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Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations

UNAIDS

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Executive summary

The overly broad application of criminal law to HIV non-disclosure, exposure and transmission raises serious human rights and public health concerns. Because of these concerns, the Joint United Nations Programme on HIV/AIDS (UNAIDS) urges States to (i) concentrate their efforts on expanding the use of proven and successful evidence-informed and rights-based public health approaches to HIV prevention, treatment and care, and (ii) limit any application of criminal law to truly blameworthy cases where it is needed to achieve justice. States should strengthen HIV programmes that enable people to know how to protect themselves from HIV and to avoid transmitting it, and they should help people access the services and commodities they need for HIV prevention, treatment, care and support.

As stated in the *Policy brief on criminalisation of HIV transmission*—issued in 2008 by UNAIDS and the United Nations Development Programme (UNDP)—the concerns raised by the overly broad criminalisation of HIV non-disclosure, exposure and transmission can be addressed in part by limiting the application of criminal law 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).

Though UNAIDS stands by this position, it is concerned by the continued application of criminal law beyond *intentional transmission* to cases involving unintentional HIV transmission, non-disclosure of HIV status, or exposure to HIV where HIV was not transmitted. As a result, this document not only restates UNAIDS' position, but it also provides specific considerations and recommendations to address the concerns raised in all cases where criminal law is applied to HIV non-disclosure, exposure or transmission. It offers these to help governments, policy-makers, law enforcement officials, and civil society—including people living with HIV—to achieve the goal of limiting and hopefully ending the overly broad application of criminal law to HIV. These considerations and recommendations are also provided to help ensure, to the best degree possible, that any application of criminal law in the context of HIV achieves justice and does not undermine public health.

The following considerations and recommendations are based on the general position that the use of criminal law in relation to HIV should (i) be guided by the best available scientific and medical evidence relating to HIV, (ii) uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and (iii) protect the human rights of those involved in criminal law cases. A rational application of criminal law in the context of HIV should reflect this general position. In particular, it should be guided by the following considerations and recommendations as summarised below:

a. With regard to the assessment of the **harm** caused by HIV:

- In the absence of the actual transmission of HIV, the harm of HIV non-disclosure or exposure is not significant enough to warrant criminal prosecution. Non-disclosure of HIV-positive status and HIV exposure should therefore not be criminalised.

- In jurisdictions that allow prosecution in the absence of HIV transmission, such use of criminal law should be exceptional. It should require, at a minimum, proof of an appropriate culpable mental state, and it should be limited to circumstances where—based on scientific and medical facts—there is a significant risk of HIV infection.
- Any criminal charge for HIV non-disclosure, exposure or transmission should take into account the current reality of HIV infection, including the benefits of HIV treatment. HIV infection is a serious health condition that has become chronic and manageable with treatment. As a result, a person with HIV can now live a near normal lifespan.
- Since HIV infection is now a chronic, treatable health condition, it is inappropriate for criminal prosecution for HIV non-disclosure, exposure or transmission to involve charges of "murder", "manslaughter", "attempted murder", "attempted manslaughter", "assault with a deadly weapon", "aggravated assault" or "reckless homicide".

b. With regard to the assessment of the **risk** of HIV transmission:

- Where criminal liability is extended to cases that do not involve actual transmission of HIV, such liability should be limited to acts involving a "significant risk" of HIV transmission.
- The determination of whether the risk of HIV transmission from a particular act is significant should be informed by the best available scientific and medical evidence.
- The risk of HIV transmission should not be considered "significant", "substantial", "unjustifiable", "serious", or "likely" for the purpose of criminal prosecution or liability when condoms were used consistently, other forms of safer sex were practiced (including non-penetrative sex and oral sex), or the person living with HIV was on effective HIV treatment or had a low viral load.
- Because there is no risk of HIV transmission from kissing, biting, scratching, hitting, or from spitting or throwing bodily fluids (*e.g.* blood, saliva and semen) or excretions (*e.g.* urine and faeces), such acts should not form the basis of criminal prosecution or liability for HIV non-disclosure, exposure or transmission.

c. With regard to the assessment of the **mental culpability** of the person accused:

- Any application of criminal law to HIV non-disclosure, exposure or transmission should require proof, to the applicable criminal law standard, of intent to transmit HIV.
- Intent to transmit HIV cannot be presumed or solely derived from knowledge of positive HIV status and/or non-disclosure of that status.
- Intent to transmit HIV cannot be presumed or solely derived from engaging in unprotected sex, having a baby without taking steps to prevent mother-to-child transmission of HIV, or by sharing drug injection equipment.

- Proof of intent to transmit HIV in the context of HIV non-disclosure, exposure or transmission should at least involve (i) knowledge of positive HIV status, (ii) deliberate action that poses a significant risk of transmission, and (iii) proof that the action is done for the purpose of infecting someone else.
- Active deception regarding positive HIV-status can be considered an element in establishing intent to transmit HIV, but it should not be dispositive on the issue. The context and circumstances in which the alleged deception occurred—including the mental state of the person living with HIV and the reasons for the alleged deception—should be taken into consideration when determining whether intent to transmit HIV has been proven to the required criminal law standard.
- Jurisdictions that accept "recklessness" as a sufficient culpable mental state for HIV non-disclosure, exposure or transmission should narrowly define and/or apply it only where it is established that there is a "conscious disregard" in relation to acts that represent, on the basis of best available scientific and medical evidence, a significant risk of HIV transmission.
- Because it involves serious risks of overly broad interpretation and miscarriages of justice, "negligence" should not be accepted as a sufficient culpable mental state in the context of criminalisation of HIV non-disclosure, exposure or transmission.
- Strict liability offences (*i.e.* offences that do not require proof of a culpable mental state) should not be applied in the context of criminalisation of HIV non-disclosure, exposure or transmission.
- In no case should prosecution for HIV non-disclosure, exposure or transmission proceed when one of the following circumstances exists:
  - the person did not know he or she was HIV-positive;
  - the person did not understand how HIV is transmitted;
  - the person disclosed his or her HIV-positive status to the person at risk (or honestly and reasonably believed the other person was aware of his or her status through some other means);
  - the person did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
  - the person took reasonable measures to reduce the risk of HIV transmission, such as practicing safer sex through using a condom, or engaging in non-penetrative sex or oral sex;
  - the person agreed on a level of mutually acceptable risk with the other person; or
  - the person believed that he or she could not transmit HIV given his or her effective treatment or low viral load.

d. With regard to the determination of **defences** to prosecution or conviction:

- Disclosure of HIV-positive status and/or informed consent by the sexual partner of the HIV-positive person should be recognized as defences to charges of HIV exposure or transmission.

- Because scientific and medical evidence demonstrates that the risk of HIV transmission can be significantly reduced by the use of condoms and other forms of safer sex—and because these behaviours are encouraged by public health messages and HIV prevention strategies that should not be undermined—condom use or the practice of other forms of safer sex (including non-penetrative sex and oral sex) should be recognized as defences to charges of HIV non-disclosure, exposure or transmission.
- Effective HIV treatment or low viral load should be recognized as defences to charges for HIV non-disclosure, exposure or transmission.

e. With regard to the assessment of elements of **proof**:

- As with any crime, all elements of the offence of HIV non-disclosure, exposure or transmission should be proved to the required criminal law standard.
- HIV phylogenetic evidence alone is not sufficient to establish, to the required criminal law standard, that one person *did* infect another person with HIV.
- HIV phylogenetic evidence can establish conclusively that one person *did not* infect another person, but expert administration is necessary to ensure that the results are accurate and appropriately interpreted.
- CD4 count, viral load, and Recent Infection Testing Algorithm (RITA) evidence cannot alone establish, to the required criminal law standard, that the HIV infection occurred within a certain period of time, nor can they lead to a definitive conclusion about the individual source of HIV infection.
- Communications between defendants and health-care workers or HIV counsellors, as well as medical records, should be considered as privileged to the extent afforded to these communications and documents in other legal and court contexts. Health-care providers should not release a patient's HIV-related records and information in the absence of patient authorisation or court order.
- Scientific and medical experts called in HIV-related criminal matters should be properly qualified and trained to highlight accurately the merits and limitations of data and evidence relating to the risk, harm and proof of HIV transmission (among other issues).

f. With regard to the determination of **penalties** following conviction for HIV non-disclosure, exposure or transmission:

- Any penalties for HIV non-disclosure, exposure or transmission should be proportionate to the state of mind, the nature of the conduct, and the actual harm caused in the particular case, with mitigating and aggravating factors duly taken into account.
- The assessment of the harm of HIV non-disclosure, exposure and transmission for determining penalties should be based on scientific and medical evidence relating to HIV infection, including the benefits of HIV treatment.

- Penalties for HIV non-disclosure, exposure and transmission should be similar to the penalties provided for like harms under criminal law.
- If imposed at all, sex offender status should not be applicable automatically to conviction for HIV non-disclosure, exposure or transmission. Sex offender status may only be imposed when warranted by behaviour apart from that related to HIV status and comparable to behaviour in other cases where sex offender status is applied.
- Alternatives to imprisonment—including fines, restitution, community service and probation—should be considered for individuals found guilty of HIV non-disclosure, exposure or transmission.

g. With regard to **prosecutorial guidelines**

- Countries should develop and implement prosecutorial and police guidelines to clarify, limit and harmonise any application of criminal law to HIV.
- The development of such guidelines should ensure the effective participation of HIV experts, people living with HIV, and other key stakeholders. The content of these guidelines should reflect the scientific, medical and legal considerations highlighted in the present document.

Introduction

1. Since the beginning of the HIV epidemic, several countries and legal jurisdictions have adopted HIV-specific laws or invoked general criminal law provisions to prosecute individuals who allegedly *do not disclose* their HIV status prior to sexual relations (HIV non-disclosure), *expose* others to HIV (HIV exposure), and/or *transmit* HIV (HIV transmission).[1]

2. Over the years, HIV advocates, experts in human rights and public health, and people living with HIV have expressed serious concerns about the nature and impact of criminalisation of HIV non-disclosure, exposure and transmission (sometimes referred to herein as "criminalisation").[2] Human rights and legal criticism against these laws and prosecutions point to the facts that (i) they are often not informed by the latest scientific and medical knowledge relevant to HIV, (ii) they disregard generally applicable criminal law principles, and (iii) they have resulted in disproportionately harsh sentences in several cases.[3] Public health concerns relate to the fact that there is no evidence that criminal law is an effective tool for HIV prevention.[4] Rather, there are indications that fear of prosecution discourages people from testing for HIV, talking openly to their physicians or counsellors, or disclosing their HIV-positive status.[5]

3. Thus, there is concern that in many legal jurisdictions the application of criminal law in the context of HIV non-disclosure, exposure and transmission is overly broad; that is, it not only disregards scientific and medical evidence about HIV, but that it also ignores critical criminal law principles (including foreseeability, intent, causality, proportionality, defence and proof). This overly broad application of criminal law leads to miscarriages of

1 See, among others, Bernard EJ, *HIV and the criminal law*, 2010; Global Network of People Living with HIV (GNP+), *The global criminalisation scan report 2010: Documenting trends, presenting evidence*, 2010; and International Planned Parenthood Federation (IPPF), GNP+ and International Community of Women living with HIV (ICW), *Verdict on a virus: Public health, human rights and criminal law*, 2008. Bibliographical information and links to sources (where applicable) can be found in the "References" section at the end of this document.

2 See, among others, Athena Network, *Ten reasons why criminalization of HIV exposure or transmission harms women*, 2009; Burris S, Cameron E and Clayton M, "The criminalization of HIV: Time for an unambiguous rejection of the use of criminal law to regulate the sexual behavior of those with and at risk of HIV", *Social Science Research Network*, 2008; Global Commission on HIV and the Law, *HIV and the law: Risks, rights and health*, 2012; Mykhalovskiy E, "The problem of 'significant risk': Exploring the public health impact of criminalizing HIV non-disclosure", *Social Science & Medicine*, 2011, 73:668–675; Open Society Foundations, *Ten reasons to oppose the criminalization of HIV exposure or transmission*, 2008; UNAIDS, *Criminal law, public health and HIV transmission: A policy options paper*, 2002; United Nations Human Rights Council, *Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 14th Sess., U.N. Doc. A/HRC/14/20, 27 April 2010.

3 See, among others, Center for HIV Law and Policy, *Prosecutions for HIV exposure in the United States, 2008–2012*, 2012, and UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Background and current landscape*, Revised version, 2012.

4 See, notably, O'Byrne P, "Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?", *Sexuality Research and Social Policy*, 2012, 9(1):70–79.

