napwa national association of people living with HIV/AIDS

AFAO

HIV, Criminal Law

&

Public Health Forum

Canberra

29th September 2011

REPORT

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This resource has been produced from the presentations given at the AFAO and NAPWA HIV, Criminal Law & Public Health Forum, held in Canberra on the 29th of September 2011.

Introduction

HIV, Criminal and Public Health

Criminal prosecutions involving HIV transmission or exposure are becoming more common around the world – including in Australia, where the number of prosecutions in recent years has been increasing. This has sparked renewed interest in the intersection of public health measures and the criminal law. There has been particular focus on the negative impacts that application of these laws can have on people living with HIV, on people from affected communities and on the wider community's understanding of the HIV epidemic.

To facilitate discussion of these issues and potential options for policy reform, the Australian Federation of AIDS Organisations (AFAO) and the National Association for People Living with HIV/AIDS (NAPWA) jointly hosted the HIV, Criminal Law and Public Health forum at the National Gallery of Australia in Canberra on the 29th of September 2011.

Guest speakers and delegates discussed the application of criminal laws, public health laws and civil law relating to the sexual transmission of and exposure to HIV. In particular, discussions focused on the arbitrary application of criminal laws regarding HIV transmission and exposure and the consequent criminalisation of people living with HIV. There was also some focus on progressive reforms and potential interventions to reduce the reliance on criminal sanctions to manage people who place others at risk of HIV infection.

A range of speakers from affected communities, public health, government, health and community based sectors presented on the Australian context with some scope provided for comparisons with international experience.

The forum was closed to media and attendance was by invitation only. This report offers a brief synopsis of each presentation, a copy of the forum Communiqué and an evaluation report.

Delegates were officially welcomed by Robert Mitchell (NAPWA President) who acknowledged the traditional owners of the land on which the forum was held, the Ngunnawal people, and paid respects to their elders past and present.

HIV criminalisation overview

Sally Cameron (AFAO Consultant)

Australian prosecutions for HIV exposure and transmission

Sally Cameron provided an overview of the HIV and criminalisation terrain suggesting that the application of criminal law to cases of HIV exposure or transmission during consensual sex is problematic for a range of reasons including:

Undermine public health initiatives

Criminal prosecutions and the media they generate undermine public health initiatives. All Australian prosecutions to date have successfully maintained that HIV-positive people must disclose their HIV status. That argument creates a false sense of expectation (and hence a false sense of security) that HIV-positive people will disclose. It enables those who believe themselves to be HIV-negative to waive responsibility for their own and their partners' sexual health. Prosecutions also create the expectation that HIV-positive people who do not disclose will or should be punished, which runs directly counter to the core, long-term message of shared responsibility for HIV prevention. Rather than enable disclosure, HIV-related prosecutions appear to make individuals less likely to disclose. Importantly, the

recent *HIV Futures 6* study found that 42% of the more than 1000 HIV-positive respondents agreed with the statement 'I am worried about disclosing my HIV status to sexual partners because of the current legal situation'.

Reduce trust in healthcare practitioners

Healthcare practitioners are the frontline in HIV prevention and support, however, there is growing awareness that the confidentiality provisions applying to medical and associated health records are not absolute, and that healthcare practitioners may be called to give evidence against former patients. There is also a perception that healthcare practitioners may report a patient to an overly intrusive health department or to police on the basis of risk behaviours or the presence of STIs. The possibility of criminal sanctions makes people living with HIV less likely to seek support or disclose information about risky behaviour. The *HIV Futures 6* study found that 28% of respondents 'expressed concern about the legal implications of disclosure of sexual practices to service providers'.

Reinforce stigma surrounding HIV/AIDS

While media reporting of HIV-related prosecutions has been about a very small number of individuals in the context of legal action, media coverage has wide reaching impact: constructing community understanding of 'who HIV-positive people are'. HIV-related prosecutions reinforce stigma based on the 'othering' of all HIV-positive people. Such stigma triggers discrimination, makes it difficult for HIV-positive individuals to come to terms with and manage their illness, and undermines HIV prevention efforts.

Too arbitrary/cultural filtering

Given that there are approximately 1000 cases of HIV transmission each year, at least 90% of which are through sexual contact, it is clear that unsafe sex does occur. As the number of criminal cases has increased so too have the circumstances in which charges have been laid. It is not possible to say what differentiates criminal cases from other cases in which charges have not been laid, so the laying of only some 30 charges over two decades means that criminal prosecutions are unacceptably arbitrary. Moreover, the 'profile' of accused is inconsistent with HIV epidemiological data, suggesting some kind of social or cultural filtering is occurring.

Relying on disclosure

All cases to date have relied on the absence of a person's HIV-positive status prior to the risk event. That framework co-exists with public health policy which urges shared responsibility in lieu of a reliance on disclosure because:

- Many people living with HIV cannot disclose because they are unaware they are HIV infected. For example, in 2008, the Australian National Centre in HIV Epidemiology and Clinical Research undertook scientific modelling based on surveillance data and estimated that 30% of new HIV infections among men who have sex with men (MSM) in Australia occur as a result of transmission from the estimated 9% of MSM who are unaware they are HIV positive.
- Many HIV-positive and HIV-negative gay men believe that they have disclosed status through 'sero-sorting': a process whereby men engage in sexual acts only with men they believe to be of the same HIV-status as themselves. Some men (occasionally, sometimes or frequently) practice forms of non-verbal HIV-status disclosure, and miscommunication does occur. In numerous locations, HIV health promotion campaigns specifically address sero-sorting practice. If such practices are well established and understood in particular communities, it is important that legislation and the legal process are able to take account of those practices.
- Some people living with HIV don't always disclose their HIV-positive status prior to a risk event. This may be because they:
    - use other risk reduction strategies, such as condoms

- fear loss of privacy. Once disclosed, even in a very specific context, a person loses control over who else may learn they are HIV-positive and particularly, how people may respond. Information about individuals' HIV-positive status can and does travel. *HIV Futures 6* reports that 51% of respondents were aware of their HIV status being disclosed to a third party (or parties) without their permission.
- fear rejection, including sexual rejection but also the sudden end to a long-term or a developing relationship. Numerous behavioural studies have found sexual rejection following HIV disclosure is common.
- fear violence, ostracism and abandonment. People living with HIV are well aware of the stigma and discrimination HIV attracts. *HIV Futures 6* records significant levels of discrimination (in health care 25%, insurance 17%, workplace 16% and accommodation 8%). Discrimination and stigmatisation also extends into private life. Disclosing HIV infection may trigger any of a wide range of reactions, including two recent NSW cases in which disclosure of HIV-positive status was cited as the trigger for murder.

Recognising that not all people living with HIV disclose before every risk event is not an argument against disclosure but an argument that disclosure is ill-conceived as core HIV prevention policy. It recognises the reality of the science surrounding transmission risk (that often risk is small, negligible or absent) and the lived reality of the many thousands of people living with HIV. While not mandating disclosure, HIV prevention policy should do everything possible to enable disclosure. Disclosure is most likely to occur in an enabling environment. That environment is undermined by the potential for criminal prosecution.

Criminal Laws

Australian criminal laws that may be applied to HIV exposure or transmission are state laws. These laws vary, ranging from charges of 'intentionally causing grievous bodily harm or transmitting a serious disease' to 'reckless conduct that places or may place another at risk of serious injury. Given the potential of criminal law to criminalise a broad range of actions (and degrees of intention) it is vital to understand how criminal laws are being applied, and also to locate individuals' 'criminalised 'behaviour within our understanding of what goes on during negotiations and practice of sex.

As at September 2011, there had been 32 known prosecutions. Those prosecutions include prosecutions for exposure and prosecutions for transmission, cases where charges have been dropped (5), convictions resulting from a guilty plea (at least 8), and cases that resulted in the individual being found 'not guilty' of any charge (11). Cases do not reflect the Australian HIV epidemic, with heterosexual men, particularly African heterosexual men, over-represented among the accused.

The first known prosecution occurred in 1991, with 10 prosecutions during that first decade, mostly in Victoria. More than twice that number has been recorded during the last decade (see figure 1).

