & AIDS*, 20, 613–618.
- GNP+ & UNAIDS. (2009a). Positive Health, Dignity and Prevention. Technical Consultation Report. Amsterdam: GNP+.
- GNP+. (2009). What price reproductive rights? *Global Criminalisation Scan*. Retrieved from [http://www.gnpplus.net/criminalisation/index.php?option=com\\_content&task=view&id=387&Itemid=53](http://www.gnpplus.net/criminalisation/index.php?option=com_content&task=view&id=387&Itemid=53)
- Government of PNG. (2008). UNGASS Country Progress Report.
- Gray, R., Kigozi, G., Serwadda, D. et al. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*, 369 (9562), 615.
- Grierson, J., Power, J., Croy, S., Clement, T., Thorpe, R., McDonald, K., Pitts, M. (2006). HIV Futures 6: Making Positive Lives Count. The Living with HIV Program. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.
- Grover, A.M. (2010). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest Attainable standard of physical and mental health. United Nations Human Rights Council General Assembly.
- Groves, A. and Cameron, S. (2009). Criminal prosecution of HIV transmission: the policy agenda. AFAO.
- Groves, M. (2007). The transmission of HIV and the Criminal Law. *Criminal Law Journal*. Australia.

Gueye, M. (2010, February 17). Sénégal: Loi sur le vih/sida - Sanctions sévères pour toute contamination délibérée. *Le Soleil*. Retrieved from <http://fr.allafrica.com/stories/201002170754.html>

Harcourt, C., Donovan, B. (2005). The many faces of sex work. *Sexually Transmitted Infections*, 81.

IPPF, GNP+ and International Community of Women Living with HIV/AIDS. (2008). *Verdict on a Virus: public health, human rights and criminal law*. London: IPPF.

IRIN. (2008). Crime and Punishment: Criminalisation and HIV. *PlusNews Global HIV/AIDS News and Analysis*.

IRIN West Africa. (2008). HIV law “a double-edged sword”. IRIN/OCHA.

Jeffreys, E., Matthews, K., Thomas, A. (2010). HIV Criminalisation and Sex Work in Australia. *Reproductive Health Matters*, 18 (35), 129–136.

Jin, F., Jansson, J., Law, M., Prestage, G. et al (2010). Per-contact probability of HIV transmission in homosexual men in Sydney in the era of HAART. *AIDS*, published online ahead of print.

Jordan, J. (2005). *The Sex Industry in New Zealand: A Literature Review*. Wellington: Ministry of Justice.

Jürgens, R., Cohen, J., Cameron, E., Burris, S., Clayton, M., Elliott, R. (...), Cupido, D. (2008). 10 Reasons to oppose criminalisation of HIV exposure or transmission. New York: Open Society Institute, ARASA, UNDP.

Kehler, J., Clayton, M., and Crone, T. (2009). 10 Reasons Why Criminalisation of HIV Exposure or Transmission Harms Women. Windhoek: ARASA, Athena.

Kielburger, C., Kielburger, M. (2009, July 6). Burden of HIV disclosure falls on Uganda’s women.

Lazzarini, Z., Bray, S. and Burris, S. (2002). Evaluating the Impact of Criminal Laws on HIV Risk Behavior. *Journal of Law, Medicine and Ethics*.

Lund, I. (2007). Negative consequences of the Swedish law against the purchase of sexual services.

Marks, G., Crepaz, N., Janssen, R.S. (2006) Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*, 20 (10), 1447-1450.

Matthews, K. (2008). Needs Assessment of Sex Workers Living With HIV. Scarlet Alliance, Australian Sex Workers Association.

Medley, A., Garcia-Moreno, C., McGill, S., Maman, S. (2004). Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission program. *Bulletin WHO*, 82 (4).

Michael, W. (2009, December 4). EAST AFRICA: Move Towards Common HIV/AIDS Law. Interpress Service. Retrieved from <http://ipsnews.net/news.asp?idnews=49543>

Mitchell, G. (2009). Criminal transmission of human immuno-deficiency virus: a guide for legal practitioners in New South Wales. Australia: HIV/AIDS Legal Centre & DLA Philips Fox.

Montaner, J., Wood, E., Kerr, T. et al (2010). Abstract 88LB: Association of expanded HAART coverage with a decrease in new HIV diagnoses, particularly among injection drug users in British Columbia, Canada. San Francisco: 17th Conference on Retroviruses and Opportunistic Infections.

Muiruri, F. (2007, January 22). Boy murdered over his HIV status buried. *Kenya Times Newspaper*.

Musoni, E. (2010, January 26). Government cannot criminalize homosexuality – Minister. *New Times* (Kigali).

National Board of Health and Welfare. (2004). Prostitution in Sweden 2003 Knowledge, Beliefs and Attitudes of Key Informants.



National Centre in HIV Epidemiology and Clinical Research. (2009). HIV/AIDS, Viral Hepatitis & sexually Transmissible Infections in Australia. *Annual Surveillance Report*. Australia: National Centre in HIV Epidemiology and Clinical Research.

National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services. (2001). Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention report.

Niles, C. (2008). Poverty drives Kenyan girls into sex work. UNICEF.

OHCHR and UNAIDS. (2006). International Guidelines on HIV/AIDS and Human Rights. Geneva: OHCHR.

Ottosson, D., (2009). State-sponsored homophobia: a world survey of laws prohibiting same sex activity between consenting adults. *International Lesbian and Gay Association (ILGA) report*, 5.

Phillips, M., Poulton, M. (2010). HIV transmission, the law and the work of the clinical team. London: British HIV Association/British Association of Sexual Health and HIV.