5 See, among others, Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV", *AIDS and Behavior*, 2006, 10:451–461; O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men's sex survey", *Journal of the Association of Nurses in AIDS Care*, 2013, 24(1):81–87; and O'Byrne P *et al.*, "Nondisclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada", *BMC Public Health*, 2013, 13:94.

justice and undermines public health efforts to address HIV.[6]

4. This document provides critical scientific, medical and legal considerations by which States can end or mitigate the overly broad criminalisation of HIV non-disclosure, exposure and transmission. The aim of providing these considerations to law and policy-makers, judges, prosecutors and advocates is to help to ensure that any application of criminal law in the context of HIV achieves justice in truly blameworthy cases, while still safeguarding public health goals and human rights.

5. This document builds on the UNAIDS/UNDP *Policy Brief on criminalisation of HIV transmission*[7] (UNAIDS/UNDP *Policy Brief*) issued in 2008. This UNAIDS/UNDP *Policy Brief* makes three key recommendations to countries. First, it urges countries 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".[8] Secondly, it calls on countries to avoid introducing *HIV-specific* laws to address criminalisation of HIV non-disclosure, exposure and transmission, but instead apply *general* criminal law offences in a manner that is consistent with international human rights law obligations.[9] Finally, the UNAIDS/UNDP *Policy Brief* recommends against the use of criminal law in any of the following circumstances:

- where there is no significant risk of HIV transmission;
- where the person did not know that he or she was HIV-positive;
- where the person did not understand how HIV is transmitted;
- where the person disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his or her status through some other means);
- where the person did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- where the person took reasonable measures to reduce the risk of HIV transmission, such as practising safer sex through using a condom or taking other precautions; or
- where the person previously agreed on a level of mutually acceptable risk with the other person.[10]

6. The recommendations in the UNAIDS/UNDP *Policy Brief* remain valid and should continue to be considered by countries. However, in light of recent advances in science and medicine related to HIV—as well as the continued overly broad criminalisation of HIV non-disclosure, exposure and transmission in many countries—UNAIDS has developed the present document to guide further consideration of the issues involved.

6 *Ibid.*

7 UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*, 2008.

8 *Ibid.*, p. 1.

9 *Ibid.*, p. 1.

10 *Ibid.*, p. 1.

7. In particular, the present document provides critical considerations and recommendations regarding the latest scientific and medical facts and developments relating to HIV, and important legal principles that are essential to assessing:
   - what level of harm, if any, has been caused to another person as a result of HIV non-disclosure, exposure and transmission;
   - whether the nature/level of risk of HIV transmission from particular sexual acts warrants criminal liability;
   - what elements should be recognized as defences to charges of HIV non-disclosure, exposure and transmission; and
   - the merits and limitations of methods of proof used in the context of HIV non-disclosure, exposure and transmission.

   In addressing these issues, this document draws on recent legal, judicial and policy developments in a number of jurisdictions regarding the application of criminal law to HIV non-disclosure, exposure and transmission.

8. Two key scientific and medical developments call for re-considering the application of criminal law in the context of HIV. First, effective HIV treatment has significantly reduced AIDS-related deaths and extended the life expectancy of people living with HIV to near-normal lifespans.[11] Secondly, effective HIV treatment has also been shown to significantly reduce the risk of HIV transmission from people living with HIV to their sexual partners.[12]

9. Thus, effective HIV treatment has transformed HIV infection from a condition that inevitably resulted in early death to a chronic and manageable condition that is significantly less likely to be transmitted.[13] In a number of countries and jurisdictions, these scientific and medical breakthroughs have led advocates, policy-makers and the judiciary to reconsider how to best apply key criminal law concepts related to risk, harm, mental culpability, defences, proof and penalties to HIV non-disclosure, exposure and transmission.[14]

10. The meaning and implications of these scientific and medical developments for the criminalisation of HIV non-disclosure, exposure and transmission have been interpreted and applied differently by some courts and legislators. Taking into account the benefit of

11 See Lewden C *et al.*, "HIV-infected adults with CD4 cell count greater than 500 cells/mm3 on long-term combination antiretroviral therapy reach same mortality rates as the general population", *Journal of Acquired Immune Deficiency Syndromes*, 2007, 46:72–77; Palella FJ, Jr. *et al.*, "Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. HIV outpatient study investigators", *New England Journal of Medicine*, 1998, 338:853–860; and Sanne IM *et al.*, "Long term outcomes of antiretroviral therapy in a large HIV/AIDS care clinic in urban South Africa: A prospective cohort study", *Journal of the International AIDS Society*, 2009, 12:38.

12 See Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy", *New England Journal of Medicine*, 2011, 365:493–505.

13 *Ibid.*

14 For an overview of these developments in law and policy, see (among others), UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Background and current landscape*, Revised version, 2012, and UNAIDS "Countries questioning laws that criminalize HIV transmission and exposure", 26 April 2011.

effective HIV treatment in reducing the risk of HIV transmission, a court in Switzerland acquitted a person living with HIV of charges of "attempted spread of disease" and "attempted serious bodily harm" on grounds that he was on "proper antiretroviral treatment, had undetected [viral load] and did not have any other infections" and therefore could not transmit HIV.[15] In contrast, the Supreme Court of Canada held that "low viral count as a result of treatment" alone "still exposes a sexual partner to a *realistic possibility* of transmission" (emphasis added).[16] These different findings illustrate variation in appreciation by the courts of scientific and medical evidence relating to HIV.

11. This document primarily addresses the criminalisation of HIV non-disclosure, exposure and transmission in the context of sexual relations, but it also refers on occasion to transmission of HIV from mother-to-child and through the sharing of drug injection equipment. The considerations and recommendations contained herein are valid in relation to any use of criminal law in the context of HIV.

15 See Geneva Court of Justice, *S v. S and R*, 23 February 2009.

16 Supreme Court of Canada, *R. v. Mabior*, 2012, SCC 47, para 101.

Box 1: A project to marshal the latest scientific and medical evidence and best legal practices on HIV and criminal law

Between 2010–2012, UNAIDS implemented a project involving research, policy dialogue, and evidence and consensus-building on criminalisation of HIV non-disclosure, exposure and transmission. This was done to ensure that any application of criminal law in the context of HIV achieves justice and does not jeopardize public health objectives.

The project consisted of the following:

- the development of background and technical papers on current laws and practices, as well as recent medical and scientific developments, that are relevant to criminalisation of HIV non-disclosure, exposure and transmission;[17]
- an expert meeting (convened on 31 August–2 September 2011 in Geneva, Switzerland) that brought together scientists, medical practitioners and legal experts in order (i) to consider the latest scientific and medical facts about HIV that should be taken into account in the context of criminalisation, and (ii) to explore how to best address issues of harm, risk, intent and proof—including alternative responses to criminalisation—in light of this science and medicine;[18] and
- a high-level policy consultation, jointly convened by the Government of Norway and UNAIDS in Oslo on 14–15 February 2012, that gathered policy-makers from around the world to discuss options and recommendations for addressing criminalisation of HIV non-disclosure, exposure and transmission.[19]

The recommendations contained in the present document are informed by the findings of this two-year initiative that benefited from the financial support of the Government of Norway.

17 See UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Background and current landscape*, Revised version, 2012, and UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues*, Revised version, 2012.

18 UNAIDS, *Report of the expert meeting on the scientific, medical, legal and human rights aspects of the criminalisation of HIV non-disclosure, exposure and transmission*, 31 August–2 September 2011.

19 UNAIDS, *Report of the high level policy consultation on criminalisation of HIV non-disclosure, exposure and transmission*, 14–15 February 2012.

Applying criminal law principles and best scientific and medical evidence

12. Any criminal law response to HIV should:
    - appropriately reflect the best and latest available scientific and medical knowledge relating to HIV;
    - treat HIV proportionally to similar harms and risks – not singling out HIV for harsh treatment; and
    - require generally applicable criminal law principles and elements in support of any prosecution or guilty verdict.

    These criminal law principles require a harm to another person, mental culpability, proof to the appropriate standard to support a guilty verdict, and proportionality between the offence and the penalty. These principles should inform any legal provisions or judicial proceedings relating to HIV non-disclosure, exposure or transmission, as well as the development of prosecutorial or police guidelines on HIV-related criminal law issues.

HARM

13. The use of criminal law in the context of HIV can be legitimate where there is an actual and significant harm intentionally caused to another person.[20] UNAIDS' position is that the harm can only be deemed actual and significant, thus warranting criminal prosecution, where the conduct of the person living with HIV *resulted in HIV transmission*.[21]

14. Individuals who have been exposed to HIV would understandably be concerned and upset, and they may be fearful that they have contracted HIV. The question, however, is whether these concerns and fears should be sufficient to justify the use of criminal law, society's most severe sanction. UNAIDS' position is that criminal law should only be invoked where HIV has been transmitted. This is because the use of criminal law in the context of HIV can have a number of negative and unjust consequences that should be avoided, to the degree possible, by limiting its use to truly blameworthy cases where the harm is significant. UNAIDS is concerned that overly broad criminalisation of HIV non-disclosure, exposure and transmission can have a negative impact on national AIDS responses by discouraging people from testing for HIV, talking openly to their physicians or counsellors, or disclosing their HIV-positive status.[22] UNAIDS is also concerned about the negative impact of the overly broad criminalisation on people living with HIV, who may be charged, prosecuted and incarcerated even though they did not intend to cause harm or did not cause any significant harm.[23] Furthermore, it would be unfair

20 See UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*, and UNAIDS, *Report of the expert meeting on the scientific, medical, legal and human rights aspects of the criminalisation of HIV non-disclosure, exposure and transmission*.

21 UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*.

22 See, among others, O'Byrne P, "Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?"; O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men's sex survey"; and O'Byrne, P *et al.*, "Nondisclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada".

23 See, for example, Strub S and Gonzalez C, "Criminal injustice", *POZ Magazine*, June 2012:43–47.

to hold people living with HIV criminally responsible for the reactions of those who have been exposed to HIV, as those reactions are often driven by irrational fear, exaggerated apprehension and misinformation about HIV.

15. In England and Wales, prosecutions are not allowed where people have not actually transmitted HIV, unless the prosecutor can prove the highest standard of mental culpability, namely "intent to transmit HIV".[24] England and Wales does allow prosecutions for reckless transmission of HIV, but only where a *serious harm* has been caused to another. A serious harm is defined as HIV having been actually transmitted to the sexual partner by the person living with HIV.[25]

16. UNAIDS notes, however, that in a number of other jurisdictions, individuals may be prosecuted where transmission of HIV does not occur. Such prosecutions may even occur in the absence of proof of any culpable mental state. For the reasons stated above, UNAIDS is concerned about criminal prosecution in the absence of actual HIV transmission. Where criminal law is to be applied in the absence of actual transmission, UNAIDS urges that, at a minimum, it should never be applied without proof of an appropriate culpable mental state and a *significant* risk of HIV infection (as determined by the best available scientific and medical evidence; see section below on "Risk"). Such a position has been adopted in the guidance issued by the Crown Office and Procurator Fiscal Services of Scotland, which advises that "where there has been no resultant transmission of the infection, prosecution for the crime […] would only be contemplated in exceptional circumstances."[26] The guidance defines these exceptional circumstances to include instances "where an accused embarks on a flagrant course of conduct, having unprotected intercourse with several partners, failing to disclose his or her status, but through good fortune alone, fails to transmit the infection".[27]

17. The discovery and subsequent use of antiretroviral therapy (ART) in the mid-to-late 1990s has resulted in a re-characterisation of HIV infection, thus radically altering the *level and degree* of harm caused by HIV transmission.[28] Though HIV infection remains a serious, lifelong, and chronic health condition, it has become manageable for the majority of those on antiretroviral therapy.[29]

24 The prosecutorial guidelines of England and Wales state that "[i]f the prosecution can prove that the defendant intended to transmit sexually an infection to a person but failed to do so, a charge of attempting to commit section 18 can be brought". See Crown Prosecution Service, *Legal guidance on intentional or reckless sexual transmission of infection*.

25 *Ibid*.

26 Crown Office and Procurator Fiscal Service of Scotland, *Guidance on intentional or reckless sexual transmission of, or exposure to, infection*, p. 5.

27 *Ibid*.

28 See De Cock KM, Jaffe HW and Curran JW, "Reflections on 30 years of AIDS", *Emerging Infectious Diseases*, 2011; Roxby P, "'Medical triumph' of prolonging HIV positive lives", *BBC News*, 17 June 2011; and UNAIDS, *AIDS at 30: Nations at the crossroads*, 2011.

29 See, among others, CASCADE Collaboration, "Determinants of survival following HIV-1 seroconversion after the introduction of HAART", *Lancet*, 2003, 362:1267–1274, and Lima VD *et al.*, "Continued improvement in survival among HIV-infected individuals with newer forms of highly active antiretroviral therapy", *AIDS*, 2007, 21(6):685–692.

People living with HIV are able to study, work, marry, give birth and raise children.[30] Where these drugs are accessible, HIV infection no longer necessarily results in premature death.[31] Therefore, the harm of HIV infection is no longer the same as it was in the early years of the HIV epidemic. Arguably, based on current evidence, the harm of HIV should not be treated differently than that of other serious sexually transmitted infections (*e.g.* hepatitis B or C). Non-disclosure, exposure and transmission of these sexually transmitted infections (STIs), however, is seldom subject to criminal prosecution.