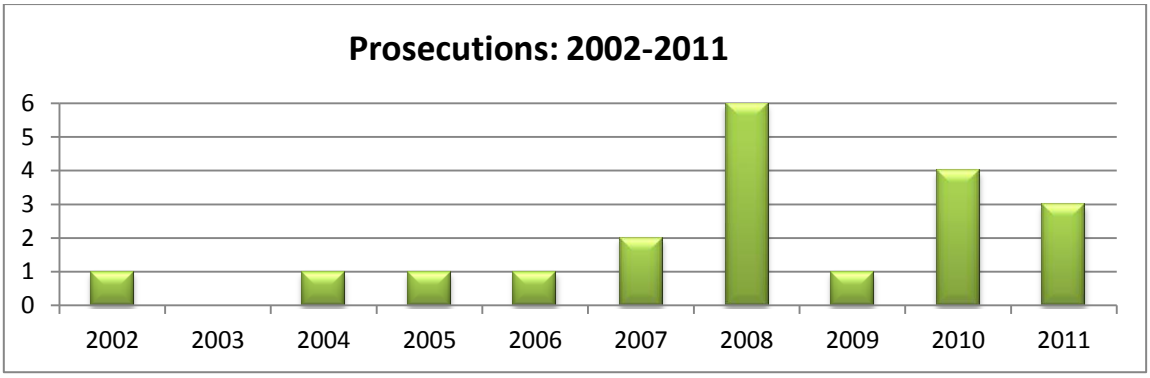


Figure (1)

The frequency of prosecutions varies by state and bares no relationship to the epidemiology of states' HIV epidemic, including the number of people living with HIV in each state (see figure 2).

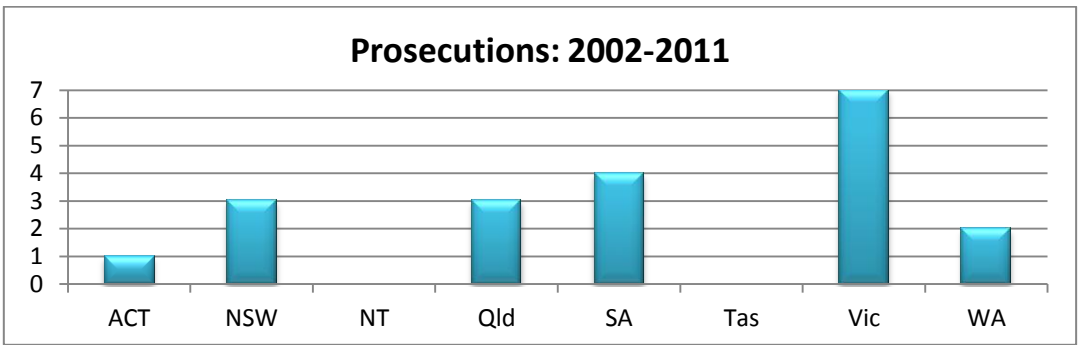


Figure (2)

As the number of prosecutions has increased, so too has the range of circumstances in which charges have been laid. Cases now include instances of transmission/exposure relating to men and women, during casual and committed relationships, and during new and long term relationships. Some accused have been charged in relation to one partner and others in relation to multiple partners. Some of the people involved had previously come to the attention of public health officials, some had not. Some clearly lied about their HIV status (including forging documents); in other instances, whether or not the accused lied has been difficult to establish. In some cases, transmission occurred recently, while in others it occurred many years ago. Recently, two cases were pursued (in NSW and Victoria) involving transmission a decade ago or longer Notably, the Victorian man was convicted despite the two parties having married five years after the woman had been infected and diagnosed.

Developing a response to criminalisation

In developing a response to the prosecutions of individuals for HIV exposure and transmission, some core questions remain:

- Should criminal law ever be used?
- What are the alternatives to criminal action?
- Do prosecutions prevent HIV infection?
- Should criminal law treat HIV differently from other communicable diseases?
- How does use of criminal law impact upon people living with HIV/AIDS?
- Does use of criminal law undermine the public health response ... and if so, are prosecutions worth it?

Criminal prosecutions do not sit 'outside' Australia's formal HIV response as prosecutions clearly affect the broad, health based HIV response. The question is not whether HIV infection harms people but whether that harm merits criminal law scrutiny. People are harmed every day in ways that never become the subject of criminal investigations: from participation in organised sport to knowingly exposing others to infection with diseases considered less socially problematic. In HIV-related prosecutions, the defendant's desire to have unprotected sex is frequently conflated with a desire to transmit HIV however, both the intention to harm and the *actual* risk of harm from a single unprotected sexual encounter is quite different from intention and risk when a person throws a punch, stabs with a knife or fires a gun.

Those living with HIV should be informing the criminal law response which is, after all, a subjective social response. An HIV representative sits on the panel in every state were a health panel may be convened to discuss the behaviours of HIV-positive individuals who place others at risk of infection. Why then is it acceptable for the HIV sector and HIV sector organisations in particular, to remain uninformed about the rationale and mechanics of criminal laws application to HIV? In two states, community organisations have begun to organise a formal response: VAC/GMHA and PLWHA (Vic), and Positive Life (SA). It is hoped their models of response will prove useful examples others may follow.

HIV-positive perspectives

Dr Sean Slavin (Assistant Director, NAPWA)

The collateral damage from HIV criminal cases

Criminal prosecutions for transmission of or exposure to HIV have effects that extend far beyond the individuals involved in any particular case. Media reports of such cases are often salacious and stigmatising of whole classes of people including; people living with HIV, gay men with HIV, heterosexual men with HIV and African Australians.

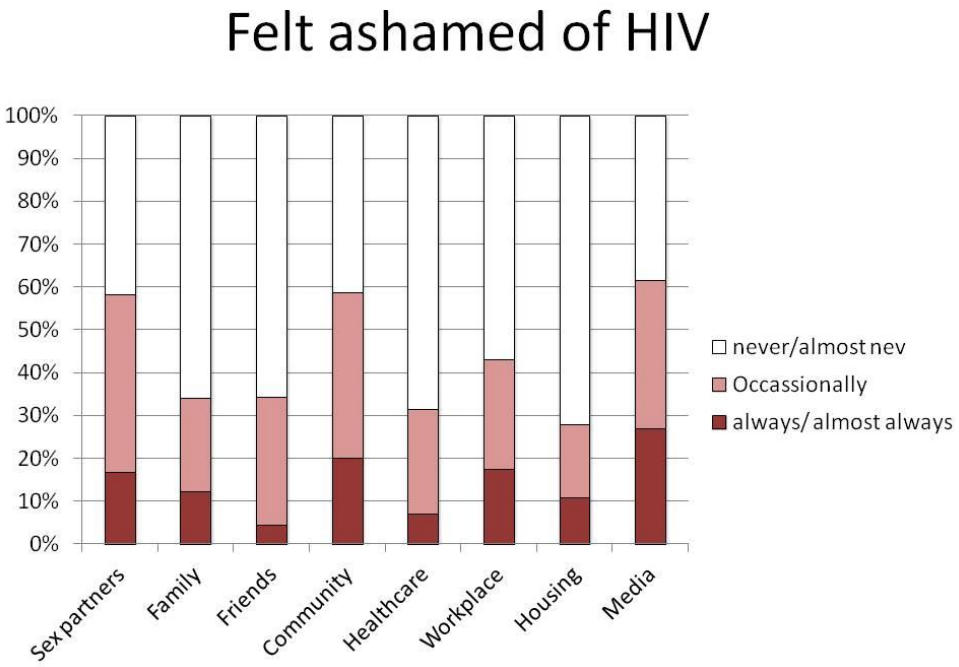
HIV continues to be a stigmatised disease due to a number of factors including its association with sex and/or drug use, its capacity to create anxiety about mortality and infection, and its association with 'low status groups' including homosexual men, sex workers and drug users. Many PLHIV continue to report feelings of shame and guilt about their status.

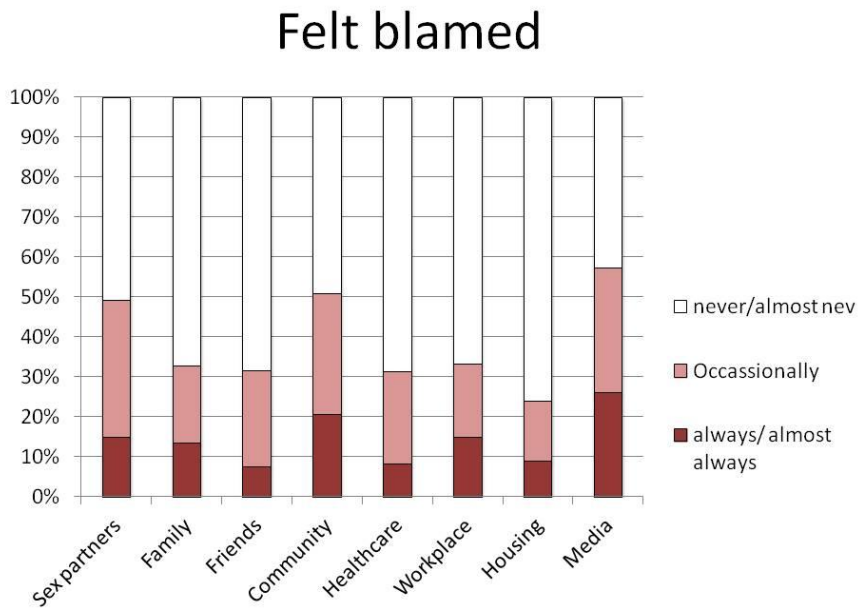
Both the law and the reporting of the law are actively involved in making meaning and this produces cultural effects that reach beyond the individuals directly involved. The effects of meaning making also extend beyond each specific case and have real impact on the lives of those in the community as stigma around the virus is generated.

