



ISSUE PAPER FOR THE SESSION:
Criminalization of HIV transmission

Defining the Issue

1. In 2002, UNAIDS issued a policy options paper on criminal law, public health and HIV transmission that outlined principles that should guide policy development in the area of the criminalization of HIV transmission and exposure. Recently, there have been indications that the criminal law is increasingly being applied in such cases. Countries where such cases have been recorded include Holland, Denmark, Sweden, the United Kingdom, as well as other countries in Europe and Central Asia. Furthermore, there have been recent examples of countries developing or amending their criminal laws to include HIV transmission or exposure, e.g. in Uganda and Niger. In the United Kingdom, the Crown Prosecution Service is currently developing policy to guide prosecutions related to the transmission of HIV and other sexually transmitted infections.
2. The increased use of the criminal law in cases of HIV transmission/exposure raises a number of previously expressed concerns, primarily that it represents a return to “blaming” people living with HIV, a possible increase in stigma against people living with HIV, and a possible decrease in people taking individual responsibility for protecting themselves. The criminalization of HIV transmission is also a matter of concern in light of the need and trend to increase access to testing and to knowledge of status in order to achieve universal access to HIV prevention, treatment and care and support. People might decline an offer for HIV testing in health settings, be less inclined to seek the services of VCT clinics, and/or be less inclined to discuss their HIV status with sexual and drug-injecting partners - if they fear application of the criminal law. There also remain, in the criminal prosecution of HIV transmission/exposure, very difficult issues of proof, knowledge, intent, and discriminatory application of law.

Background

3. Coercion, compulsion and restriction have been part of a public health approach to communicable diseases. In the case of HIV, this approach has been rejected as ineffective and abusive. Instead, there has largely been a rights-based approach emphasizing human dignity, responsibility, voluntariness, and empowerment through access to health information, services and community support and participation. This approach recognizes that responsibility for sexual health is shared between the individual and the State.
4. In this context, the application of criminal law to HIV transmission/exposure has been seen as inappropriate and counterproductive to public health goals. In the 2002 UNAIDS policy option paper it was stated that “Criminal prosecution, as the most coercive and stigmatizing of measures, should be reserved for those cases where public health interventions have not succeeded in achieving the objective of preventing further HIV transmission” (page 39). In October, 2006, WHO Europe convened, in collaboration with the European AIDS Treatment Group and AIDS Action Europe, a technical consultation on the criminalization of HIV and other sexually transmitted infections to consider recent developments regarding

the application of the criminal law. This consultation and other discussions have highlighted a number of outstanding issues.

Some issues that require greater clarification

5. **Is HIV specific legislation ever justified?** In the UNAIDS policy options paper and in the International Guidelines on HIV and Human Rights, it is recommended that “Criminal and/or public health legislation should not include specific offences against deliberate and intentional transmission of HIV but should rather apply general criminal offences to these exceptional cases”. At the WHO Consultation, this position was supported, although it was also acknowledged that HIV specific legislation might be justified by the “legality principle” which requires that, before imposing punishment, the law must clearly delineate which conduct is prohibited. Further, it was noted that while HIV legislation may be stigmatizing, the prosecutions themselves are also stigmatizing, whatever the legal basis.
6. **Should the criminal law be applied to “exposure to transmission”, or only “actual transmission”?** It has been recommended that the application of criminal law should be limited to cases of actual HIV and STI transmission, as the law might extend too broadly if it were to criminalize all instances of exposure to HIV and STI infection. Further, it has been argued that the per-act risk of infection is too low to justify the application of criminal law. However, by limiting the application of criminal law to transmission, it could be argued that acts of recklessness, which might justify criminal sanction, are not covered. Questions of knowledge, intent and consent become critical in such application.
7. **Should the criminal law be applied only to “intentional infection” or also to “recklessness” or “negligence”?** While there seems to be consensus that intentional exposure/transmission of HIV should be liable for criminal sanctions, in most of the cases where HIV positive persons have been convicted, the conviction has been based on a finding that the person acted recklessly. It has been argued that, if the law provides criminal liability for reckless conduct, the prosecuted person should have been diagnosed prior to the conduct in question, and the conduct should carry significant risk of transmission.
8. **Can there be “consent” to exposure to HIV, and if so, how to define it?** It has been argued that there is no justification for criminal prosecution for transmission of/exposure to HIV in cases where there was consent on the part of sexual/drug-injecting partner. How does one define “consent” in the context of exposure to HIV and does the HIV positive person have a legal (or moral) obligation to disclose his or her sero-status? Active deceit can be seen to undermine the autonomy of the sexual/drug-injecting partner who seeks to minimize his or her risk by basing his or her decisions on information provided. In some countries, HIV positive people are obligated to disclose their status or to practice/insist on practicing safer sex. This issue also raises the circumstances where the HIV positive person “justifiably” does not disclose status for fear of violence or other negative consequences.

Questions for discussion

- a) What is the best way for UNAIDS to help provide guidance in this area? What is the best way to reach consensus on the difficult issues raised above?
- b) Should a system be established by which to monitor developments in relation to prosecution of and legislation regarding exposure to/transmission of HIV, and if so, who is best placed to do it?
- c) How can people living with HIV, other civil society groups and parliamentarians be best mobilized/supported to take on this issue?

Supporting document

- WHO Europe: “WHO technical consultation in collaboration with the European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections” October, 2006.

References

- Moono Nyambe: “Criminalization of HIV transmission in Europe” GNP+, 2005.
- UNAIDS: “Criminal Law, Public Health and HIV Transmission – A Policy Options Paper”, 2002.
- Executive Committee on AIDS Policy and Criminal Law: “Detention or prevention? – a report on the impact of the use of criminal law on public health and the position of people living with HIV” Amsterdam, 2004
- Matthew Weait and Yusef Azad: “The criminalization of HIV transmission in England and Wales: questions of law and policy”, in *HIV/AIDS Policy and Law Review* vol.10/2, August 2005.
- WHO Europe: “WHO technical consultation in collaboration with the European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections” October 2006.