18. The manner in which legislators, prosecutors and courts characterise HIV infection and the harm resulting from it for the purposes of defining criminal liability, initiating prosecution or determining penalties, should reflect current advances in HIV treatment and the reality of living with HIV today (if an individual is on treatment and under care). The fact that treatment drastically improves the length and quality of life of people living with HIV means that HIV infection can no longer reasonably be the basis of criminal charges of "murder", "manslaughter", "attempted murder", "attempted manslaughter", "assault with a deadly weapon", "aggravated assault" or "reckless homicide" (as it continues to be in some jurisdictions).[32]

19. HIV infection should be recognized as a serious, chronic health condition, and criminal law should treat it equally with comparable health conditions or harms. Developments in a number of countries indicate recognition of this fact. For instance, in February 2011, the Danish Justice Minister suspended the HIV-specific law of Denmark. In support of his decision, the Minister relied on evidence provided by the Health Protection Agency of Denmark that explained that, with effective HIV treatment, the "life-expectancy of someone with HIV is no different from the age- and gender-matched background population".[33] In August 2012, a court in Denmark acquitted a person living with HIV who had been found guilty in the first instance for exposing another to a "life-threatening illness".[34] The court reasoned that there is now evidence that HIV is not a "life-threatening condition".[35]

30 See Beard J *et al.*, "Economic and quality of life outcomes of antiretroviral therapy for HIV/AIDS in developing countries: A systematic literature review", *AIDS Care*, 2009, 21:1343–1356; Rosen S *et al.*, "Economic outcomes of patients receiving antiretroviral therapy for HIV/AIDS in South Africa are sustained through three years on treatment", *PLoS ONE*, 2010, 5(9):e12731; and United States Department of Health and Human Services, "Living with HIV/AIDS", 2007.

31 For example, the age-adjusted HIV-related death rate in the United States dropped from 17 per 100 000 people in 1995 to about 5 per 100 000 people by the end of the decade. Mocroft A *et al.*, "Changes in the cause of death among HIV-positive subjects across Europe: results from the EuroSIDA study", *AIDS*, 2002, 16(12):1663–1671; Sanne IM *et al.*, "Long term outcomes of antiretroviral therapy in a large HIV/AIDS care clinic in urban South Africa: A prospective cohort study"; and US Centers for Disease Control and Prevention (CDC), "Trends in annual age-adjusted rate of death due to HIV disease, United States, 1987–2006".

32 See Center for HIV Law and Policy, *Prosecutions for HIV exposure in the United States, 2008–2012*; GNP+, *The global criminalisation scan report 2010: Documenting trends, presenting evidence*; and UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Background and current landscape*.

33 *See Bernard EJ, "Denmark: Justice Minister suspends HIV-specific criminal law, sets up working group"*, 17 February 2011.

34 See Eastern High Court, *Prosecutor v. Jackie Madsen*, 7 August 2012 (unofficial translation).

35 *Ibid.*

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide the understanding and response to **harm** in the context of any criminalisation of HIV non-disclosure, exposure and transmission:

a. In the absence of the actual transmission of HIV, the harm of HIV non-disclosure or exposure is not significant enough to warrant criminal prosecution. Non-disclosure of HIV-positive status and HIV exposure should therefore not be criminalised.

b. In jurisdictions that allow prosecution in the absence of HIV transmission, such use of criminal law should be exceptional. It should require, at a minimum, proof of an appropriate culpable mental state, and it should be limited to circumstances where—based on scientific and medical facts—there is a significant risk of HIV infection.

c. Any criminal charge for HIV non-disclosure, exposure or transmission should take into account the current reality of HIV infection, including the benefits of HIV treatment. HIV infection is a serious health condition that has become chronic and manageable with treatment. As a result, a person with HIV can now live a near normal lifespan.

d. Since HIV infection is now a chronic, treatable health condition, it is inappropriate for criminal prosecution for HIV non-disclosure, exposure or transmission to involve charges of "murder", "manslaughter", "attempted murder", "attempted manslaughter", "assault with a deadly weapon", "aggravated assault" or "reckless homicide".

RISK

20. The 2008 UNAIDS/UNDP *Policy Brief* recommends that "criminal law should not be applied to cases where there is no significant risk of [HIV] transmission".[36] However, in many jurisdictions, criminal laws and prosecutions for HIV non-disclosure, exposure and transmission continue to be applied to acts and sexual practices that represent either no risk or an insignificant risk of HIV transmission.[37] Such application of criminal law is overly broad, as it disregards scientific and medical evidence on the nature and level of risk of HIV transmission.

21. HIV is not contagious by air or casual contact. It is not transmitted by touching, sneezing, kissing, or using plates or utensils of an HIV-positive person.[38] There has been no reported case of HIV transmission through spitting, scratching or throwing bodily fluids on another person.[39] The risk of HIV transmission through biting is

36 UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*, p. 1.

37 See, for instance, Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV", and UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues*.

38 See, among others, Brett-Smith H and Friedland GH, "Transmission and treatment" in Burris S *et al.*, eds., *AIDS law today: A new guide for the public*, 1993:18–45, and Howe JM and Jensen PC, "An introduction to the medical aspects of HIV disease" in Webber DW, eds., *AIDS and the law*, 1997:1–49.

39 Brett-Smith H and Friedland GH, "Transmission and Treatment", p. 29.

considered "unlikely [and] epidemiologically insignificant".[40] However, several individuals living with HIV have been charged and/or convicted for HIV exposure for acts such as throwing of bodily fluids, scratching, spitting or biting, all of which are acts that carry no risk of HIV transmission.[41]

22. The risk of HIV infection through various sexual acts is much lower than generally perceived. For example, the per-act risk of HIV infection for a woman who engages in unprotected vaginal intercourse with an untreated HIV-positive man—a circumstance considered to represent a higher risk of HIV infection—is estimated at 1 in 1250 (0.08%).[42] Furthermore, recent evidence regarding the impact of antiretroviral treatment on the risk of HIV transmission calls for reassessing the nature of the risk posed by, and hence the criminal liability of, individuals who are on such treatment. The results of the HIV Prevention Trials Network (HPTN) 052 trial, which were released in early 2011, indicate a 96% reduction of the risk of HIV transmission within serodiscordant couples when the HIV-positive person is on effective antiretroviral therapy.[43] This finding, together with other studies reporting dramatic reduction of sexual transmission of HIV from HIV-positive people who are on antiretroviral therapy to their partners,[44] indicate that the risk of HIV transmission posed by individuals on effective HIV treatment should be considered insignificant in the context of criminal law.[45]

23. A recent position statement issued by the British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA) addresses the validity of the above findings (among others) in relation to homosexual sexual practices. The position statement notes that "published data are largely from heterosexual couples and there are insufficient data to conclude that successful ART use can provide similar levels of protection in relation to other sexual practices, including unprotected anal intercourse between men or between men and women. However, it is expert opinion that an *extremely low risk of transmission can also be anticipated* for these practices"[46] (emphasis added).

40 Richman KM and Rickman LS, "The potential for transmission of human immunodeficiency virus through human bites", *Journal of the Acquired Immune Deficiency Syndrome*, 1993, 6(4):402–6.

41 Center for HIV Law and Policy, *Prosecutions for HIV exposure in the United States*, 2008–2012.

42 Boily MC *et al.*, "Heterosexual risk of HIV-1 infection per sexual act: Systematic review and meta-analysis of observational studies", *Lancet Infectious Diseases*, 2009, 9:118–129.

43 See Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy". The reported 96% reduction was related to cases of HIV transmission that were genotypically-linked to an HIV-positive person participating in the trial.

44 See, among others, Castilla J *et al.*, "Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV", *Journal of Acquired Immune Deficiency Syndromes*, 2005, 40:96–101, and del Romero J *et al.*, "Lack of HIV heterosexual transmission attributable to HAART in serodiscordant couples", AIDS 2008—XVII International AIDS Conference 2008, Abstract no. THPE0543, 3–8 August 2008, Mexico City, Mexico.

45 As discussed above, the Geneva Court of Justice reached this conclusion in its 2009 decision to acquit an individual charged with HIV exposure on the basis of expert testimony indicating that effective antiretroviral therapy significantly reduces the risk of HIV transmission. See Geneva Court of Justice, *S v. S and R*, 23 February 2009.

46 The British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA), *Position statement on the use of antiretroviral therapy to reduce HIV transmission*, January 2013.

24. In all cases, the assessment of the nature and level of risk of HIV transmission from various sexual acts and practices should rest primarily on medical and scientific evidence (see table below).

Estimated per-act risk of HIV infection from various sexual acts

Nature of act	Per-act risk of HIV infection (for details on confidence intervals and other considerations, see sources)
Woman who engages in unprotected vaginal intercourse with an untreated HIV-positive man	**0.08% (1 in 1250)**[47]
Man who has unprotected vaginal intercourse with an untreated HIV-positive woman	**0.04% (1 in 2500)**[48]
Unprotected anal intercourse with an untreated HIV-positive insertive partner (risk for the receptive partner)	**0.82% (1 in 122)**[49]
Unprotected anal intercourse with an untreated HIV-positive receptive partner (risk for the insertive partner)	**0.06% (1 in 1666)**[50]
Unprotected sex within heterosexual discordant couples where the HIV-positive partner is on ART with viral load below 400 copies/ml	**0.013% (1 in 7900)**[51]
Oral sex (orogenital contact)	**From 0 to 0.04%**[52]
Penetrative sex with condom	**Further 80% reduction of risk of HIV transmission**[53]

47 Boily MC *et al.*, "Heterosexual risk of HIV-1 infection per sexual act: Systematic review and meta-analysis of observational studies".

48 *Ibid.* A recent trial conducted among serodiscordant couples in several African countries found lower unadjusted per-act risks of unprotected male-to-female and female-to-male transmission during the latent phase of HIV infection (neither early infection nor late infection). The risks were at 0.0019% and 0.0010% respectively (1 to 2 cases per 1000 sexual acts). See Hughes JP *et al.*, "Determinants of per-coital-act HIV-1 infectivity among African HIV-1–serodiscordant couples", *Journal of Infectious Diseases*, 2012, 205(3):358–365.

49 Vittinghoff E *et al.*, "Per-contact risk of Human Immunodeficiency Virus transmission between male sexual partners", *American Journal of Epidemiology*, 1999, 150(3):306–311.

50 *Ibid.*

51 Attia S *et al.*, "Sexual transmission of HIV according to viral load and antiretroviral therapy: Systematic review and meta-analysis", *AIDS*, 2009, 23:1397–1404. The authors of this study concluded that "available studies found no episodes of HIV transmission in discordant heterosexual couples if the HIV-infected partner was treated with ART and had a viral load below 400 copies/ml, but the data were also compatible with one transmission per 79 person-years." One transmission per 7900 sex acts translates into a per-act risk of 1 in 7900 or 0.013%.

52 Baggaley RF, White RG and Boily MC, "Systematic review of orogenital HIV-1 transmission probabilities", *International Journal of Epidemiology*, 2008, 37(6):1255–1265. This review identified three studies that estimate the per-act probability of HIV transmission through orogenital contact, with findings ranging from 0% to 0.04%. The upper range (0.04%) was related to unprotected receptive oral intercourse with ejaculation between men with an HIV-positive or unknown serostatus partner.

53 Weller SC and Davis-Beaty K, "Condom effectiveness in reducing heterosexual HIV transmission (Review)", *Cochrane Database of Systematic* Reviews, 2002, Issue 1.

25. There is a complex combination of circumstances and elements that influence (*i.e.* heighten or reduce) the risk of HIV transmission, including:
    - the type of sexual activity (*i.e.* whether it is non-penetrative and/or penetrative, vaginal, anal and/or oral intercourse);
    - the roles of sexual partners during penetrative sex (*i.e.* insertive or receptive);
    - the frequency and overall number of sexual events;
    - whether or not a condom (male or female) or other barrier that is effective at preventing HIV exposure during penetrative sex was used correctly and consistently;
    - whether or not the insertive partner was circumcised;[54]
    - the presence or absence of other STIs in the individuals involved;
    - the concentration of HIV (viral load) in the bodily fluid to which the at-risk person has been exposed; and
    - whether or not the HIV-positive person was on antiretroviral therapy that significantly reduced the concentration of HIV in bodily fluids to non-infectious levels.