For example, many people living with HIV report that they conduct their sexual lives with reference to HIV criminal prosecutions. They report that instead of being a source of nourishment and pleasure, sex becomes a source of fear and anxiety with positive people feeling they are entirely responsible for preventing transmission.

Earlier this year NAPWA and the NCHSR conducted research into experiences of stigma among PLHIV. This included an online survey of mostly gay men and a smaller sample of diverse PLHIV who participated in qualitative in depth interviews. We asked people both about their experiences of stigma and about the feelings that constitute stigma.

In the survey we asked people about the sources of stigma in terms of feeling ashamed of having HIV and feeling blamed for having HIV. Possible responses included: sexual partners; family; friends; health care providers; housing; community and "in relation to media". In relation to media was the most frequent response.





When asked in qualitative interviews to discuss the impact of criminal prosecutions participants particularly identified the cases of Michael Neal in Victoria and Godfrey Zaburoni in Queensland.

Michael Hurley and Samantha Croy have written on the case of Michael Neal who was tried and found guilty on various counts in relation to HIV transmission in 2005. His was the first

high profile case of a criminal prosecution of a gay man and was widely reported in the national media. Hurley and Croy[1] note the following features of the reporting.

- There was a focus on HIV transmission which was caused by Neal and for which he was responsible. There was an absence of any notion of shared responsibility.
- Neal was the 'perpetrator' and the men he infected were (innocent)' victims'. There was no agency attributed to the victims.
- HIV is a disaster for those who contract it. It is a fatal disease.
- Not all gay men or HIV positive people are as bad as Neal. He was involved in a 'seedy' 'subculture' that does not reflect mainstream gay values or behaviours. This is reinforced by the common reporting of the fact that he was a 'grandfather' from suburbia. i.e. not a normal gay man.
- This is a deeply moral story in which Neal figures as an 'evil fiend', a 'grim reaper' and a sexual predator on par with a paedophile.
- Some of these narratives were repeated by the sentencing judge.

Asha Persson and Christy Newman's[2] work on the media portrayal of African men is relevant to the case of Zaburoni in Queensland where media reports commonly contained a picture of the accused shirtless and noted he was an acrobat. The following general characteristics applied to the reporting.

- Zaburoni was portrayed as an exotic Lothario.
- He seduced 'innocent' white women who were powerless to resist (or ask for safe sex). This narrative endorses heteronormative assumptions about the active nature of men and the passive nature of women. It also essentialises the female partners as Australian and Zaburoni as foreign. In one report 'our' Danni (the other Minogue) might even have been at risk when he appeared as a contestant on Australia's got talent.
- Australian heterosexuality is regarded as exempt from risk of HIV.
- His sexual urges were uncontrollable. This sort of narrative is stock standard across hundreds of years of colonial discourse about black male sexuality.
- African male sexuality is produced as 'monstrous' in ways that play upon concerns about race, migration and nationhood in contemporary Australia.

What all these authors make clear is that both the law and the reporting of the law are actively involved in making meaning. This is an important sociological point and runs counter to what many who work in the law and the media believe: that the exercise of law is about uncovering the truth and the reporting of the law is about transmitting the truth.

Instead there is no singular truth, but truths. This results from the fact that the making of cultural meaning is highly contested and beyond the control of those directly involved. Meaning is made in the context of existing cultural values, practices, prejudices and social inequalities. The effects of meaning making extend far beyond each specific case and have real impact on the lives of others in the community.

[1] Hurley M and Croy S (2009) The Neal Case: the Neal case: HIV infection, gay men, the media and the law in *The Criminalisation of HIV transmission in Australia: legality, morality and reality.* NAPWA Monograph, Sydney.

[2] Persson A and Newman C (2008) Making monsters: heterosexuality, crime and race in recent Western media coverage of HIV. *Sociology of health and Illness.* 30(4), pp.632-646.

In conclusion, criminal prosecutions and the reporting of criminal prosecutions help to shape the meaning of HIV infection in ways that are usually negative and add to the stigma carried by PLHIV. While this meaning is cultural its effects are highly individualised. The message is that people with HIV are solely responsible for its transmission and new infections are never an accident. This encourages secrecy around status, directly undermining prevention efforts based on shared responsibility and safe disclosure.

However, it would be a mistake to regard criminal prosecutions as the sole cause of this individualisation. Rather we live in an age and a culture that is obsessed with blame and incapable of recognising accidents. Unfortunately, in the case of HIV, many positive people blame themselves for their condition and increasingly HIV negative people absolve themselves from responsibility for prevention.

The response to HIV in Australia has been based on the idea of mutual sexual responsibility among individuals and collective responsibility among government and community framed as the HIV partnership. If we are not to undo decades of socially progressive and effective work that has made the Australian approach the envy of many other countries around the world, we need to take an immediate step back from these legal processes and reengage with the idea of a collective partnership response that now, more than ever, should include both police and the legal sector.

HIV-positive perspectives

Kane Mathews and Elena Jeffreys (Scarlet Alliance)

The presentation examined the experiences of sex workers living with HIV. Some of the experiences discussed were derived from respondents who participated in a recent study conducted by Scarlet Alliance. Respondents in the study spoke about how they approached issues around HIV and criminalisation, and how criminalisation impacts on them.

One respondent spoke of his approach to disclosure, which he asserts was the same for his personal sexual activity as it was for paid sexual activity. He described the ‘early days’ of living with HIV, and the advice from HIV organisations and AIDS councils, the changing laws and regulations and how these were seldom consistent.

It was reported that the respondent decided early on that he would establish his own “set of rules” regarding disclosure and safe sex boundaries, which he did. He has stuck to this for years, regardless of the changing ‘legal, regulatory and advisory’ frameworks.

A key aspect of criminalisation for sex workers living with HIV is media reaction, which they feel stigmatises people with HIV, and HIV-positive sex workers in particular. The presenters spoke of several examples of HIV-positive sex workers living beyond metropolitan areas who are fearful for their physical safety. These sex workers provided second hand reports of an HIV-positive gay man being ‘run out of town’ by others - add to this the stigma around sex work, and the sex workers are indeed justifiably concerned.

The presentation also discussed problems regarding sex worker access to health services, advice and information. In particular, changing and different legal frameworks across jurisdictions may mean that health workers are not clear about current regulations or the HIV sector’s approach to best practice support and advice for people living with HIV. Participants in the Scarlet Alliance study reported that health workers were found to often provide incorrect advice including informing HIV-positive sex workers they were not allowed to work.

This was confirmed by a further Scarlet Alliance survey which showed that health workers had 'reported' HIV-positive sex workers to authorities for no other reason than their file indicating they did sex work and that they were HIV-positive.

The level of stigma faced by HIV-positive sex workers goes beyond criminalisation. The issues combine to create a loop effect. Sex workers are significantly affected by the threat and occurrence of criminalisation proceedings that subsequently act to further increase stigma and discrimination for this population.

HIV-positive perspectives

Marama Pala, Kaiwhakahaere, Co-Founder/Executive Director

In July 1993 Marama Pala met a Kenyan musician in a New Zealand night club - the night she became infected with HIV. In October of that year Marama recognised the man's name in the newspaper along with a phone number and a request for anyone who had contact with the man to ring the police.

Marama contacted the police who she said were very professional, swift and thorough with their investigation. They organised a place where people who had met the man could come together in a facilitated session and share their stories. Very quickly however, Marama was encouraged by the police and clinicians 'to help prevent the man from infecting other women. Marama agreed, though she said of that time she 'had no idea what that would entail'. Marama's case was the first of its kind in New Zealand. Switzerland had a case pending as Marama's proceeded.

Marama recalled how, as the trial progressed; it became increasingly difficult for the police and prosecution to provide evidence of intent. The police became more insistent and graphic with the stories of others involved in the case and convinced Marama to continue. As Marama explained, 'I was at the end of my tether and wanted everything to end. The police told me that the man had raped a 16 year old virgin and infected her. 'I felt then that it was my responsibility to take this man off New Zealand's streets'.

Although Marama participated as a witness for the prosecution, she has since come to the view that criminal prosecutions for transmission of HIV should not occur indiscriminately.

Marama described the isolation she experienced from family and community; the health and HIV sectors and the media. Marama also spoke of the important role culture and mental health played in her story, aspects Marama claims were overlooked in the criminal process.

Family and community

Most in Marama's community knew of her diagnosis before she could quell the story. The reaction was instantaneous, rejection, disgust and persecution. 'There was some anger and indignation about how an African man could come to our country, our town and do this'. Marama became ostracized and felt she needed to redeem herself in the eyes of her community. Marama recalled how she agreed to be a complainant in the court case, hoping that perhaps her family and community would see her as a 'victim' if she were to take the man to court.