Prostitution Law Reform Committee. (2008). Report of the Prostitution Law Reform Committee. New Zealand: Ministry of Justice.

Sambo, R. (2001) The Situation of Sex Workers in Sweden. Taipei: Paper presented at the Sex Worker Conference.

Sanon, P., Kabore, S., Wilen, J.U., Smith, S. and Galvao, J. (2009). Advocating prevention over punishment: the risks of HIV criminalisation in Burkina Faso. *Reproductive Health Matters*, 17 (34).

Rawstone, P., Holt, M., Kippax, S., Worth, H., Wilkinson, J., Bittman, M. (2009). E-male survey 2008: key findings from a national online survey of men who have sex with men in Australia. *Monograph 3/2009*. Sydney: National Centre in HIV Social Research.

Treatment Action Campaign. (2009). Arrest of MSM in Senegal.

UNAIDS, UNICEF, WHO. (2009 October). Uganda Epidemiological Fact Sheet on HIV and AIDS: Core data on epidemiology and response 2008 Update. Retrieved from [http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_UG.pdf](http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_UG.pdf)

UNAIDS. (2002). Sex work and HIV/AIDS: UNAIDS Technical Update. Geneva: UNAIDS.

UNAIDS. (2005). HIV-related Stigma, Discrimination and Human Rights Violations. Geneva: UNAIDS.

UNAIDS. (2006). International Guidelines on HIV/AIDS and Human Rights. Geneva: UNAIDS.

UNAIDS. (2008a). Policy Brief. Criminalisation of HIV Transmission. Geneva: UNAIDS.

UNAIDS. (2008b). Report on the Global AIDS Epidemic. Geneva: UNAIDS.

UNAIDS. (2009a). AIDS epidemic update. Geneva: UNAIDS.

UNAIDS. (2009b). UNAIDS Guidance Notes on HIV and Sex Work. Geneva: UNAIDS.

UNAIDS. (2009c). UNAIDS Senior Advisor for Human Rights and Law, Susan Timberlake, interview December 2009.

UNAIDS and UNDP. (2010). Statement by the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme (UNDP): 14th Session the Human Rights Council - Agenda Item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. Geneva.

USAID AWARE. (2005). Success Story: A Specific Law on HIV/AIDS. Retrieved from <http://www.fhi.org/NR/rdonlyres/eih2fipgyy4qxbpac5vw3qgvvp2dqunpkhdemepkub2qkok33gmj2mwt4bn4pltlasi4xhntqcfj4h/SUCCESSSTORYBENIN2enhv.pdf>

USAID Health Policy Initiative. (2008). Tanzania adopts HIV law: USAID assistance culminates in law prohibiting discrimination against HIV. Washington DC: USAID/PEPFAR.

Vernazza, P., Hirschel, B., Bernasconi, E. and Flepp M. (2008). Les personnes seropositives ne souffrant d'aucune autre MST et suivant un traitement anti retroviral efficace ne transmettent pas le VIH par voie sexuelle (Swiss Cohort Study). *Bulletin des Medecins Suisses*, 89.

Viljoen, F. and Eba, P. (Undated). A human rights assessment of the Draft Bill on Defending Human Rights and the Fight Against the Stigmatisation and Discrimination of People Living with HIV and AIDS of Mozambique. SADC Parliamentary Forum.

Vittinghoff, E., Douglas, J., Judson, F., McKirnan, D., MacQueen, K., Buchbinder, S.P. (1999). Per-contact risk of human immunodeficiency virus transmission between male sexual partners. *American Journal Epidemiology*, 150 (3).

Wald, A. et al (2002). Risk of human immunodeficiency virus infection in herpes simplex virus type-2 seropositive persons: a meta-analysis. *Journal of Infectious Diseases*, 185.

Wawer, M.J., Gray, R.H., Sewankambo, N.K., et al (2005). Rates of HIV-1 transmission per coital act by stage of HIV-1 infection, in Rakai, Uganda. *Journal of Infectious Diseases*, 191, 1403–1409.

Wainberg, M.A. (2009, March 17). Criminalizing HIV transmission may be a mistake. *CMAJ*, 180 (6).

Welbourn, A. (2008). Into the firing line... placing young girls and women at greater risk. South Africa: AIDS Legal Network.

Wilson, D., Hoare, A., Regan, D., Law, M. (2008). Mathematical models to investigate recent trends in HIV notifications among men who have sex with men in Australia. Sydney: National Centre in HIV Epidemiology and Clinical Research.

WHO, UNAIDS, UNICEF. (2008). Towards universal access: scaling up priority HIV/AIDS interventions in the health sector – Progress report 2008.

WHO. (2009a). HIV and infant feeding: Revised Principles and Recommendations Rapid Advice. Geneva: WHO.

WHO. (2009b). Priority interventions: HIV prevention, treatment and care in the health sector (version 1.2). Geneva: WHO.

WHO. (2010a). PMTCT Strategic Vision 2010–2015: Preventing Mother-to-Child Transmission of HIV to Reach the UNGASS and Millennium Development Goals. Geneva: WHO.

WHO. (2010b). Screening donated blood for transfusion-transmissible infections: recommendations. Geneva: WHO.

Xinhua. (2009, December 3). Gansu requires HIV carriers to inform partners. *China Daily*.

Zablotska, I., Imrie, J., Prestage, G., Crawford, J., Rawstorne, P., Grulich, A. (...), Kippax, S. (2009). Gay men's current practice of HIV seroconcordant unprotected anal intercourse: serosorting or seroguessing? *AIDS Care*, 21.





CARIBBEAN  
REGIONAL  
NETWORK+



*The Heart  
of the Caribbean*



[www.gnppplus.net/criminalisation](http://www.gnppplus.net/criminalisation)