26. The above circumstances, combined with the per-act risk resulting from particular sexual acts, should guide the determination of whether there is sufficient risk of HIV transmission to warrant the initiation of prosecution and conviction in a specific case. There is arguably no significant or substantial risk of HIV transmission when individuals take measures recommended by public health experts to prevent HIV transmission (such as using a male or female condom). For instance, the *Guidance on intentional or reckless sexual transmission of infection* produced by the Crown Prosecution Service for England and Wales advises prosecutors as follows: "Evidence that the suspect took appropriate safeguards to prevent the transmission of their infection throughout the entire period of sexual activity, and evidence that those safeguards satisfy medical experts as reasonable in light of the nature of the infection, will mean that it will be highly unlikely that the prosecution will be able to demonstrate that the suspect was reckless".[55]

27. Similarly, there is no significant or substantial risk of transmission involved when individuals are on effective HIV treatment[56] or have a low viral load. Viral load (*i.e.* the quantity of HIV copies in the blood or other bodily fluid) is an important predictor of HIV transmission.[57] Several studies have correlated the decrease of the risk of HIV transmission

54 In late 2006, the United States National Institutes of Health announced the results of two trials on the impact of male circumcision on HIV risk conducted in Kenya and Uganda. The studies revealed at least 53% and 51% reduction in risk of acquiring HIV infection, respectively. These results supported earlier findings from a trial conducted in 2005 in South Africa that showed at least a 60% reduction in HIV infection among men who were circumcised. See WHO and UNAIDS, *New data on male circumcision and HIV prevention: Policy and programme implications. WHO/UNAIDS technical consultation on male circumcision and HIV prevention—Research implications for policy and programming*, Montreux, 6–8 March 2007.

55 See Crown Prosecution Service, *Legal guidance on intentional or reckless sexual transmission of infection*.

56 See Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy".

57 Quinn TC *et al.*, "Viral load and heterosexual transmission of human immunodeficiency virus type 1", *New England Journal of Medicine*, 2000, 342:921–9.

with the reduction of viral load through effective HIV treatment.[58] Medical experts and public health bodies have endorsed the evidence that low viral load dramatically reduces the risk of HIV transmission. They have indicated, however, differing opinions regarding thresholds for the level of viral load below which the likelihood of HIV infection may be considered low enough to significantly reduce the risk of HIV infection.[59] Some studies and experts have set this threshold at 1500 copies/ml, while others refer to 400 copies/ml, 50 copies/ml, or even 40 copies/ml.[60]
In the context of criminal law, it is recommended that 1500 copies/ml be considered as the minimum threshold below which people living with HIV are deemed to have a viral load sufficiently low to avoid criminal liability. Based on this recommendation, people living with HIV who have a viral load below 1500 copies/ml should not be prosecuted or held criminally liable for HIV non-disclosure, exposure or transmission. This recommended minimum threshold of 1500 copies/ml is supported by scientific evidence[61] and was recently endorsed by the Supreme Court of Canada[62].

28. A number of pronouncements made in relation to the reduction of infectiousness among people living with HIV who are on effective HIV treatment have elaborated on elements or conditions necessary to achieve such reduction. The position statement issued by BHIVA and EAGA in January 2013 states that the "risk of a person living with HIV, who is taking effective ART, passing HIV on to sexual partners through vaginal intercourse is extremely low, *provided the following conditions are fulfilled*:
    - There are no other sexually transmitted infections (STIs) in either partner.
    - The person who is HIV positive has a sustained plasma viral load below 50 HIV RNA copies/mL for more than 6 months and the viral load is below 50 copies/mL on the most recent test"[63] (emphasis added).

29. The 2008 statement of the Swiss *Commission fédérale pour les problèmes liés au sida* (also known as the "Swiss statement") provided similar conditions by requiring that: "the HIV-positive individual fully complies with the antiretroviral therapy and is monitored by an attending physician; the viral load

58 See, among others, Castilla J *et al.*, "Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV"; Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy"; del Romero J *et al.*, "Lack of HIV heterosexual transmission attributable to HAART in serodiscordant couples"; and Quinn TC *et al.*, "Viral load and heterosexual transmission of human immunodeficiency virus type 1".

59 See, for instance, BHIVA and EAGA, *Position statement on the use of antiretroviral therapy to reduce HIV transmission*; Castilla J *et al.*, "Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV"; Centers for Disease Control and Prevention, *Fact sheet on effect of antiretroviral therapy on risk of sexual transmission of HIV infection and superinfection*; Quinn TC *et al.*, "Viral load and heterosexual transmission of human immunodeficiency virus type 1"; and Vernazza P *et al.*, "Les personnes seropositives ne souffrant d'aucune autre MST et suivant un traitement antiretroviral efficace ne transmettent pas le VIH par voie sexuelle", *Bulletin des Médecins Suisses*, 2008, 89:165–169.

60 *Ibid.*

61 Quinn TC *et al.*, "Viral load and heterosexual transmission of human immunodeficiency virus type 1".

62 Supreme Court of Canada, *R. v. Mabior*, 2012, SCC 47, para 101.

63 BHIVA and EAGA, *Position statement on the use of antiretroviral therapy to reduce HIV transmission*.

(VL) has been non-detectable for at least six months (*i.e.*, viremia has been suppressed for at least six months); the HIV-positive individual does not have any other sexually transmitted disease (STD)".[64]

30. While, noting the importance of such conditions to the issue of whether the risk of infection was significant, it is recommended that, where these elements are invoked in the context of criminal law, consideration should be given to the following facts:
    - whether the person living with HIV knew of the importance of the above elements/conditions and their influence on the effectiveness of treatment in reducing the risk of HIV transmission (or had been informed of these conditions);
    - whether the person living with HIV was aware that he or she had any other sexually transmitted infection and that, as a result of this infection, there was a significant risk of HIV transmission; and
    - whether the person living with HIV had access to free or affordable regular viral load testing.
31. In general, a person living with HIV should not be subject to prosecution or conviction for HIV non-disclosure, exposure or transmission if he or she took effective precautions to prevent HIV transmission (*e.g.* used condoms for vaginal or anal sex, or engaged in other forms of safer sex, including non-penetrative and oral sex), *or* if he or she was on effective HIV treatment or had a low viral load. Any one of these circumstances (effective protection, effective treatment, *or* low viral load) should be sufficient to preclude criminal prosecution and liability for HIV non-disclosure, exposure or transmission.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide the understanding and response to **risk** in the context of any criminalisation of HIV non-disclosure, exposure and transmission:

a. Where criminal liability is extended to cases that do not involve actual transmission of HIV, such liability should be limited to acts involving a "significant risk" of HIV transmission.

b. The determination of whether the risk of HIV transmission from a particular act is significant should be informed by the best available scientific and medical evidence.

c. The risk of HIV transmission should not be considered "significant", "substantial", "unjustifiable", "serious", or "likely" for the purpose of criminal prosecution or liability when condoms were used consistently, other forms of safer sex were practiced (including non-penetrative sex and oral sex), or the person living with HIV was on effective HIV treatment or had a low viral load.

d. Because there is no risk of HIV transmission from kissing, biting, scratching, hitting, or from spitting or throwing bodily fluids (*e.g.* blood, saliva and semen) or excretions (*e.g.* urine and faeces), such acts should not form the basis of criminal prosecution or liability for HIV non-disclosure, exposure or transmission.

64 Vernazza P *et al.*, "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle".

MENTAL CULPABILITY

32. Mental culpability serves to identify and classify the degree of blameworthiness as resulting from the state of mind of an individual who engages in conduct prohibited under criminal law.[65] Mental culpability is a key element that must be proven to the required standard to secure a guilty verdict under criminal law.[66] There is in general a great variety of standards and requirements relating to mental culpability across countries and jurisdictions. These differences in standards also exist in the context of the criminalisation of HIV non-disclosure, exposure and transmission.[67] In some jurisdictions, in order to secure conviction, the prosecution must prove deliberate or purposeful intent to expose others to HIV or to transmit HIV. In other jurisdictions, however, it is required to prove "recklessness" for criminal liability for HIV non-disclosure, exposure or transmission.[68] There are also jurisdictions that consider HIV-related offences as "strict liability" offences. In such jurisdictions, knowledge of HIV-positive status and engaging in a prohibited conduct (usually sex without disclosure of status) are sufficient to find a person guilty of an offence (see more on "strict liability" at paragraph 39, below).

33. The 2008 UNAIDS/UNDP *Policy Brief* urges countries to "limit criminal liability 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" (emphasis added).[69] Setting the bar for mental culpability to this high threshold is aimed at finding the right balance between ensuring that truly blameworthy cases are brought to justice (*i.e.* where the person acted intentionally and maliciously to harm, and real harm occurred) and avoiding an overly broad application of criminal law to HIV that undermines public health and human rights in the context of HIV. As discussed in the section above on "Harm", the potential negative impact of overly broad criminalisation on individuals and HIV responses raises serious concerns.[70] For these reasons, criminal law should only be invoked where there is strong justification for it. It is UNAIDS' view that in the context of HIV, the justification for invoking criminal law should only be considered strong enough where an individual acts with the *intention* to transmit HIV *and* HIV is actually transmitted.

65 Brody DC, Acker JR and Logan WA, *Criminal law*, 2011.

66 *Ibid.*, p. 179.

67 See UNAIDS, *Criminal law, public health and HIV transmission: A policy options paper*, and UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues*.

68 *Ibid.*

69 UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*.

70 See, among others, Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV"; O'Byrne P, "Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?"; O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men's sex survey"; and O'Byrne, P *et al.*, "Nondisclosure prosecutions and population health outcomes: Examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada".

34. Intent to transmit HIV should not be presumed when a person who knows he or she is HIV-positive engages in unprotected sex or has sex without disclosing his or her HIV status. There are many reasons why people may not disclose their HIV-positive status and/or may engage in unprotected sex, including fear of abandonment, discrimination or violence; shame or embarrassment; and/or the psychological inability to accept one's HIV-positive status, often referred to as a person "being in denial" about their status.[71] None of these reasons indicate an "intent to transmit HIV" or a desire to harm their sexual partner on the part of the HIV-positive individual.

35. Similarly, people may also lie about their positive HIV status for the reasons highlighted above. Thus, active deception—including lying when asked about one's HIV status—may not indicate, on its own, intent to transmit HIV or to cause harm. Prosecutors and courts should not automatically equate deception with intent to transmit HIV or any other culpable mental state. Rather, care should be exercised to determine the nature, context and material circumstances of any alleged deception.

36. UNAIDS does not support criminal liability on the basis of "negligent" or "reckless" states of mind. In law, a negligent state of mind is determined by reference to how a fictional "reasonable person"—an imaginary person of ordinary intelligence, knowledge and prudence—would have acted.[72] If the defendant's behaviour deviates from that of a "reasonable person", he or she is considered negligent. In some jurisdictions, this is a sufficient culpable mental state for criminal liability for HIV non-disclosure, exposure or transmission. Such a low standard for mental culpability permits overly broad criminal prosecutions of people living with HIV because under such standard, even people who did not know that they were HIV-positive or how HIV was transmitted may be held criminally liable on grounds that a "reasonable person should have known".[73]

37. A "reckless" state of mind applies to a person who, although aware of a substantial risk of harm, consciously disregards it.[74] UNAIDS notes that a number of jurisdictions allow for the prosecution of HIV non-disclosure, exposure and transmission on the basis of a reckless state of mind. Circumstances in which individuals may

71 See, among others, Chandra PS, Deepthivarma S and Manjula V, "Disclosure of HIV infection in South India: Patterns, reasons and reactions", *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 2003, 15(2):207–215; Obermeyer CM, Baijal P and Pegurri E, "Facilitating HIV disclosure across diverse settings: A review", *American Journal of Public Health*, 2011, 101(6):1011–1023; Serovich JM and Mosack KE, "Reasons for HIV disclosure or nondisclosure to casual sexual partners", *AIDS Education and Prevention*, 2003, 15(1):70–80; and Simbazi LC *et al.*, "Disclosure of HIV status to sex partners and sexual risk behaviours among HIV-positive men and women, Cape Town, South Africa", *Sexually Transmitted Infections* 2007, 83:29–34.

72 Eba PM, "'Pandora's box: The criminalisation of HIV transmission or exposure in SADC countries", in Viljoen F and Precious S, eds., *Human rights under threat: Four perspectives on HIV, AIDS and the law in Southern Africa*, 2007, 13–54, and South African Law Commission, *Fifth interim report on aspects of the law relating to AIDS: The need for a statutory offence aimed at harmful HIV-related behavior*, 2001:97–98.