Health an HIV sectors

Marama also recalled that the fear of the consequences of her case in New Zealand was very high. National HIV organisations condemned criminalising HIV. 'The organisations that were there for people living with HIV were not there for Marama - a person living with HIV putting another in prison'.

The health professionals dealing with Marama's' diagnosis were honest and frank. Marama recalled, 'I was told I had less than 8 years to live; that I should forget about having children; that I could have a sexual relationship only with condoms and I was sent on my way... I was also told, and am still told today, that the man who infected me was pathological and he deserved what he got'.

The media

Marama recalled that the media coverage of the case was intense and played an important role in her story. The media acted as a tool for the police to seek potential complainants. However, it became a nemesis for Marama. The media continued to vilify the accused as a monster. When the media began to judge and make comments about Marama as a complainant, 'I felt violated over again'. Marama explained that some media outlets began bidding to pay for the story, throwing money at an already controversial situation.

'I was gullible enough to accept, as I had never had money like that before' and as Marama explained, 'this opened the flood gates and my personal testimony was often misrepresented, framing me as 'a victim', 'a nut case' or 'a sad case'. Comments were also made about Marama's upbringing, her intelligence, and her mental health. This made Marama regret ever saying anything about what happened. Marama suggests that the media need to stop sensationalising HIV. 'Where do you draw the line? For me the media personified the victim in me and continued to keep me in that place'.

Culture and mental health

Marama was clear however, that she does not see herself as a victim. She described how the legal process failed to account for cultural differences including; how a prosecution might affect a Māori person from a small community, and issues of mental health. Marama believes that all people involved in cases of HIV transmission should be provided with culturally appropriate care and support.

Marama believes that cultural diversity and mental health were crucial to her situation however; these were overshadowed by the sensationalism and fear of HIV. 'In retrospect I ask questions about what was his mental state at the time? Did he comprehend the cultural difference between Africa and New Zealand? As a Māori woman, I felt culturally violated, I was never able to face him, to express my thoughts and feelings, to yell, scream and cry. If I could have done it again, I would have asked for that support for us both.'

Marama admitted she has no answer on how to deal with situations like hers. 'I am aware of how many people were hurt and that some women are still angry 18 years later. I ask myself often though; was locking him up the justice he deserved? Does it make me feel any better? No it doesn't. Does it make me feel better knowing he never had the chance to infect other women? Maybe…'

Legal and health responses

Dr Helen Watchirs OAM (ACT Human Rights and Discrimination Commissioner)

Summarised by Scott Lockhart

Human Rights discourse

Dr Helen Watchirs discussed the role of human rights discourse in addressing the issue of HIV criminalisation and suggested that human rights have an important role to play in terms of prevention and in a remedial way in terms of a response. Dr Watchirs suggested that human rights address vulnerabilities by empowering communities to respond effectively and

that human rights are also remedial when they enable people to cope with the impact of infection, particularly in view of anti-discrimination laws.

However, she emphasised that criminal law is a mixed bag in relation to HIV and human rights. Public health law is much clearer as a result of the lead Australia took in the late 1980's and early 1990's. The convergence of external stigma of others and the internal shame and guilt that people living with HIV have of themselves makes the disease problematic in relation to HIV transmission and exposure offences. Dr Watchirs went on to discuss the key areas of HIV criminalisation reform.

The Sixth National HIV Strategy

The *Sixth National HIV Strategy 2010-2013* highlights human rights legislation and anti-discrimination laws as a priority area of action. However, criminalisation is a state and territory issue requiring the Federal Government to play a leadership role. To implement human rights legislation and anti-discrimination laws, legal barriers must be identified to provide an evidence base for prevention strategies across jurisdictions.

MACBBVSS

One year ago Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS) established a legal working group. The working group has developed draft papers on discrimination and criminalisation as well as barriers to the Needle and Syringe Program (NSP), sex work and drug control. In relation to HIV specific laws, Victoria is the only state that has a HIV specific criminal law with other jurisdictions having more generic laws. One of the most problematic areas for the criminalisation of HIV is the reckless endangerment laws developed through a model criminal code in 1992 which some jurisdictions have adopted.

International Guidelines on HIV and Human Rights

Australia's Inter-Governmental Committee on AIDS (ICGA) Legal Working Party reported in 1992 that public health, discrimination and criminal laws remain quite valid and have formed the basis for the International Guidelines on HIV/AIDS and human rights. However, Dr Watchirs pointed out that the report doesn't address exposure issues which we are better able to address today. Firstly, because antiretroviral therapy (ARV) was not common until 1996 and today there are also the issues raised in the Swiss Statement, viral load and transmissibility – though there maybe some difference between heterosexual and the same sex populations in terms of how reliable the data may be.

Australia's Inter-Governmental Committee on AIDS' (ICGA) 1992 report suggested that public health laws should include a graded series of interventions, including restrictions on living circumstances and employment where there is an unreasonable risk of infection to others. Australian National Guidelines are based on this report. Dr Watchirs suggested however, that the 1992 report should be revisited. The 1992 report recommended that criminal matters should only be bought after approval by public health authorities, rather than being initiated by police so that there can be a scientific evaluation of the risk of transmission and an individual assessment as to whether the graded health-based intervention should be applied. That recommendation was never implemented and Dr Watchirs suggested that urgent reform is required.

The Australian Guidelines were not endorsed by the UN, but are based on UN Human Rights treaties to which Australia is a party. Guideline (4) says that states should review and reform criminal laws to ensure they are consistent with international human rights obligations and not misused in the context of HIV or targeted at vulnerable groups. The text of the guidelines explains that criminal and public health legislation should not include specific offences against a deliberate and intentional act of transmission of HIV/AIDS but rather

should apply general criminal offences to exceptional cases and that should ensure the element of "foreseeability, intent, causality and consent" before there is a conviction. In 2008 UNAIDS commissioned a policy on the criminalisation of HIV.

UN Political Declaration of 2011

On 10th June 2011, the UN General Assembly Political Declaration, for the first time, identified vulnerable populations. A number of articles (29, 77, and 78) in the UN Declaration apply to the criminalisation of HIV. The Declaration also recommends the protection and promotion of human rights and monitoring the impact of the legal environment on HIV, prevention, treatment, care and support.

The impact of criminal laws

Dr Watchirs provided a précis of the impact of the criminalisation of HIV, suggesting that broad criminal laws hold the potential to violate human rights in terms of privacy, sexual autonomy, liberty and health. This occurs particularly in terms of restricting testing and seeking appropriate care and support because of people's concerns about surveillance by authorities. Coercion does not work in the context of intimate, complex relationships and behaviours. Dr Watchirs suggested that an important impact of these laws is that the people most likely to come to the attention of the police and prosecutors are the most vulnerable, including those with mental health or drug or alcohol addiction.

Dr Watchirs argued that selective and intrusive policing undermines respect for the criminal justice system and exposes judgemental attitudes, encourages scapegoating and, encouraged by the media, stigmatises people living with HIV as criminals. Criminalisation also affords the general population a false sense of security and excuses some from taking full responsibility for their own health and preventative measures. For Dr Watchirs, the criminal law's focus on punishment, deterrents and retribution comes at a cost to rehabilitation, which she suggested was the proper aim of public health law and public health practices.

Dr Watchirs concluded by suggesting that public health should take precedence over the criminal law in cases involving HIV. This goal could be furthered by including an agenda in relation to criminal law in the HIV national strategy partnership. Some of the recommendations from the MACBBVS legal working group include establishing cross-sectoral links and protocols between police and public health authorities.

Legal and health responses

Michael Williams (PLWH/A Victoria, President)

Neal v The Queen: Overview and Implications

The Victorian prosecution of Michael Neal for the intentional and reckless transmission of HIV (amongst other offences) is the most high profile case of HIV criminalisation to date. Jailed by Judge Parsons J in the County Court for 19 years with a non-parole period of 14 in 2009, Neal appealed the judge's jury directions on various counts. The Victorian Court of Appeal upheld some of Neal's arguments but dismissed others, re-sentencing him to 12 years with a non-parole period of 9.

As the case shows, Neal was managed by officials within the Department of Health under their *Guidelines for the Management of People Living with HIV who Place Others at Risk* from 2001 until 2006. Despite repeated warning not to engage in unsafe sex, he continued to do so. It was also clear that, on occasions, Neal actively deceived his partners about his status. However, the trial was characterised by salacious, inaccurate and highly stigmatising

media reporting of gay male subcultures and people living with HIV. We never heard, until the sentencing remarks of Parsons J, that Neal had been sexually abused as a child and had suffered multiple nervous breakdowns.