73 See South African Law Commission, *Fifth interim report*, pp. 114-115.

74 See Brody DC, Acker JR and Logan WA, *Criminal law*.

be deemed to be reckless in the context of HIV in these jurisdictions vary greatly. Some jurisdictions consider almost any sexual behaviour by an HIV positive person to be "reckless" for purposes of criminal law, even where there is no conscious disregard and no risk of infection. Other jurisdictions carefully circumscribe what behaviour will be considered "reckless". For example, the guidance of the Crown Office and Procurator Fiscal Service of Scotland provides that "it is unlikely that the requisite degree of recklessness will be established [when] [t]he person infected is receiving treatment and has been given medical advice that there is a low risk of transmission or that there was only a negligible risk of transmission in some situations or for certain sexual acts".[75]

38. UNAIDS' concern with "reckless state of mind" as a basis for criminal liability in HIV cases relates to the fact that lack of sufficient understanding about HIV may lead prosecutors and courts to consider the risk of HIV transmission to be substantial or significant, even in circumstances where it is not. Furthermore, because of prejudices against people living with HIV—including those from marginalized and stigmatized populations (*e.g.* sex workers, men who have sex with men, migrants, and people who use drugs)—it is possible that in applying the test of "conscious disregard of a substantial risk of harm" that is required to prove recklessness, prosecutors or courts may consider any sexual acts by these individuals as warranting the use of criminal law.[76] UNAIDS therefore calls on jurisdictions that apply recklessness as a sufficient culpable mental state for HIV non-disclosure, exposure or transmission to narrowly define and/or apply it *only* where it is established, at a minimum, that there is a "conscious disregard" in relation to acts that represent, on the basis of best available scientific and medical evidence, a significant risk of HIV transmission.

75 Crown Office and Procurator Fiscal Service of Scotland, *Guidance on intentional or reckless sexual transmission of, or exposure to, infection*, p. 5.

76 UNAIDS, *Criminal law, public health and HIV transmission*, p. 37.

Box 2: Mother-to-child transmission of HIV

There is an estimated 30% risk of HIV transmission from an HIV-positive mother to her child during pregnancy, delivery or breastfeeding. This risk is reduced to below 5% when the mother and child are given antiretroviral treatment.[77] In 2011, however, 330 000 children became newly infected with HIV through mother-to-child transmission globally, mostly due to lack of access to treatment and services that prevent vertical transmission of HIV.[78]

Some countries have prosecuted HIV-positive mothers for exposing their children to HIV or have enacted legislation that applies (explicitly or implicitly) to mother-to-child transmission of HIV.[79] UNAIDS does not recommend such an application of criminal law because:

- everyone has the right to have children,[80] 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;
- serious circumstances may exist that make it virtually impossible for women living with HIV to avoid exposing their foetus or infant to HIV, including:
  - the fear that their HIV-positive status will become known and they will face violence, discrimination or abandonment; and
  - the fact that, due to the lack of breast milk substitutes or clean water to prepare them or because of national policies promoting breastfeeding, HIV-positive mothers often have no safer options than to breastfeed.

Public health measures, including counselling and social support, are more appropriate to address the rare cases of pregnant women or mothers with HIV who may refuse treatment to avoid transmission from mother-to-child. Governments should ensure that both parents have information and access to measures to reduce mother-to-child transmission, including access to HIV testing and treatment. Women also need effective measures to protect themselves and their infants from violence and discrimination related to their HIV status. In 2011, UNAIDS launched a *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*[81] that stresses how respect for the human rights of women living with HIV is essential to reaching zero new HIV infections among children.

Adapted from UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief,* 2008, *p. 6.*

77 WHO, *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Recommendations for a public health approach*, 2010 version, p. 1.

78 UNAIDS, *Together we will end AIDS*, 2012, p. 26.

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

80 Article 16 (1) of the *Universal Declaration of Human Rights*, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

81 UNAIDS, *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive 2011-2015*, 2011.

39. Strict liability offences are those for which there is no requirement to prove any culpable mental state of the alleged offender.[82] Strict liability in the context of criminal law is generally restricted to situations in which the action of the offender and the related harm are viewed as so inherently dangerous and serious that proof of a culpable intent is deemed unnecessary.[83] In a number of jurisdictions, offences such as driving under the influence of alcohol and pornography involving minors are strict liability offences.[84]

40. UNAIDS is concerned by the existence of legal provisions (often HIV-specific) in some jurisdictions that remove the requirement of a culpable mental state (whether intentional, reckless or negligent) in support of criminal liability for HIV-related non-disclosure, exposure or transmission, thus creating strict liability.[85] The application of strict liability to HIV non-disclosure, exposure or transmission is often based on a misinformed perception of the risk of HIV infection and the harm resulting from it.

41. Some commentators have called the application of strict liability in HIV-related criminal cases an "opportunistic" approach, because it simplifies prosecution for alleged HIV non-disclosure, exposure and transmission by removing the "hurdle" of proving an intention to harm.[86] Application of such laws can result in almost any sexual acts by people living with HIV being considered criminal offences, regardless of whether or not the person had the intent to expose another to HIV or transmit HIV.[87] In many jurisdictions, these strict liability offences take the form of criminal liability for non-disclosure (*i.e.* when a person living with HIV is held criminally liable for engaging in a sexual act without disclosing his or her HIV status). These non-disclosure offences do not require any mental culpability on the part of the person living with HIV. Moreover, in a number of jurisdictions, non-disclosure offences may be invoked to prosecute people living with HIV for acts that represent no risk of HIV transmission.[88] For these reasons, UNAIDS does not support the application of strict liability to HIV non-disclosure, exposure or transmission.

82 See, among others, Singer RG, "The resurgence of *mens rea*: The rise and fall of strict criminal liability", *Boston College Law Review*, 1989, 30(2):337–408, and Wasserstrom RA, "Strict Liability in the Criminal Law", 1960 *Stanford Law Review*, 12(4):731.

83 *Ibid.*

84 *Ibid.*

85 UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues.*

86 Hermann DHJ, "Criminalizing conduct related to HIV Transmission", *Saint Louis University Public Law Review*, 1990, 9:371, and Markus M, "A treatment for the disease: Criminal HIV transmission/exposure laws", *Nova Law Review*, 1998–1999, 23:871–872.

87 See UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues*, and UNAIDS, *Report of the expert meeting on the scientific, medical, legal and human rights aspects of the criminalisation of HIV non-disclosure, exposure and transmission.*

88 For examples of such jurisdictions, see Lambda Legal, *HIV criminalization: State laws criminalizing conduct based on HIV status*, 2010.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide the understanding and response to **mental culpability** in the context of criminalisation of HIV non-disclosure, exposure and transmission:

a. Any application of criminal law to HIV non-disclosure, exposure or transmission should require proof, to the applicable criminal law standard, of intent to transmit HIV.

b. Intent to transmit HIV cannot be presumed or solely derived from knowledge of positive HIV status and/or non-disclosure of that status.

c. Intent to transmit HIV cannot be presumed or solely derived from engaging in unprotected sex, having a baby without taking steps to prevent mother-to-child transmission of HIV, or by sharing drug injection equipment.

d. Proof of intent to transmit HIV in the context of HIV non-disclosure, exposure or transmission should at least involve (i) knowledge of positive HIV status, (ii) deliberate action that poses a significant risk of transmission, and (iii) proof that the action is done for the purpose of infecting someone else.

e. Active deception regarding positive HIV-status can be considered an element in establishing intent to transmit HIV, but it should not be dispositive on the issue. The context and circumstances in which the alleged deception occurred—including the mental state of the person living with HIV and the reasons for the alleged deception— should be taken into consideration when determining whether intent to transmit HIV has been proven to the required criminal law standard.

f. Jurisdictions that accept "recklessness" as a sufficient culpable mental state for HIV non-disclosure, exposure or transmission should narrowly define and/or apply it only where it is established that there is a "conscious disregard" in relation to acts that represent, on the basis of best available scientific and medical evidence, a significant risk of HIV transmission.

g. Because it involves serious risks of overly broad interpretation and miscarriages of justice, "negligence" should not be accepted as a sufficient culpable mental state in the context of criminalisation of HIV non-disclosure, exposure or transmission.

h. Strict liability offences (*i.e.* offences that do not require proof of a culpable mental state) should not be applied in the context of criminalisation of HIV non-disclosure, exposure or transmission.

i. In no case should prosecution for HIV non-disclosure, exposure or transmission proceed when one of the following circumstances exists:
   - the person did not know he or she was HIV-positive;
   - the person did not understand how HIV is transmitted;
   - the person disclosed his or her HIV-positive status to the person at risk (or honestly and reasonably believed the other person was aware of his or her status through some other means);
   - the person did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
   - the person took reasonable measures to reduce the risk of HIV transmission, such as practicing safer sex through using a condom, or engaging in non-penetrative sex or oral sex;
   - the person agreed on a level of mutually acceptable risk with the other person; or
   - the person believed that he or she could not transmit HIV given his or her effective treatment or low viral load.

DEFENCES

42. To date, defences accepted in laws and court cases relating to HIV non-disclosure, exposure and transmission include:
    - disclosure of HIV-positive status;
    - consent to the risk and/or harm by the person exposed to HIV;
    - use of condoms or the practice of other safer sex methods to reduce the risk of HIV infection; and
    - effective HIV treatment or low viral load.

43. In some jurisdictions, these elements are alternative defences; in others, they are considered cumulative, meaning that several or all of them should exist for a person to avoid criminal liability.[89] Though generally referred to as "defences", these elements are part of the offence itself in some jurisdictions.[90] Where these elements are part of the offence, the prosecutor, in order to secure a conviction, must establish that the defendant did not perform the required act (*e.g.* disclosing his or her HIV-positive status, using a condom or obtaining the consent of the sexual partner).[91]

Disclosure and/or consent as defences

44. Respect for the principle of personal autonomy means that, as a general rule, the criminal law should not be invoked where a person consented to engage in acts that he or she knew involved a possible risk of harm (*e.g.* unprotected sex).[92] UNAIDS' position is that consent should be recognized as a defence to prosecution for HIV non-disclosure, exposure and transmission. Failing to recognize consent as a defence in the context of HIV would be unfair and contrary to personal autonomy, and it would subject all sexually active individuals living with HIV to the possibility of prosecution for HIV exposure or transmission. It would also expose to criminal liability those in serodiscordant sexual relationships where one sexual partner's HIV-positive status is known by the other partner, thus undermining the rights of the individuals involved to have a sexual life and children.

45. Disclosure of HIV-positive status by a person living with HIV should be recognized as a defence to criminal liability for HIV exposure and transmission. To prosecute individuals who have disclosed their HIV status to their sexual partners prior to consensual sex would be contrary to the principle of personal autonomy. From a public health perspective, it would also be counterproductive and unfair to encourage people to disclose their HIV status as part of HIV prevention strategies[93] while simultaneously providing, through criminal law, for the prosecution of those who do disclose their status.[94]

89 See UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues.*

90 *Ibid.*

91 Markus M, "A treatment for the disease: Criminal HIV transmission/exposure laws".

92 See UNAIDS, *Criminal law, public health and HIV transmission: A policy options paper*, p. 34.

93 See, among others, Maiorana A *et al.*, "Helping patients talk about HIV: Inclusion of messages on disclosure in prevention with positives interventions in clinical settings", *AIDS Education and Prevention*, 2012, 24(2):179–192.

94 Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV".

Box 3: Criminalisation of HIV non-disclosure

In a number of jurisdictions, people living with HIV may be held criminally liable for not disclosing their HIV status prior to sex. UNAIDS recommends against such overly broad application of criminal law. It is inappropriate and unfair to impose a blanket requirement to disclose one's HIV status or to provide for automatic criminal liability for failing to do so, regardless of the nature and circumstances of sexual acts. People may not disclose their status for a number of reasons, including:

- They are ignorant of (or misinformed about) the risk of HIV transmission involved in the sexual acts in which they are engaging.
- They rightly think the sexual acts do not pose a risk of transmission because they are engaging in non-penetrative sex or oral sex, or because they are using condoms, are on effective antiretroviral treatment, or have a low viral load.
- They are in denial about their HIV-positive status and/or the potential consequences of their behaviour.
- They rightly or wrongly think that their HIV status is known or presumed by their sexual partner, and they assume that the partners' consent to sex is an acceptance of the risk of exposure to HIV.
- They fear that if they disclose they will experience abandonment, rejection, loss of confidentiality, discrimination or violence. Women may be more reluctant to disclose than men because they may be more likely to be subject to abandonment, abuse and violence if they reveal their HIV status.[95]

Because there are so many reasons why people may not disclose their HIV status, public health messages on HIV prevention have cautioned people against relying on disclosure of HIV status by their sexual partners to protect them from HIV infection. Instead, public health messages urge people to engage in safer sex through the use of condoms and other means when their partner's HIV status unknown. This has given rise to the concept of "shared responsibility" for sexual health, which highlights that the HIV-negative person also has a responsibility to take measures to protect his or her own health.[96]

Criminal laws that mandate disclosure may create the impression that disclosure is something that can be relied upon by a sexual partner and lead to a false sense of security in the population that, in turn, may result in more risky behaviour.[97] Rather than promote reliance on disclosure of HIV status that is dictated by a far-removed threat of criminal prosecution, public health and policy interventions should continue to encourage safer sex where the HIV status of the sexual partner is not known. [98]

95 See The Athena Network, *Ten reasons why criminalization of HIV exposure or transmission harms women*.

96 See GNP+ and UNAIDS, *Positive Health Dignity and Prevention: A policy framework*, 2011.

97 *Ibid.*

98 See Marks G *et al.*, "Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: Implications for HIV prevention programs", *Journal of Acquired Immune Deficiency Syndromes*, 2005, 39 (4):446–453, and UNAIDS, *Combination HIV prevention: Tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections*, 2010.