In *Neal v the Queen*, Justices Nettle, Redlich and Kyrou delivered a dispassionate decision, devoid of moral judgment. While the judgment is only one of a single appellate court, it appears to be the most comprehensive judicial explication in Australia on 'informed consent' in the context of HIV transmission. It holds important implications for the future development of the law in similar cases and, while leaving many questions unanswered, points to some useful advocacy strategies for community based, HIV organisations keen to see an end to criminal prosecutions of HIV transmission and exposure.

The most significant holding in the case is that informed consent can now clearly operate as a defence to a charge of reckless conduct. As their Honours say:

> *In our view, informed consent is capable of providing a defence to a charge of recklessly endangering a person with HIV through unprotected sexual intercourse, so long as the consent is communicated to the offender ... It follows that, in order for the Crown to succeed in a prosecution for an offence of reckless conduct endangering a person with HIV through unprotected sexual intercourse, if the accused puts consent in issue, the Crown must prove beyond reasonable doubt that the complainant did not give informed consent to the risk or that the accused did not honestly believe that the complainant had given informed consent to the risk.*

However, beyond this the judges did not say what constitutes 'informed consent' or the appropriate communication of that consent. It is safest to assume that the judges envisaged *verbal* communication of both an individual's status to their sexual partner and *verbal* communication to the accused to run the risk of infection prior to intercourse.

While condoms (and other risk reduction practices) were not addressed, we can deduce from the reasoning of the judges that using condoms would otherwise provide a defence to any charge of engaging in reckless conduct.

A further important principle to emerge from the case is that an individual has to believe they are able to transmit HIV (i.e. that they are 'infectious') to be guilty of attempting to infect another person. Without this belief, they will lack the requisite 'mental element' of the crime. There is now evidence that a person who is ARV compliant and who has an undetectable viral load may not be infectious. This is fast becoming the scientific and clinical consensus. *Neal* shows that a person's belief about their own (non)-infectiousness can be tendered in court as a defence to certain charges.

A final point is that the Court rejected arguments by Neal's lawyers that 'the risk of infection was so low that it was not open to conclude that the applicant's behaviour subjected the complainants to danger of infection with HIV, which is to say, an appreciable risk'... This means that arguments based on the statistical risks of HIV infection being too small will not succeed in relation to specific charges (although they may succeed in relation to others).

In conclusion, *Neal v the Queen* provides our sector with much needed clarity around informed consent in the context of reckless conduct and HIV. It is currently the only decision in Australia that has addressed informed consent in this context in any comprehensive way. Given this, and while not binding on their decisions, it may influence the deliberations of courts in other jurisdictions in similar cases. Its principles will influence the investigations of police and the prosecution practices of the Office of Public Prosecutions ('OPP') in Victoria,

the state where around half of all criminal proceedings to date regarding HIV exposure or transmission have occurred.

While cases such as Neal's provide useful guidance on the criminal law in this context, we may only see the end of criminal prosecutions against people living with HIV when appropriate guidelines are adopted by the OPP that clarify and appropriately circumscribes, the cases in which prosecutions will proceed.

Legal and health responses

John Godwin (Consultant)

Prosecutions *versus* public health case management: Problems with our two-track system for addressing HIV risk behaviours

In the 1980s, Justice Michael Kirby famously claimed to have identified the HIL virus, the virus of highly ineffective laws that threatened to undermine effective HIV responses. At the time the concern related to the possible application of the old draconian infectious disease laws to HIV, with powers of isolation and quarantine. With 16 HIV exposure or transmission prosecutions since 2007, we may be seeing the re-emergence of this damaging HIL virus, this time in the form of punitive criminal laws.

Since the 1980s, our public health laws have been modernised (with the exception of Western Australia). In New South Wales, the trigger for reform was the case of a sex worker, Sharleen Spiteri, who was detained under the Public Health Act in 1989 after stating on national TV that she was HIV-positive and working as a sex worker. The law she was detained under was originally introduced to address tuberculosis. In 1990, the relevant law was reviewed and a process was undertaken to develop case management guidelines to ensure that there were due process safeguards and a system of checks and balances for future HIV cases that arose.

In 1992, the federal Inter-Governmental Committee on AIDS (IGCA) issued a report containing wide-ranging legal and policy recommendations. The IGCA Legal Working Party Report initiated an unprecedented period of reform on issues such as decriminalisation of homosexuality, anti-discrimination protections, privacy rights and sex work law reform. Collectively these reforms provided the enabling legal environment for HIV prevention, treatment and care, underpinning the strength of Australia's National HIV Strategies. The IGCA Report recommended that risk behaviours be addressed by two systems: case management under public health laws and prosecutions under existing general criminal laws. The NSW Guidelines were approved by the IGCA, and ultimately each jurisdiction went on to develop their own case management guidelines along similar lines.

The characteristic of the public health management approach is the application of a series of escalating measures, starting with the least restrictive measure of voluntary counselling. In the case of a person who repeatedly engages in risk behaviour, compulsory orders can be made under public health legislation or, in serious cases, the person may be referred to the police for prosecution. In 2007, the Department of Health and Ageing issued National Guidelines defining five levels of individualised case management.

Until 2006, the two-track system appeared to be working reasonably well. There were usually only one or two criminal prosecutions per year. These were regarded as highly exceptional cases. Most jurisdictions avoided introducing HIV-specific offences and relied on the general criminal law when serious cases arose.

Most people whose risk behaviour came to the attention of authorities were managed under public health case management track. Health department policies allow for individualised

case management, informed by panels of experts with capacity to refer to mental health, drug and alcohol or disability services as appropriate. The approach is flexible but predictable, in that there are a series of defined steps. The case management approach has come to be recognised as global best practice.

On the other hand, the other track – prosecutions – developed in an ad hoc manner. There was no process to develop national consensus on guiding principles. We now have a situation where there may be up to seven or eight different criminal offences that can be applied to HIV exposure or transmission in each jurisdiction, with little consistency between states. In total, over fifty different criminal offences could theoretically be used to base a prosecution for exposure, transmission or non-disclosure of HIV status. For people living with HIV, this is highly confusing and generates fear. Confusion prevails as to concepts of consent, recklessness, intention and negligence as they apply to sexual behaviours.

From the standpoint of people living with HIV, the application of the criminal law is unpredictable, and there is no enshrined principle that punitive measures are a 'last resort'. Rather, a prosecution may be a first resort, as it can be triggered by a complaint to the police at any time and can proceed without referral to Health Department.

With over half of the 33 prosecutions that have ever occurred in Australia being launched since 2007, it is apparent that the two-track system is flawed. The 'enabling legal environment', a hallmark of the national HIV response, is being compromised. It is not clear that public health management options are being considered before prosecutions are initiated and it appears that we are shifting to a more punitive approach. Structural factors exacerbate the situation, in that HIV experts seldom engage with legal institutions, and police, prosecutors and the judiciary seldom have expertise or understanding of HIV and public health.

To resolve this problem, we have perhaps three obvious choices. The first is to strengthen and align the two systems. This would require:

- national consensus on prosecution guidelines that address public health factors;
- national consensus on how criminal offences that should be defined in state and territory laws (preferably restricting offences to intentional conduct that actually results in transmission);
- capacity development programs to build expertise among police, departments of public prosecutions and the judiciary;
- coordination and referral protocols between Health Departments and the justice system;
- participation of people living with HIV in developing legislative and policy solutions; and
- research to better understand and evaluate the individual and community impacts of different approaches.

The second option is to integrate the two systems by taking prosecution decisions away from police and departments of public prosecutions. Instead, governments could require all HIV and STI prosecutions to be initiated by Health Departments, as an integral part of the case management approach. Prosecutors could agree not to prosecute any HIV or STI exposure or transmission cases under criminal laws. Each jurisdiction would need to have in place an offence for intentional HIV transmission in its public health legislation that could be used as the last resort option under the case management approach.

The third option is to eliminate all offences for HIV exposure, transmission or non-disclosure. Cases would be addressed under the public health case management approach, with the ultimate sanction of an order detaining a person under public health legislation should the circumstances warrant it. This option merits consideration, even though it would likely be

opposed as an unjustifiable form of 'AIDS exceptionalism'. All policy options should be on the table.

Leadership is required to ensure an informed process for considering all options. At the national level, the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, the Blood Borne Virus and Sexually Transmissible Infection Sub-committee and the Standing Committee of Attorneys General need to focus their energies, coordinate and lead the response.

Legal and health responses

Colin Batrouney (Victorian AIDS Council)

After the dust settles

In exploring the implications that may arise for health promotion with regard to HIV and criminalisation, it is instructive to view the issue through the prism of the Michael Neal case because among other things, it has been the trigger for an enormous amount of discussion around the issues of criminalisation, HIV transmission, disclosure, desire, personal agency and HIV related stigma and discrimination.

The Neal case represents the convergence of a number of situational elements that resulted in a media frenzy that sought to dramatise, distort and to some degree incite hysteria around sex orgies, HIV, contagion, gay sex, evil predators and innocent victims. In a sense, one could see just by a simple reading of the charge sheet how the case was irresistible to the media. In fact, the Neal case became a lightning rod for the expression of a multitude of prejudices, phobias and concerns where nearly every aspect of the gay community was implicated negatively and the only winners were the media.