Use of condoms or the practice of other safer sex methods as defences

46. An extensive body of research has established that the consistent use of male or female condoms provides a high level of protection against HIV and other sexually transmitted infections.[99] A review of studies on the effectiveness of condoms found that condoms contribute to reducing the risk of HIV transmission by 80%.[100] In addition to condoms, other safer sex methods and practices—such as oral sex, mutual masturbation and other forms of non-penetrative sexual stimulation—can eliminate or significantly reduce the risk of HIV transmission during sex.

47. The use of condoms—and more generally, the practice of safer sex—are central themes in HIV prevention strategies. Prosecutions for HIV non-disclosure, exposure and transmission against individuals who use condoms or practice other forms of safer sex (including non-penetrative sex and oral sex) are contrary to medical and scientific evidence on HIV. Such prosecutions undermine proven public health strategies, send confusing and contradictory messages, and could act as disincentives to safe and protective behaviour.[101] It also appears inherently unfair to prosecute someone who is following public health messages that encourage condom use as an effective mean of HIV prevention. Thus, the use of condoms and other forms of safer sex should be recognized as defences in any criminalisation of HIV non-disclosure, exposure and transmission. For example, a court in New Zealand acquitted a person living with HIV charged, among others, for having unprotected oral sex.[102] The court considered that the person living with HIV took reasonable care and precautions to avoid HIV transmission based on the evidence that "the risk of transmission of the virus as a result of oral intercourse without a condom is not zero because it is biologically possible, *but it is so low that it does not register as a risk*" [103] (emphasis added). Unfortunately, several jurisdictions have laws allowing for the prosecution of (or have actually prosecuted) people who practice safer forms of sexual activity that posed no or a very low risk of HIV transmission.[104]

99 See, among others, French PP *et al.*, "Use-effectiveness of the female versus male condom in preventing sexually transmitted disease in women", *Sexually Transmitted Diseases*, 2003, 30(5):433–439, and Weller SC and Davis-Beaty K, "Condom effectiveness in reducing heterosexual HIV transmission (Review)".

100 Weller SC and Davis-Beaty K, "Condom effectiveness in reducing heterosexual HIV transmission (Review)".

101 Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV".

102 *New Zealand Police v. Dalley*, [2005] 22 C.R.N.Z. 495.

103 *Ibid.*, at para. 39.

104 For example, the law of Missouri (United States) provides that it is unlawful for someone to "[a]ct in a reckless manner by exposing another person to HIV without [their] knowledge and consent through contact with blood, semen or vaginal secretions in the course of *oral*, anal, or vaginal intercourse" (emphasis added). The law goes on to state that "the use of condoms is *not* a defense to this violation" (emphasis added). See Center for HIV Law and Policy, *Prosecutions for HIV exposure in the United States, 2008–2012*, and Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV".

48. Condom use should be recognized under criminal law as an independent defence from prosecution for HIV non-disclosure, exposure or transmission, and the use of condoms should not be subjected to additional conditions. This position is justified by scientific evidence on the effectiveness of consistent condom use in reducing HIV transmission, regardless of other elements (such as viral load). UNAIDS is concerned that in some jurisdictions, condom use alone (without low viral load) is not recognized as sufficient to exclude criminal liability.[105] Condom use is further justified as a separate defence for ethical reasons as one of the few means of HIV prevention that is affordable and available to those people living with HIV who are not on treatment and/or who do not have a low viral load. It is estimated that, in 2011, only 54% of people eligible for antiretroviral therapy in low- and middle-income countries were receiving it.[106] Similarly, it is estimated that a third of those living with HIV in the United States are "not in care".[107] Recognising condom use as a separate defence enables individuals not receiving treatment to protect themselves against prosecutions for HIV non-disclosure, exposure or transmission.

Effective HIV treatment and low viral load as defences

49. As described above in the section on "Risk", several studies have shown a very significant reduction of the risk of HIV infection among people living with HIV who have a viral load below a certain threshold.[108] These studies were confirmed by the results of the HPTN 052 study, which found a 96% reduction in HIV transmission within discordant couples when the HIV-positive person is on effective treatment.[109] This compelling scientific and medical evidence should be appropriately reflected in the legal and judicial response to HIV, including by the recognition of effective HIV treatment and low viral load as defences to charges of HIV non-disclosure, exposure or transmission. As indicated previously, the present document recommends that individuals with a viral load below 1500 copies/ml should be considered to have a low viral load, and as a result, they should not be held criminally liable for HIV non-disclosure, exposure or transmission.

50. Available scientific and medical evidence has clearly established that effective HIV treatment or low viral load significantly reduces the risk of HIV infection. This should be a material matter for prosecutors and courts to take into account in

105 This position was adopted, for instance, by the Supreme Court of Canada. See Supreme Court of Canada, *R. v. Mabior*, 2012, SCC 47, para 101.

106 UNAIDS, *Global report: UNAIDS report on the global AIDS epidemic 2012*, 2012, p. 47.

107 Government of the United States of America, *National HIV/AIDS strategy for the United States*, July 2010, p. 7.

108 See notably, Attia S *et al.*, "Sexual transmission of HIV according to viral load and antiretroviral therapy: Systematic review and meta-analysis"; Castilla J *et al.*, "Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV"; Quinn TC *et al.*, "Viral load and heterosexual transmission of human immunodeficiency virus type 1"; and Vernazza P *et al.*, "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle".

109 Cohen MS *et al.*, "Prevention of HIV-1 infection with early antiretroviral therapy".

the context of any application of criminal law to HIV non-disclosure, exposure and transmission. Furthermore, some people living with HIV, especially women in abusive or coercive relationships, are not able to negotiate or impose condom use.

Recognising effective HIV treatment or low viral load as a separate defence is evidence-based, and it also provides a defence in case of prosecution to people living with HIV who are unable to ask for (or impose) condom use.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide the understanding and response to **disclosure, consent and other defences** in the context of criminalisation of HIV non-disclosure, exposure and transmission:

a. Disclosure of HIV-positive status and/or informed consent by the sexual partner of the HIV-positive person should be recognized as defences to charges of HIV exposure or transmission.

b. Because scientific and medical evidence demonstrates that the risk of HIV transmission can be significantly reduced by the use of condoms and other forms of safer sex—and because these behaviours are encouraged by public health messages and HIV prevention strategies that should not be undermined—condom use or the practice of other forms of safer sex (including non-penetrative sex and oral sex) should be recognized as defences to charges of HIV non-disclosure, exposure or transmission.

c. Effective HIV treatment or low viral load should be recognized as defences to charges for HIV non-disclosure, exposure or transmission.

PROOF

51. For an individual to be found guilty of HIV exposure or transmission, the elements of the alleged offence should need to be proven to the required standard, just as they would be for any other criminal offence. In the case of the offence of intentional HIV transmission, these elements will include proof of intent to transmit HIV, of acting on that intent by engaging in the prohibited conduct and of causing the harm in question through that conduct.

52. While proof of intent to transmit HIV and proof of engaging in prohibited conduct rely mainly on evidence derived from the examination of witnesses and other sources, proof of causation, in relation to HIV transmission, should always be based on evidence derived from a number of relevant sources, including medical records, rigorous scientific methods and sexual history.

53. For individual A to be found guilty for transmitting HIV to individual B, the prosecution has to establish that A (and not someone else) actually transmitted HIV to B. HIV phylogenetic analysis has increasingly been used in criminal prosecutions in the context of HIV transmission, but although it can be an important tool, HIV phylogenetic analysis has serious limitations that should be understood by all parties.[110] HIV phylogenetic analysis uses computational tools to estimate how closely related the samples of HIV taken from two individuals (*e.g.* the complainant and the defendant) are likely to be in comparison to other samples. Phylogenetic analysis, however, cannot conclusively prove that A infected B,[111] and it does not eliminate the possibility that the complainant may have been infected by a third party. Thus, phylogenetic analysis cannot, on its own, prove that A infected B, but it might be an important piece of information when combined with other evidence, such as sexual histories of previous partners of the parties.[112]

54. In contrast, HIV phylogenetic analysis can prove definitively that an individual *cannot* have been the source of HIV infection in another person.[113] Where the samples are not closely related with a high degree of confidence, this is evidence that the defendant could *not* have infected the complainant. In such instances, there is sufficient doubt to allow the prosecution to drop the charges or for the judge to recommend to the jury that they acquit.[114]

55. A further tool that may be used as an element of proof is the Recent Infection Testing Algorithm (RITA) test. Although such a test is important for estimating HIV incidence rates at the population level, it has serious limitations in establishing the timing of transmission in the context of individual criminal court cases.[115] Results of RITA tests should therefore not be considered dispositive in establishing when one person was infected with HIV.[116]

56. Evidence relating to viral load and CD4 levels has sometimes been presented as relevant to establish the *timing* of HIV transmission. Although these might be useful elements when considered along with other factual and scientific evidence, there is serious concern about the reliability of using viral load and CD4 count to estimate *when* someone

110 See Eshleman SH, "Analysis of genetic linkage of HIV from couples enrolled in the HIV Prevention Trials Network 052 trial", *Journal of Infectious Diseases*, 2011, 204(12):1918–1926, and Learn GH and Mullins JI, *The microbial forensic use of HIV sequences*, 2003.

111 Abecasis AB, "Science in court: The myth of HIV fingerprinting", *The Lancet Infectious Diseases*, 2011, 11(2): 78–79 and Bernard EJ *et al.*, "HIV forensics: Pitfalls and acceptable standards in the use of phylogenetic analysis as evidence in criminal investigations of HIV transmission", *HIV Medicines*, 2007, 8(6):382–387.

112 *Ibid.*

113 Bernard EJ *et al.*, "HIV forensics: Pitfalls and acceptable standards in the use of phylogenetic analysis as evidence in criminal investigations of HIV transmission".

114 Pillay D *et al.*, "HIV phylogenetics: Criminal convictions relying solely on this to establish transmission are unsafe", *British Medical Journal*, 2007, 335:460–461.

115 See Bernard EJ *et al.*, *Estimating the likelihood of recent HIV infection: Implications for criminal prosecution*, 2011.

116 *Ibid.*

was infected or *how long* they have been living with HIV.[117] Therefore, no firm conclusions regarding the *timing* of HIV transmission can be drawn from such data.

57. Another issue is the *direction* of infection (that is, who was infected first and subsequently transmitted HIV to the other person). The direction of infection is often *assumed* in criminal cases based on who tested HIV-positive first or who brought charges against the other. Such assumptions mean that the police and/or prosecution fail to examine the possibility that the complainant infected the defendant rather than the other way around or, as stated above, that the complainant acquired HIV from other sexual partners.

58. In the context of HIV non-disclosure, exposure and transmission cases, investigations generally focus on securing medical records that would normally be subject to heightened privacy protection. In proving their case, prosecuting authorities may use warrants or subpoenas to obtain records of diagnoses, viral load trends, and medical histories, as well as health-care providers' records about behavioural changes that had been recommended to the defendant. The use of medical records by the criminal justice system may decrease trust in the privileged nature of the relationship between patients and health-care providers, a relationship that is critical for individual and public health, including in the context of responding to the HIV epidemic.[118] Caution should therefore be exercised so that medical records are only made available to criminal investigations where there is good cause, and always in accordance with appropriate legal procedures relating to the release of confidential medical information.[119]

117 Rodriguez B *et al.*, "Predictive value of plasma HIV RNA level on rate of CD4 T-cell decline in untreated HIV infection", *Journal of the American Medical Association*, 2006, 296(12):1498–1506.

118 See Hoppe T, "Controlling sex in the name of 'public health': Social control and Michigan HIV law", *Social Problems*, 2013, 60(1):27–49.

119 See O'Byrne P, "HIV, nursing practice, and the law: What does HIV criminalization mean for practicing nurses", *Journal of the Association of Nurses in AIDS Care*, 2011, 22 (5):339–344; O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men's sex survey; and the Open Society Foundations, *Ten reasons to oppose the criminalization of HIV exposure or transmission*.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide the understanding and response to **proof** in the context of criminalisation of HIV non-disclosure, exposure and transmission:

a. As with any crime, all elements of the offence of HIV non-disclosure, exposure or transmission should be proved to the required criminal law standard.

b. HIV phylogenetic evidence alone is not sufficient to establish, to the required criminal law standard, that one person *did* infect another person with HIV.

c. HIV phylogenetic evidence can establish conclusively that one person *did not* infect another person, but expert administration is necessary to ensure that the results are accurate and appropriately interpreted.

d. CD4 count, viral load, and Recent Infection Testing Algorithm (RITA) evidence cannot alone establish, to the required criminal law standard, that the HIV infection occurred within a certain period of time, nor can they lead to a definitive conclusion about the individual source of HIV infection.

e. Communications between defendants and health-care workers or HIV counsellors, as well as medical records, should be considered as privileged to the extent afforded to these communications and documents in other legal and court contexts. Health-care providers should not release a patient's HIV-related records and information in the absence of patient authorisation or court order.

f. Scientific and medical experts called in HIV-related criminal matters should be properly qualified and trained to highlight accurately the merits and limitations of data and evidence relating to the risk, harm and proof of HIV transmission (among other issues).