The first mention in the Victorian media of the Michael Neal case was in the gay press in May 2006. *The Melbourne Star Observer* headed an article by Doug Pollard, 'HIV man arrested'. In this article and in subsequent articles Neal was referred to as the 'HIV man' reducing this individual to the status of a potentially deadly pathogen. Although the label was picked up by the mainstream media it is of interest that it was originally coined in the gay press. In a sense, Neal became the embodiment of a 'shocking subculture' within the gay community consisting of 'drug fuelled orgies in private homes and sado-masochistic games' so described in the media to engender outrage among the good citizens of mainstream Australia. The particularities of the Neal case aside, drug fuelled group sex involving sado masochism are not uncommon occurrences in the gay community, but then, nor is the capacity for these behaviours to stir outrage restricted to the non-gay mainstream. In fact, it could be argued that sections of the gay community, in an effort to underwrite a broader social agenda around human rights, gay marriage and parenting have essentially pushed any expression of gay sex to the margins.

I have no doubt that the very idea of gay sex without condoms is intolerable for many gay men and beyond the comprehension of mainstream Australia. However discomfiting it may be for some, gay men engage in anal sex without condoms and much of this unprotected sex is safe with regard to the onward transmission of HIV if it is between sero-concordant couples. Even if it is between sero-discordant couples, strategies gay men employ such as strategic positioning, and undetectable viral load are often utilised in an effort to reduce the risk of transmission during unprotected anal intercourse. Although these practices are well established amongst some gay men, in the light of the Michael Neal case there is a not unreasonable fear that deployment of risk reduction as opposed to 100 percent condom use could result in HIV transmission cases ending up in court. But I guess I would argue that for such cases to be bought successfully, they would need to rely on the complete passivity of complainants who have ceded personal responsibility and control to an individual (or

individuals) who knowingly intend to infect them with HIV. These passive 'victims' would also need to successfully argue that the sex they engaged in consensually and the contexts in which they engaged in it were, to the best of their belief, safe, and that their sero-conversion was entirely due to the deception and cruel intent of the accused. This was, in part, how the original case against Neal was constructed. But as was discovered during the process of the original trial and the subsequent appeal, the law is a profoundly blunt instrument when it comes to prevention. In this regard lawmakers are faced with the same dilemma that those of us working in prevention have faced for nearly three decades and the problem is deceptively simple. The sex drive, as B. M. de Waal, the Dutch-American primatologist describes it "Follow(s) its own autonomous motivational dynamic." Its default setting isn't safety, it is pleasure, and sometimes that pleasure involves risk. You accept this fact and continue to work in prevention or you find another job. A clear example of the autonomous motivational dynamic of sex was brought to light in the Neal trial when an ex partner of Neal's testified that he had unprotected sex with Neal "in moments of passion and intoxication" but didn't blame Neal for exposing him to the virus. He said, "Anything I did with the defendant at any time was consensual".

In spite of these points of clarification I think it's fair to say that the legacy of the Neal case has been generally negative. The problems that the case has left us with aren't just related to health promotion. After all, health promotion operates within an ever-changing set of social dynamics and the social ramifications of the case are potentially very damaging indeed. Because, once we leave the racy exotica of drug-fuelled orgies peopled by evil gift givers and their victims we are left with some all too real issues to deal with.

- Firstly, increasing the level of stigma and discrimination suffered by HIV positive people.
- Further stigmatisation of gay men in general.
- It potentially makes disclosure of status more difficult, or leads to a more generalised set of anxieties on the part of HIV positive people and people in sero-discordant relationships with regard to sex.
- It could lead to HIV positive and negative gay men becoming confused about the legal status of their choices.
- It could contribute to an already documented sense of over vigilant morbid anxiety related to HIV transmission in some gay men.

Over the past 27 years prevention in this country has followed an ever expanding iterative path. From campaigns like the grim reaper to 'if it's not on, it's not on', to negotiated safety, strategic positioning, withdrawal, undetectable viral load, to post exposure prophylaxis and pre-exposure prophylaxis. Every one of these developments has been led by the needs and desires of gay men to control our sex lives in a sense, collectively. Health promotion has been able to educate, support and clarify along the way. Successive periodic surveys and studies such as Pleasure and Sexual Health and the Three or More study consistently demonstrate that the majority of gay men actively engage in some form of risk reduction, be it condoms and water based lube, to undetectable viral load or withdrawal when engaging in anal sex. These processes are not acts of ignorance and they are governed by individual judgement and decision making around the accommodation of risk that take into account the specific contexts in which those sexual acts take place, whether they are in a drug fuelled orgy or the confines of a bedroom. The discipline of health promotion, community participation, engagement and mobilisation are the strongest and most effective tools we have in prevention. The problem for all of us once criminalisation is invoked as a preventive measure against exposure and transmission, with its processes of monitoring, control, curfew, of public health orders, of detention, reporting and prosecution is that the process is

immediately exposed as cumbersome, inefficient and impractical. Even as a punitive process it is staggeringly expensive and fraught with difficulty.

Rather than wasting our time in an effort to entertain ideas around criminal sanctions against exposure and transmission we ought to put our efforts into strengthening the agency of gay men, (who, after all, bought safe sex into being) to determine our own decision making around sex, around disclosure, around safety, around risk, and around acceptance and mutual respect. After all, it's not as if there's a viable alternative.

Health Department panel and facilitated discussion

Simon O'Connor (Queensland), Ken Wadell (Western Australia), Alan Brotherton (New South Wales)

This session considered state and territory treatment of individuals who 'put others at risk': how that treatment impacts broader HIV priorities; the clash of health and criminal law contexts; and the limits of criminal law's capacity to consider the reality of individual's behaviours. Laws and formal policy mechanisms frame Australia's response to HIV, informing both prevention practice and protection of the human rights of people living with HIV. Those same laws and policies may also come into play in specific instances when a person living with HIV puts another at risk of HIV infection. Tensions arise between the ethos of population based frameworks encouraging healthy behaviours and systems to restrict or punish the behaviours of those with a disregard for their own or others' health and safety.

Responding to cases of HIV Criminalisation

Delegate discussion – Facilitator, Tim Leach

This session used three hypothetical scenarios that provided participants with the opportunity to formulate responses to cases of HIV transmission/exposure and prosecutions. Criminal cases involving HIV present many challenges for those working in the HIV sector. Community based HIV organisations may come into contact with both 'victims' and 'perpetrators' at different times. Furthermore, mainstream media reporting of cases of criminal prosecution for HIV exposure or transmission are often problematic, betraying either ignorance of the complexity of transmission risk, moralistic assumptions about various sexual cultures or salaciousness. At various times this combination has threatened to escalate into moral panics that demonise people living with HIV.

Advocacy & remedies

Michael Frommer (Policy Analyst, AFAO)

Remedies

AFAO began work on criminalisation of HIV transmission and exposure many years ago. In 2009, Sally Cameron and Abi Groves produced the first AFAO Criminalisation Discussion Paper, which was an extensive exploration of the issue. In 2010, it was decided that an updated briefing paper was required, and in particular, a document that outlined practical steps that can be taken to address the issue, including jurisdictional reform. Thus, the 2011 *HIV, Crime and the Law in Australia – Options for Policy Reform – a law reform advocacy kit* was produced. The first section provides an updated policy analysis of the issues involved

in HIV prosecutions

The second section - the advocacy kit - presents a range of strategies that may help reform the approach taken to cases of alleged HIV transmission and exposure. They range from high-level projects, such as the creation of prosecutorial guidelines to be undertaken over time, to more immediate options such as better media liaison and use of the current legal mechanisms, such as suppressions orders.

The list of options in the second part of the discussion paper is not prescriptive, as the legal settings, the cultural/political circumstances, and the facts on the ground vary considerably around the country. While specific responses must be tailored to local dynamics, it is very important there is national oversight of the situation, including appropriate monitoring and responses to the cumulative effect of increasing HIV criminalisation.

The advocacy tool kit canvasses the following options:

- Detailing discussion and policy development
- Developing mechanisms to learn more about individual cases
- Promoting research priorities
- Working with police
- Working with justice agencies
- Working with public health officials
- Enhancing Judges' understanding of HIV
- Working with correctional authorities
- Working with media
- Working with state-based community organisation agencies
- Improving use of expert witnesses
- Addressing over-representation of African-born accused.

Working with justice agencies – *prosecutorial guidelines?*
The *Sixth National HIV Strategy* states 'it is essential that a partnership approach be reflected in all jurisdictional and non-government agency planning, implementation, monitoring and evaluation and that lessons learned are shared'. That mandate extends across departmental 'silos' within individual governments, and as well as across jurisdictions.