PENALTIES

59. In many jurisdictions, penalties imposed for HIV non-disclosure, exposure and transmission are influenced by misconceptions about the actual nature of the risk and harm of HIV infection. These include widespread and incorrect assumptions that not only does exposure to the bodily fluids of a person living with HIV inevitably lead to HIV infection, but that HIV infection inevitably leads to death. Sentences prescribed for HIV non-disclosure, exposure or transmission vary widely among jurisdictions and countries. In the United States, for example, sentences ranging from 60 days to 60 years have been documented for the period of 2008–2012.[120]

120 See Center for HIV Law and Policy, *Prosecutions for HIV exposure in the United States*, 2008–2012.

60. Analyses of sentences and penalties for HIV non-disclosure, exposure or transmission in many countries reveal much higher penalties than sentences for comparable or more serious offences (such as driving under the influence of alcohol or vehicular homicide).[121] In the relatively rare cases where it is justifiable to apply criminal law to HIV, accurate characterization of the harm of HIV infection should translate into an appropriate charge and a proportionate sentence for any person found guilty of HIV-related offences.

61. People found guilty of HIV non-disclosure, exposure or transmission may be considered "sex offenders" in countries that allow for sex offender registration.[122] In the United States, for example, sex offender registration permits any person to identify and monitor, through publicly available databases, those registered as sex offenders.[123] Sex offenders may be subjected to constraints that include regularly reporting to police, prohibition of certain occupations, and restrictions on place of residence. Serious concerns have been raised about the consequences of sex offender registration for those subjected to this process.[124] These concerns are particularly valid in the case of individuals prosecuted or found guilty of HIV non-disclosure, exposure or transmission for consensual sexual relations (in distinction to cases of forced or coerced sex).

62. The experience and consequences of detention as a result of HIV-related offences also raise issues for people living with HIV. In prisons, medical care may be lacking or sub-standard, and confidentiality may, by design or through negligence, be disregarded; antiretroviral drugs may be dispensed at inappropriate intervals or entirely unavailable, and there may be little protection from discrimination, harassment and violence based on positive HIV status.[125] The risk of HIV transmission in prisons also is often higher than outside prisons, due to lack of effective HIV prevention and treatment, the prevalence of injecting drug use, and consensual or forced sex between inmates (often without protection).[126] As a result, where individuals living with HIV are found guilty for HIV non-disclosure, exposure or transmission, judicial authorities should consider alternatives to imprisonment. Such alternatives could involve fines, restitution, community service and probation.

121 UNAIDS, *Criminalisation of HIV non-disclosure, exposure and transmission: Scientific, medical, legal and human rights issues*.

122 Strub S and Gonzalez C, "Criminal injustice".

123 See, for instance, Tewksbury R, "Collateral consequences of sex offender registration", *Journal of Contemporary Criminal Justice*, 2005, 21:67–81.

124 *Ibid*.

125 See, for example, UNODC, UNAIDS and World Bank, *HIV and prisons in sub-Saharan Africa: Opportunities for action*, 2007, and Wakeman SE and Rich JD, "HIV treatment in US prisons", *HIV Therapy*, July 2010, 4(4):505–510.

126 See Dolan J *et al*., "HIV in prison in low-income and middle-income countries", *Lancet Infectious Diseases*, 2007: 32–43 and Jürgens R *et al*., "Interventions to reduce HIV transmission related to injecting drug use in prison", *Lancet Infectious Diseases*, 2009, 9:57–66.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to guide any application of **penalties** in the context of criminalisation of HIV non-disclosure, exposure and transmission:

a. Any penalties for HIV non-disclosure, exposure or transmission should be proportionate to the state of mind, the nature of the conduct, and the actual harm caused in the particular case, with mitigating and aggravating factors duly taken into account.

b. The assessment of the harm of HIV non-disclosure, exposure and transmission for determining penalties should be based on scientific and medical evidence relating to HIV infection, including the benefits of HIV treatment.

c. Penalties for HIV non-disclosure, exposure and transmission should be similar to the penalties provided for like harms under criminal law.

d. If imposed at all, sex offender status should not be applicable automatically to conviction for HIV non-disclosure, exposure or transmission. Sex offender status may only be imposed when warranted by behaviour apart from that related to HIV status and comparable to behaviour in other cases where sex offender status is applied.

e. Alternatives to imprisonment—including fines, restitution, community service and probation—should be considered for individuals found guilty of HIV non-disclosure, exposure or transmission.

63. The 2008 UNAIDS/UNDP *Policy Brief* recommends a number of alternative approaches to the overly broad criminalisation of HIV transmission, including significantly expanding HIV prevention, treatment, care and support programmes. It also recommends the adoption of prosecutorial and police guidelines to clarify and limit the circumstances and conditions under which individuals may be investigated or prosecuted for HIV non-disclosure, exposure or transmission.

PROGRAMMATIC HIV RESPONSES

64. In contrast to criminal prosecution for HIV non-disclosure, exposure and transmission, evidence-informed approaches to reduce HIV-related risks at individual and population levels focus on expanding access to HIV prevention and treatment commodities, services and programmes. Such expansion is critically necessary because in many countries these HIV commodities, services and programmes are not sufficiently available. For instance, fewer than 10% of men who have sex with men worldwide have access to HIV prevention services.[127] In 2008, only "four condoms were available for every adult male of reproductive age in sub-Saharan Africa", the region of the world with the highest HIV prevalence.[128] Furthermore, the commodities and services that are available are often not sufficiently taken up because of continuing and widespread ignorance, fear, stigma and discrimination surrounding HIV. Late HIV diagnostic and treatment is also a major concern, including in Europe and North America, where effective HIV treatment is more readily available.[129] Finally, there is some evidence that the overly broad application of criminal law to HIV non-disclosure, exposure and transmission also acts as a disincentive to the uptake of HIV prevention and treatment.[130]

65. In the 2006 *Political Declaration on HIV/AIDS*, all United Nations Member States committed to promote "a social and legal environment that is supportive of safe and voluntary disclosure of HIV status".[131] In the 2011 *Political Declaration on HIV/AIDS*, Member States committed to address laws and policies that "adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV and to

127 UNAIDS, *Together we will end AIDS*, 2012, p. 67.

128 See UNFPA, "Comprehensive condom programming: A key tool for HIV prevention", 2010.

129 See, among others, Antinori A *et al.*, "Late presentation of HIV infection: A consensus definition", *HIV Medicine*, 2011, 12(1):61–64; Girardi E *et al.*, "Late diagnosis of HIV infection: Epidemiological features, consequences and strategies to encourage earlier testing", *Journal of Acquired Immune Deficiency Syndrome*, 2007, 46(Suppl 1):S3–S8; and May M *et al.*, "Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study", *British Medical Journal*, 2011:343.

130 See, among others, Galletly CL and Pinkerton SD, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV"; O'Byrne P, "Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy"; and O'Byrne P, Bryan A and Woodyatt C, "Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men's sex survey".

131 United Nations General Assembly, *Political declaration on HIV/AIDS*, A/RES/60/262, 15 June 2006, para 25.

132 United Nations General Assembly, *Political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS*, June 2011, A/RES/65/277.

consider their review".[132] These commitments call for expanding HIV prevention and treatment messages, strategies and programmes to ensure that all individuals are empowered and receive the means to protect themselves against the risk of HIV infection or, if they are living with HIV, that they are supported to avoid transmitting it. The commitments also call for eliminating laws and legal practices that act as obstacles to the uptake of HIV prevention, treatment, care and support.

66. Given the fact that treatment significantly reduces infectiousness, there are now HIV prevention reasons to expand access to treatment, care and support services (in addition to saving lives). Expansion of basic HIV programmes (*i.e.* HIV prevention, treatment and care) should be accompanied by programmes that enable them to be accessed, taken up and expanded.[133] These programmes, referred to as "critical enablers", include:
    - programmes to reduce stigma and discrimination;
    - training for health-care workers on non-discrimination, informed consent and confidentiality;
    - training of law enforcement agents (including police, prosecutors and judges) on HIV and outreach to marginalized populations;
    - rights/legal literacy and legal services that enable people living with HIV—or those vulnerable to HIV—to seek redress when harmed in the context of HIV; and
    - programmes to reduce harmful gender norms and violence against women that increase their risk of HIV infection.[134]

67. The expansion of HIV prevention and treatment programmes should be done in the framework of "Positive Health, Dignity and Prevention", which provides a comprehensive and integrated approach to programmes for people living with HIV. Such an approach ensures that people living with HIV are protected from stigma and discrimination, are provided with treatment and treatment literacy, and have their psychosocial and nutritional needs addressed.[135] This framework is crucial to enabling people to feel confident about coming forward for HIV testing, being linked to care and support services, taking up treatment (if HIV-positive), preventing new HIV infections, and disclosing their status (as appropriate).

132 United Nations General Assembly, *Political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS*, June 2011, A/RES/65/277.

133 Schwartländer B *et al*., "Towards an improved investment approach for an effective response to HIV/AIDS", *The Lancet*, 2011, 377(9782):2031–2041.

134 For a description of these programmes, see UNAIDS, *Guidance note: Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses*, 2012. These programmes are also recommended in the 2011 *Political Declaration of HIV/AIDS*, which was endorsed by states at the June 2011 High-Level Meeting on AIDS. See United Nations General Assembly, *Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS*, para 80.

135 Rather than focusing narrowly on the sexual behaviour of people living with HIV, "Positive Health, Dignity and Prevention" highlights the importance of HIV-positive individuals being at the centre of addressing their health and well-being, with access to the programmes and support they need, within a socio-cultural and legal context that protects them from stigma and discrimination. See GNP+ and UNAIDS, *Positive Health Dignity and Prevention: A policy framework*.

PROSECUTORIAL AND POLICE GUIDELINES

68. The 2008 UNAIDS/UNDP *Policy Brief* urged governments to "issue guidelines to limit police and prosecutorial discretion in application of criminal law" in the context of HIV non-disclosure, exposure and transmission.[136] Police and prosecutorial guidelines can ensure the protection of individuals against overly broad, uninformed and/or unfair investigations and prosecutions. These guidelines can help to ensure that any police investigation or prosecution is based on the best available scientific evidence relating to HIV, upholds legal and human rights principles, treats like harms alike, and aligns with public health strategies. These guidelines should specify the acts that warrant criminal prosecutions and those that do not. They should also provide evidence-informed recommendations regarding risk, harm, mental culpability, proof and defences in relation to HIV-related criminal cases.

Box 4: Addressing overly broad criminalisation through prosecutorial guidelines

In England and Wales, prosecutorial guidelines were developed in 2008 to provide guidance to prosecutors regarding which cases should or should not be subject to prosecution.[137] The development of these prosecutorial guidelines was undertaken in consultation with civil society organizations, representatives of people living with HIV, medical practitioners and HIV experts.[138] The prosecutorial guidelines also address evidential, witness and victim care issues. To avoid inconsistency and overly broad application of criminal law to HIV, the prosecutorial guidelines state that "details of all cases in which charges of intentional or reckless sexual transmission of infection are being considered must be sent to the Director's Principal Legal Advisor (PLA). This is in order to allow the PLA to oversee charging decisions being made in these cases and to provide advice in appropriate cases".[139]

In May 2012, the Crown Office and Procurator Fiscal Service of Scotland published guidance on "Intentional or reckless sexual transmission of, or exposure to, infection", which describes the conditions under which criminal law may apply to HIV and other sexually transmitted infections.[140] In its introduction, the guidance stresses that "it is important to provide clarity on the law of Scotland as it applies to the intentional or reckless sexual transmission of, or exposure to, infection. It is also recognised that there is a need for consistent decision making and transparency in understanding the reasons for those decisions".[141] The guidance further acknowledges the tensions between public health and criminal justice considerations, and it calls on prosecutors to properly apply the law and only initiate prosecution "where it is in the public interest to do so; taking account of all the circumstances and available evidence in a case, the rights of the victims to be protected by the law, public health concerns, the rights of the accused, and Convention rights".[142]

In the past few years, human rights organizations, AIDS service organizations and people living with HIV have been advocating the adoption of prosecutorial guidelines in the Canadian provinces of Ontario and Quebec as a critical step in addressing overly broad criminalisation of HIV non-disclosure, exposure and transmission.[143]

136 UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief*, p. 1.

137 See Crown Prosecution Service, *Legal guidance on intentional or reckless sexual transmission of infection*.

138 Azad Y, "Developing guidance for HIV prosecutions: An example of harm reduction?", *HIV/AIDS Policy & Law Review*, 2008, 13(1):13–19.