Directors of Public Prosecutions directly influence whether cases proceed and how they are run. While it is a requirement that prosecution of a criminal case must be in the public interest, it is not known how the 'public interest' is determined in the context of criminal cases involving HIV transmission. When AFAO has endeavoured to discover basic information about concluded cases (including questions, like what specific charge was laid), it has been challenging. Recently, the Victorian AIDS Council and People Living with HIV/AIDS Victoria jointly initiated collaboration with the Victorian Office of Public Prosecutions to create guidelines to assist in determining circumstances in which criminal prosecutions for alleged HIV transmission may be appropriate.

The overall situation in Australia contrasts to the UK experience, where the community sector persuaded the Crown Prosecution Service (CPS) to consider advice from the National AIDS Trust and the Terrence Higgins Trust when developing guidelines on prosecutions relating to sexual transmission of HIV. The CPS 'Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection' has clarified issues for the public and has provided important guidance for police and prosecutors.

Working with community-based organisations

While some Australian HIV services have provided support to complainants, defendants or witnesses involved in trials, this support has been ad hoc. Many of those who have gone through HIV exposure/transmission trials appear to have done so without accessing support from HIV-specialist services. Further work is needed to ensure that people encountering the criminal justice system are aware of the range of HIV support services available (including specialist legal services) and that appropriate support is made available both to those accused and to non-expert witnesses.

Such processes may require a scaling up of skills related to working within a criminal justice framework and the development of agency protocols regarding identification of conflicts of interest and on-referrals. They may also require some scaling up related to service provision to those under corrective services' or public health management.

Individual HIV services have been caught up in criminal proceedings in ways previously unanticipated, triggering review of administrative systems (including record keeping, filing and electronic data management) and clarification of agencies' legal obligations. Collection and discussion of those experiences within the HIV sector may be beneficial to better prepare agencies for issues that they may encounter.

Media

HIV prosecutions affect the general public's understanding of HIV. This is particularly so given media interest in the salacious details of trials (issues of fidelity, deception and of course, sex, including non-mainstream sexual conduct), and the general lack of coverage of 'human interest' stories relating to HIV to provide a more diverse representation of people living with HIV. Witnesses' evidence is reported, whether or not it is corroborated or accepted as accurate by the court.

This type of media coverage has the potential to increase stigma against people living with HIV and spread misinformation about HIV, including the experience of living with HIV and how it is transmitted. Media coverage also impacts people living with HIV by increasing their sense of stigma. It has the potential to misrepresent the rationale and the mechanics of the primary HIV response (the public health-based response) by undermining confidence in the confidentiality of medical records and suggesting that an overly vigilant government is waiting to pounce on individual's presumed indiscretions.

Proactive work is required to educate journalists and editors, and to increase coverage of the diverse lives and experiences of people living with HIV. Initiatives such as the media briefing by Positive Life (NSW) and the AFAO Media Guide provide initial examples of such work.

Reactive work is also essential, as demonstrated with the recent reporting of the Chan case. The headline in several online news services, including Adelaide Now, read 'SA man admits infecting women'. This headline was incorrect; the man in question was convicted of HIV exposure through unprotected sex, not of HIV transmission - i.e., none of the witnesses had been infected with HIV. AFAO took prompt action, alerting the news services of the inaccuracy, and the article was pulled altogether. However, this was not before time, as multiple online media sites had already reproduced the inaccurate headline.

Responses to HIV criminalisation require a holistic view. They must take into account

jurisdictional particularities and be driven by local dynamics, reflecting the spirit of the partnership approach that has characterised Australia's successful HIV response to date.

Advocacy & remedies: an international perspective

Edwin Bernard (Writing about HIV, www.edwinbernard.com)

Most HIV-related criminal cases around the world have been framed by prosecutors and media as being especially egregious cases of 'deliberate' or 'intentional' HIV transmission when, in fact, the vast majority involved neither intent nor transmission.[1] The use of the criminal law in this way is of great concern in the following areas:

- Perceiving consensual sex in the absence of disclosure of known HIV-positive status as a physical or sexual assault when there was no intention to harm and when this may actually be a consequence of communication failures within relationships.
- Prosecuting consensual sex even when there was prior disclosure of known HIV-positive status and/or that posed a very low risk of HIV infection and that did not result in transmission.
- Applying enhanced prison sentences to alleged HIV 'exposure' during non-consensual acts that pose very little or no risk of HIV infection, e.g., spitting, biting and scratching.
- Applying enhanced prison sentences to sex workers living with HIV even when there is no evidence that they put their clients at risk of HIV exposure.
- Applying the criminal law to vertical transmission of HIV during pregnancy, or following birth via breastfeeding.

Australia is not the only country facing concerns over the inappropriate use of the criminal law to regulate and punish people living with HIV for behaviour that may have placed their partners at risk of acquiring HIV. Globally, at least 600 individuals living with HIV in more than 40 countries have been convicted under general or HIV-specific criminal laws.[1]

Mitigating the harm of such laws and prosecutions, criminalisation may require the long and drawn-out process of law reform, particularly when there are criminal laws which single out people with HIV (but not any other communicable disease). In Australia only Victoria has such an HIV-specific law; however, 32 states in the United States have such laws, many of them poorly drafted, overly-broad and based on out-of-date knowledge of HIV-related risk and harm.[1]

Nevertheless, most prosecutions take place under general laws, such as physical or sexual assault statutes. Their relevance to HIV non-disclosure, exposure or transmission are often based on legal precedents informed by a single case taken to appeal early in the epidemic. Again, these are commonly informed by HIV-related stigma and/or incomplete understanding of HIV science.

When the law is unclear – as it often is when it evolves based on case law – this creates uncertainty over what behaviour is criminal and what is not, ideally requiring guidelines for police and prosecutors to circumscribe the use of the law. Legal literacy for people living with HIV is also required so that we know our rights and obligations – and how to defend ourselves against wrongful accusations.

The good news is that all of these processes are currently taking place around the world, providing hope and lessons for advocacy in Australia.

Law reform
Denmark's HIV-specific law is currently suspended and likely to be abolished soon.[1] Norway has set up a committee that is spending two years to examine whether its current law used to prosecute people living with HIV for non-disclosure should be rewritten or abolished.[1] Finland, Sweden and Switzerland are all in the process of examining their laws and policies that criminalise HIV non-disclosure, exposure or transmission. And in the United States, Congresswoman Barbara Lee recently introduced the Repeal HIV Discrimination Act which creates financial incentives and support for states to review and reform HIV-specific laws that are not consistent with good public health or HIV science.[1]

Legal decisions based on good science
Years before the 'Swiss Statement' on the impact of antiretroviral therapy on infectiousness, the Netherlands' top court decided that one act of insertive unprotected anal sex when the accused was on treatment, was not significant enough a risk of serious harm. The result was the essential decriminalisation of non-disclosure and exposure with only intentional transmission remaining a criminal offence.[1] The impact of the 'Swiss Statement' was not only felt in Geneva, where HIV exposure charges were dropped because the risks were considered to be purely "hypothetical,"[1] but also in Austria[1], Canada[1] and the US Military.[1] UNAIDS is currently working on a project to create consensus on the science of HIV-related risk, harm, intent and proof in order to inform law and policy internationally, with a high level policy meeting scheduled for early 2012.[4]

Police and prosecutorial guidelines
Civil society in England & Wales lobbied the Crown Prosecution Service and later the Association of Chief Police Officers to create prosecutorial and police guidelines which have not only clarified the exact circumstances regarding when prosecutions might be warranted and reduced the flow of cases reaching court, but also led to closer relationships between the HIV sector and the criminal justice system fostering improved advocacy and mutual understanding.[1] This pragmatic response is now being replicated in Ontario, Canada[1] and – as we heard at this meeting – here in Victoria.

What all of these processes have in common is that they were conceived and led by a few influential individuals within civil society but supported by broad stakeholder collaboration. Such advocacy has often required what I term the five 'E's:

- Evidence of intended and unintended impact of laws and prosecutions on human rights and public health.
- Engagement and involvement of key players in the criminal justice system (prosecutors, police, lawyers, judges), clinicians and HIV affected communities, as well as key media (which impacts public, policymaker and criminal justice system opinion) and, in the case of law reform, key politicians.
- Education of all stakeholders about the latest advances in HIV-related medicine and science (including social and forensic science).
- Empowerment and support of people living with HIV to to be involved and engaged in HIV prevention and criminalisation issues, as well as scaling-up legal and rights literacy.
- Exchange of ideas through meetings like this one, and national and international networking and collaboration. To this end, I will be launching, in early 2012, an international network of individuals and organisations working to end criminal

prosecutions for HIV non-disclosure, exposure and non-intentional transmission, known as the HIV Justice Network.

Advocacy & remedies

Melissa Woodroffe (HIV/AIDS Legal Centre New South Wales)

Suppression of a person's HIV status before the Courts

The International Guidelines on HIV/AIDS and Human Rights 2006 state that "*People living with HIV should be authorised to demand that their identity and privacy be protected in legal proceedings in which information on these matters will be raised*".

One of the cornerstones of the Australian legal system is the principle of open justice. As such, the business of our courts is open to the public and to the media, with very limited exceptions. This has significant implications for people living with HIV who appear before the courts, either as alleged offenders or as complainants.

So, why is it important that a person's HIV status be suppressed in the court system, and how can this be achieved?

The criminalisation of HIV results in police charges against individuals suspected of intentionally or recklessly transmitting HIV or putting someone else at risk of contracting HIV. A person's HIV status inevitably arouses considerable media interest when associated with criminal charges.

HIV remains a condition that is stigmatised in society. There are only very limited circumstances in which a person is required to disclose their HIV status, and many choose to keep the information private. Australia's successful history of HIV prevention and management as compared to other countries is credited to the so-called 'enabling environment' where people affected with HIV are supported, involved and included in the government, legal and public health responses. The purpose of the enabling environment is to support those living with HIV to look after themselves and others and thus prevent the spread of HIV. This supportive environment should extend to the maintenance of confidentiality regarding a person's HIV status in the court system.

On many occasions where a person is charged with an offence, the charges will subsequently be withdrawn, dismissed or ultimately the defendant will be found not guilty. In such circumstances, it is unreasonable and unfair that a person will lose control over who has knowledge of their health condition. The disclosure of a person's HIV status can have severe and adverse effects on their family members and children. Furthermore, the sensationalised headlines relating to any criminal transmission court case have the effect of further stigmatising people with HIV, portraying people living with HIV as potential criminals. This ultimately affects the public health response to HIV, which depends on the engagement of people living with, or at risk of, HIV.

The courts have inherent powers to make suppression orders where it is in the public interest to do so, and in addition there are a number of specific pieces of legislation that allow for suppression. Suppression orders are routinely applied in the courts in matters involving children, and in relation to sexual assault matters. In relation to HIV, Section 13 of the NSW *Public Health Act* 1991 makes it an offence to fail to disclose one's HIV status prior to sexual intercourse, irrespective of whether safe sex practices are used. Section 37 of that Act allows for the local court to be closed when alleged offences under Section 13 are heard. This is an important protection, given that even a person found not guilty of the charge would still have lost control over who had knowledge of their HIV status. This power of suppression is clearly very limited however. Interestingly, the equivalent legislation in Victoria is far broader in scope and allows for suppression of a person's identity in any matter relating to

HIV, and arguably could be used for any matter in *any* court in Victoria. The Victorian Act states that a court *should* make an order to close the court where evidence is proposed to be given in a matter before a court or tribunal of any mater relating to HIV, and where the court considers that the disclosure of the information would cause adverse social or economic consequences to the person.

In New South Wales, two recent pieces of legislation in relation to suppression have recently commenced; the *Court Suppression and Non-Publication Orders Act* 2010 and the *Court Information Act* 2010. This legislation does not affect the operation of the common law powers to allow suppression and also does not affect other legislative provisions. The courts maintain their discretionary power to weigh relevant interests in the particular case before them. Nevertheless, it is hoped that the new legislation will assist the courts in balancing this difficult determination.

Very few criminal cases in relation to HIV transmission have had suppression orders granted. In many cases, suppression orders have not been allowed where it has been held that the public interest in alerting possible sexual partners of the identity of the accused so that they could seek immediate medical advice and testing outweighed the public interest in preserving the confidentiality of the accused's medical condition. In NSW, a man was charged and convicted of infecting his partner with HIV. Although his partner and their children's names were suppressed, his name was not. The unfortunate result of this was that the disclosure of his name identified his partner and children who lived in a small town in NSW.

The HIV/AIDS Legal Centre (HALC) has made and continues to make applications for suppression orders on behalf of HIV-positive clients. We also work with other legal practitioners to assist them in making such applications on behalf of their clients. We are keen to hear from any lawyers who have made such applications on behalf of their clients, whether successful or not. There remains a great deal of work to do in this area. We would like to see law reform in the longer term whereby suppression of a person's HIV status become the standard, unless there is a specific public interest in making the HIV status public knowledge.

A longer and more detailed article on Suppression and HIV appeared in the Law Society Journal earlier this year ("Closed Courts open door to justice") and is available for download from our website www.halc.org.au

Conclusion

Criminal prosecution for alleged exposure and transmission of HIV is problematic. Criminalisation undermines the mutual-responsibility, safe-sex, public-health based response that has characterised Australia's successful HIV response. Criminal prosecutions tend to stigmatise people living with HIV and this stigmatisation may discourage people who engage in high-risk behaviours from testing for HIV. As articulated in the Forum Communiqué, it is generally preferable to manage people whose behaviour places others at risk of HIV infection under Australia's public health system.

The AFAO/NAPWA Forum provided an opportunity to hear the voices of people living with HIV on how they personally respond to criminal prosecutions. As outlined in this report, experiences of stigma and marginalisation were common responses to criminal prosecutions.

Jurisdictional policy reform must be tailored to the circumstances in each state/territory, and be driven by the local community/HIV sector. The history of prosecutions and the jurisdictions' public health structure and practice vary and these differences should inform responses to criminalisation. Such a nuanced and considered approach echoes the

characteristics of the HIV partnership response more broadly, which has been pivotal to Australia's success in responding to HIV.

Appendix

HIV, criminal law and public health forum Communiqué

On 29 September 2011, AFAO and NAPWA held a national forum on HIV, criminal law & public health.

There are almost 20,000 people in Australia living with HIV, and some 1000 new infections each year, the vast majority of these resulting from consensual human sexual activity. All new HIV infections are unfortunate and have consequences that go beyond their immediate circumstances. Rarely is it helpful to apportion blame for events that are more properly understood as accidents. Most years, only one or two people are prosecuted for exposing others to the risk of or transmitting HIV, yet the fallout from those prosecutions, particularly from media coverage, is substantial: substantial enough to have kept criminalisation on the agenda of HIV policy and service agencies for almost a decade and to warrant a national forum.

This communiqué notes the shared concerns of Forum participants and sets out the key issues that need to be addressed.

Participants of the HIV, Criminal Law & Public Health Forum 2011 affirm that:

HIV is just one of many communicable diseases and each jurisdiction's response to HIV should be within a health framework.

HIV continues to attract stigma that is disproportionate and inconsistent with its actual impact on the Australian community. All stakeholders in Australia's HIV response have a responsibility to ensure HIV remains contextualised as a virus requiring a health response that is respectful of human rights.

Australia's national response to HIV is defined by the *Sixth National HIV Strategy (2010-2013)*. The Strategy notes the need for 'a renewed focus on law reform to ensure an enabling human rights-based environment for the response' and that 'areas for consideration include … … the application of criminal and public health law to HIV transmission and/or exposure offences'.

The implementation of the *Sixth National HIV Strategy* should include scrutiny of the application of criminal laws to people engaging in sexual acts that carry the risk of or result in HIV transmission.

HIV non-disclosure, exposure and transmission should not be singled out for differential treatment by criminal law.

Doing so exacerbates HIV-related stigma and fails to take full account of the social and intimate contexts in which sexual behaviour occurs and the reality that HIV is now widely regarded as a chronic manageable illness.

HIV-related criminal prosecutions undermine the HIV public health response, which is the cornerstone of Australia's HIV response.

HIV criminal prosecutions, and the media they generate, undermine HIV prevention strategies by challenging messages of shared responsibility for sexual health and by weakening the cultural environment that encourages disclosure of HIV status in intimate relationships. Criminal prosecutions can create fears of government 'surveillance' of individuals' sexual behaviours and can undermine confidence in healthcare practitioners' capacity to provide therapeutic and confidential services.

Criminal law is a confusing and ineffective tool for addressing the harms resulting from HIV exposure and infection.

Prosecutions for HIV exposure and transmission send contradictory and confusing messages. Some individuals have been found 'guilty' of crimes when HIV has not been transmitted and others 'not guilty' when HIV has been transmitted. Scientific knowledge of transmission risk (including viral load) and actual transmission (based on phylogenetic analysis), is contested among scientists themselves. Each case of HIV is a personal challenge for those concerned and the intervention of the criminal law does not help address this.

The financial and human resources spent on policing, prosecuting and defending those involved in HIV-related criminal trials have had no discernable beneficial impact on Australia's HIV response.

Such funds would be better directed towards strategies to increase the effectiveness of HIV prevention efforts and to address emerging and enduring issues affecting people living with HIV.

Australian practice is inconsistent with UNAIDS policy guidance.

The act of having unprotected sex should be distinguished from the intention to transmit HIV, particularly given that any single sexual encounter includes a limited to remote risk of HIV transmission and that HIV prevention now includes numerous strategies that do not rely on condoms.