139 See Crown Prosecution Service, *Legal guidance on intentional or reckless sexual transmission of infection*.

140 Crown Office and Procurator Fiscal Service of Scotland, *Guidance on intentional or reckless sexual transmission of, or exposure to, infection*.

141 *Ibid*, p. 2.

142 *Ibid*, p. 2.

143 See, in relation to Ontario, Ontario Working Group on Criminal Law & HIV Exposure, *Consultation on prosecutorial guidelines for Ontario cases involving non-disclosure of sexually transmitted infections: Community report and recommendations to the Attorney General of Ontario*, June 2011.

69. Prosecutorial and police guidelines should be supported with implementation mechanisms to ensure understanding and adherence. Internal referral systems should also be established to allow for the review of decisions to investigate or prosecute HIV cases. Because of their critical role in investigations, police should also be provided with clear protocols for dealing with complaints, arrests, confidentiality and other sensitive issues relating to HIV.[144]

70. Police and prosecutorial guidelines should be made available to the public in an accessible form in order to inform people living with HIV, the general public, and health-care and legal service providers of their content and stipulations.[145]

71. Similarly, efforts should be made to ensure that police, prosecutors and judges are informed and trained on issues, including:
    - relevant science and medicine relating to how HIV is and is not transmitted;
    - what constitutes effective HIV prevention;
    - how HIV treatment affects health and the risk of transmission;
    - how scientific methods should and should not be used to establish proof;
    - how confidentiality should be maintained where appropriate; and
    - how stigma and criminal prosecution impact individuals and the HIV response.

KEY CONSIDERATIONS

In light of the above, the following elements are recommended as key considerations to help identify and implement appropriate **alternatives** to overly broad criminalisation of HIV non-disclosure, exposure and transmission:

a. HIV prevention and treatment programmes that take into account the principles of "Positive Health, Dignity and Prevention" should be expanded so as to enable all people, including those living with HIV, to take steps to prevent HIV transmission.

b. Police and prosecutorial guidelines that address key issues—including intent, risk, harm and proof—should be developed in every jurisdiction where criminal law is applied to HIV non-disclosure, exposure or transmission. These guidelines should direct police and prosecutors in the exercise of their functions.

c. Given the fact that HIV and other sexually transmitted infections involve complex human behaviour—as well as scientific and medical considerations—police, prosecutors and judges should receive appropriate training that is based on the most up-to-date science and medicine to ensure that they have adequate knowledge and understanding of HIV.

144 National AIDS Trust (NAT) and Association of Chief Police Officers (ACPO), *ACPO Investigation guidance relating to the criminal transmission of HIV*, 2010.

145 A study was conducted in the United Kingdom among those providing support, health and social care services for people living with HIV on the degree of their understanding of criminal laws and prosecutions relating to HIV exposure and transmission. The results indicated high levels of confusion about the meaning of criminal recklessness in the context of HIV and the behaviour or situations that would provide a defence to criminal liability (such as the use of condoms, disclosure of HIV-positive status or having a low viral load). See Dodds C *et al.*, "Keeping Confidence: HIV and the criminal law from service provider perspectives", *Sigma Research*, 2013.

Recommendations for action

72. This document sets out the key scientific and medical facts—as well as the legal principles—that countries should take into consideration in relation to any application of criminal law to HIV non-disclosure, exposure or transmission. To translate these considerations into legal, policy and programmatic changes at national level requires specific actions by governments, civil society (including people living with HIV and their advocates), and other stakeholders involved in the HIV response. Some of these actions are suggested below.[146]

Recommendations to governments, parliamentarians and the judiciary

- Ensure that all laws and policies applicable to HIV, including criminal law, are informed by the best available scientific and medical evidence relating to HIV and modes of HIV transmission, prevention and treatment.
- Review laws in order to limit criminal prosecution in the context of HIV to cases that involve intentional HIV transmission.
- Uphold human rights and criminal law principles in any application of criminal law in the context of HIV.
- Review convictions for HIV exposure, non-disclosure and transmission where scientific and medical fact and general criminal law principles have not been applied. Such convictions should be set aside or the accused released from prison with pardons or similar actions in order to ensure that the charges do not remain on criminal or sex offender records.[147]
- Develop and adopt police and prosecutorial guidelines that clearly establish under what circumstances and conditions criminal charges could be brought for HIV-related matters. The development of such guidelines should involve police and prosecutors, people living with HIV, medical and health practitioners, legal and human rights experts, and civil society organizations.
- Conduct training for police, prosecutors and judges on relevant and up-to-date scientific and medical aspects of HIV, including those that affect the assessment of risk, harm, mental culpability, proof and defences in the context of HIV-related criminal law cases.
- Expand evidence-informed HIV prevention, treatment, care and support programmes that enable all individuals to know their HIV status and help them to take steps to reduce the risk of HIV transmission and infection. Such programmes should appropriately engage people living with HIV, including through the framework of "Positive Health, Dignity and Prevention". These programmes should also support health professionals to help address misconceptions about HIV and to strengthen their collaboration with organizations of people living with HIV in efforts to end overly broad criminalisation of HIV non-disclosure, exposure and transmission.
- Support the implementation of programmes to address stigma and discrimination, and to increase access to justice in the context of HIV, particularly the provision of HIV-related legal

146 A number of these actions are adapted from UNAIDS and UNDP, *Criminalisation of HIV transmission: Policy brief.*

147 Global Commission on HIV and the Law, *HIV and the law: Risks, rights and health*, p. 25.

services. This can include: monitoring and reforming laws, regulations and policies related to HIV; legal literacy ("know your rights") programmes; sensitization of law-makers and law enforcement agents; training for health-care providers on human rights and medical ethics related to HIV; and programmes to reduce harmful gender norms and violence against women in the context of HIV.[148]

Recommendations to civil society

- Monitor existing and proposed laws on HIV non-disclosure, exposure and transmission. Advocate that any criminal law provision applicable to HIV be informed by the best scientific and medical evidence relating to HIV, and uphold generally applicable criminal law and human rights principles.
- Support people living with HIV through programmes such as legal assistance and "know your rights" campaigns, to challenge overly broad criminalisation of HIV non-disclosure, exposure or transmission.
- Advocate and support sensitization of the media and public for a more accurate representation of HIV that reflects current advances in HIV-related prevention, treatment, care and support.
- Advocate stronger government commitment and action to expand HIV prevention, treatment, care and support services as the most effective way to address the HIV epidemic. This should be done within the framework of "Positive Health, Dignity and Prevention".
- Engage with relevant actors—including prosecutorial authorities, the police, the judiciary, health and medical experts, and people living with HIV—for the development of police and prosecutorial guidelines that set clear orientations regarding the initiation and pursuit of charges in relation to HIV exposure or transmission.

Recommendations to international partners (including donors)

- Support monitoring and research to further inform an appropriately limited application of criminal law in the context of HIV in order to support public health, justice and human rights. Such research should investigate the content and impact of HIV-related laws on public health and human rights, as well as the effectiveness of alternatives to criminalisation of HIV non-disclosure, exposure and transmission.
- Support governments to expand proven HIV prevention, treatment, care and support services, programmes that address HIV-related stigma and discrimination, and those that increase access to justice in the context of HIV.
- Support initiatives for the development of police and prosecutorial guidelines, as well as the training of civil society, police, judges and others on HIV-related legal and human rights issues.

148 See UNAIDS, *Guidance note: Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.*

Annex 1: Recommendations of the Global Commission on HIV and the Law on criminalisation of HIV non-disclosure, exposure and transmission

In July 2012, the Global Commission on HIV and the Law—an independent body composed of world leaders and advocates in the areas of HIV, public health, law and development—issued its final report on key legal issues affecting the HIV epidemic and response, including the criminalisation of HIV non-disclosure, exposure and transmission.[149] The report was the result of 18 months of extensive research, consultation, analysis and deliberation. It was based on evidence derived from "the testimony of more than 700 people most affected by HIV-related legal environments from 140 countries, expert submissions and the large body of scholarship on HIV, health and the law".[150] In its report, the Global Commission on HIV and the Law makes the following recommendations in relation to criminalisation of HIV non-disclosure, exposure and transmission:

- Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been advanced to support the enactment of such laws should be withdrawn and amended to conform to these recommendations.
- Law enforcement authorities must not prosecute people in cases of HIV non-disclosure or exposure where no intentional or malicious HIV transmission has been proven to take place. Invoking criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.
- Countries must amend or repeal any law that explicitly or effectively criminalises vertical transmission of HIV. While the process of review and repeal is under way, governments must place moratoria on enforcement of any such laws.
- Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but such prosecutions should be pursued with care and require a high standard of evidence and proof.
- The convictions of those who have been successfully prosecuted for HIV exposure, non-disclosure and transmission must be reviewed. Such convictions must be set aside or the accused immediately released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records.[151]

149 Global Commission on HIV and the Law, *HIV and the law: Risks, rights and health*, p. 25.

150 *Ibid*, p. 7.

151 *Ibid*, p. 25.

Annex 2:
Oslo Declaration on HIV Criminalisation

On 13 February 2012, the *Oslo Declaration on HIV Criminalisation* was adopted in Oslo, Norway, by a group of 20 individual experts and organizations representing civil society organizations from all regions of the world that are working to end overly broad criminal prosecutions for HIV non- disclosure, exposure and transmission. The Declaration has currently been endorsed by some 1650 civil society organizations, health and legal experts from around the world.[152] The text of the Declaration states:

1. A growing body of evidence suggests that the criminalisation of HIV non-disclosure, potential exposure and non-intentional transmission is doing more harm than good in terms of its impact on public health and human rights.
2. A better alternative to the use of the criminal law are measures that create an environment that enables people to seek testing, support and timely treatment, and to safely disclose their HIV status.
3. Although there may be a limited role for criminal law in rare cases in which people transmit HIV with malicious intent, we prefer to see people living with HIV supported and empowered from the moment of diagnosis, so that even these rare cases may be prevented. This requires a non-punitive, non-criminal HIV prevention approach centred within communities, where expertise about, and understanding of, HIV issues is best found.
4. Existing HIV-specific criminal laws should be repealed, in accordance with UNAIDS recommendations. If, following a thorough evidence-informed national review, HIV-related prosecutions are still deemed to be necessary, they should be based on principles of proportionality, foreseeability, intent, causality and non-discrimination; informed by the most up-to-date HIV-related science and medical information; harm-based, rather than risk-of-harm based; and be consistent with both public health goals and international human rights obligations.
5. Where the general law can be, or is being, used for HIV-related prosecutions, the exact nature of the rights and responsibilities of people living with HIV under the law should be clarified, ideally through prosecutorial and police guidelines, produced in consultation with all key stakeholders, to ensure that police investigations are appropriate and to ensure that people with HIV have adequate access to justice.

We respectfully ask Ministries of Health and Justice and other relevant policymakers and criminal justice system actors to also take into account the following in any consideration about whether or not to use criminal law in HIV-related cases:

6. HIV epidemics are driven by undiagnosed HIV infections, not by people who know their HIV positive status. Unprotected sex includes risking many possible eventualities – positive and negative – including the risk of acquiring sexually transmitted infections such as HIV. Due to the high number of undiagnosed infections, relying on disclosure to protect oneself – and prosecuting people for non-disclosure – can and does lead to a false sense of security.

152 See *Oslo Declaration on HIV Criminalisation* (http://www.hivjustice.net/oslo/).

7. HIV is just one of many sexually transmitted or communicable diseases that can cause long-term harm. Singling out HIV with specific laws or prosecutions further stigmatizes people living with and affected by HIV. HIV-related stigma is the greatest barrier to testing, treatment uptake, disclosure and a country's success in "getting to zero new infections, zero AIDS-related deaths and zero discrimination".
8. Criminal laws do not change behaviour rooted in complex social issues, especially behaviour that is based on desire and impacted by HIV-related stigma. Such behaviour is changed by counselling and support for people living with HIV that aims to achieve health, dignity and empowerment.
9. Neither the criminal justice system nor the media are currently well-equipped to deal with HIV-related criminal cases. Relevant authorities should ensure adequate HIV-related training for police, prosecutors, defence lawyers, judges, juries and the media.
10. Once a person's HIV status has been involuntarily disclosed in the media, it will always be available through an internet search. People accused of HIV-related 'crimes' for which they are not (or should not be found) guilty have a right to privacy. There is no public health benefit in identifying such individuals in the media; if previous partners need to be informed for public health purposes, ethical and confidential partner notification protocols should be followed.

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Notes

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