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national association of people living with hiv/aids

NAPWA MONOGRAPH 2009

**The Criminalisation
of HIV Transmission
in Australia:
Legality, Morality
and Reality**

napwa

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Since retiring from the Directorship of the NCHSR, Professor Kippax is employed as a Professorial Research Fellow. The projects in which Sue is currently involved include national studies such as the Positive Health Study, and the Health in Men Cohort Study. She is Chief Investigator on a number of studies including: exploring the role of the Internet in building social capital among gay men; investigating the ways in which general practice deals with depression in gay men; and documenting 'resilience' in Aboriginal families. She is also collaborating with researchers in South Africa to examine the part played by HIV-testing in the production of stigma. More generally, she is interested in the prevention-treatment nexus and the ways in which policies concerning HIV-treatment roll-out and HIV-testing play out in relation to prevention within modern public health.

David Menadue (CHAPTER 11)

David Menadue has been involved with HIV activism since the late 1980s, and has been President of the National Association of People living with HIV (NAPWA) and People Living with HIV/AIDS Victoria (PLWHA Vic) as well as taking on numerous other roles within the HIV sector in Australia. His current interests include participation in the development of national HIV prevention and health promotion campaigns and working on social justice issues for HIV-positive people through subcommittees of NAPWA. David writes regularly for NAPWA's *Positive Living* magazine and published his autobiography *Positive* (Allen & Unwin, 2003). In 1995 David was awarded an Order of Australia Medal for his contribution to community health, especially to people living with HIV/AIDS.

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Dean Murphy has been involved in the development of HIV health promotion and research for over a decade. This work has focused primarily on Australia's HIV community sector and its education initiatives targeting gay men and their sexual practices and cultures. Dean is currently a Research Associate at the National Centre in HIV Social Research (NCHSR) and a consultant on HIV education and biomedical prevention at the Australian Federation of AIDS Organisations (AFAO). His areas of interest are: HIV health promotion and evaluation; biomedical HIV prevention technologies; online sexual cultures; HIV genotyping and phylogenetic analysis; kinship and new reproductive technologies; and gay and lesbian parenting. He is currently working on a PhD on kinship practices among gay men in Australia and the United States who have become parents through contract surrogacy.

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Lisa Power has been involved in HIV activism since the beginning of the epidemic and has worked for Terrence Higgins Trust (THT) for over 12 years, where she now holds the post of Corporate Head of Policy. In 1999 she established THT's policy and campaigning team. Lisa sat on the Advisory Group for the Crown Prosecution Service's Guidelines for Prosecutions and has recently published *Policing Transmission*, a review of police practice in HIV transmission cases. She is active in advising on cases and speaking and training on the issue, as well as continuing to work on policy issues in collaboration with other UK agencies. Lisa has presented research and debated the issue at many events, including World AIDS Conferences. Terrence Higgins Trust has been involved in criminalisation issues since the 1990s, when they first lobbied the UK government for reform of the laws relating to violence. Through their direct services and national phone line they have been involved in many of the investigations and prosecutions for HIV transmission in the UK, giving confidential practical advice and emotional support to all parties.

Daniel Reeders (CHAPTER 10)

Daniel Reeders has been working in HIV prevention and positive health since 2004. He recently completed three years at People Living with HIV/AIDS Victoria, writing funding submissions and developing campaigns and resources. During this time he developed a discussion paper on stigma for the NAPWA Health Promotion and Education Network, followed up by a skills workshop at the 2008 AFAO Educators' Conference, which helped place stigma reduction on the health promotion agenda. In 2009 Daniel was contracted by AFAO to complete a literature review on stigma-reduction strategies, and presented a workshop on the subject at the 2009 National LGBTI Health Summit in Chicago. He is now Senior Project Worker in the Multicultural Health and Support Service at the Centre for Culture, Ethnicity and Health in Melbourne, and in 2010 Daniel will complete the last four subjects in his Arts/Law degree at the University of Melbourne.

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Dr John Rule is the Deputy Director of the National Association of People Living with HIV (NAPWA) and has assisted NAPWA in the development of program activities within the HIV Living Unit for nearly ten years. He was the NAPWA-nominated delegate to attend as a member of the Australian delegation to the 2008 UN General Assembly Special Session Review Session on HIV/AIDS. His PhD research in adult and community education was completed through

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Peter Rush is an Associate Professor, Law School, University of Melbourne. He researches and teaches in the areas of criminal law, international criminal justice, and legal theory. He is the author of publications in criminal law, law and literature, and psychoanalytic jurisprudence, as well as a novel and a film. Current projects include: rape law reform; the jurisprudence of danger; law, memory and the jurisdiction of trauma.

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David Scamell is the Manager of Policy, Planning and Research at ACON. As part of his role, David has researched, written and presented on a range of issues relating to HIV transmission and the law. He was previously the Convenor of the NSW Gay and Lesbian Rights Lobby, where he led law reform campaigns for the federal recognition of same-sex relationships and state-based parenting rights. David holds a BA/LLB from the University of NSW and is about to commence an LLM in International Human Rights Law at the University of Essex in the UK.

Stephen Tomsen (CHAPTER 6)

Stephen Tomsen is Professor of Criminology and Criminal Justice at the University of Western Sydney. His research interests include violence, hate crimes, masculinities, sexuality and social movements, and the political and collective emotional dimensions of victimhood. He is currently researching aspects of safety and danger in Sydney's night-time economy. Stephen's recent publications include *Crime, Criminal Justice and Masculinities: a Reader* (Ashgate 2008) and *Violence, Sexuality and Prejudice* (Routledge 2009).

Chris Ward (CHAPTER 3)

Chris Ward became involved in Australia's response to HIV through his work as a home-care volunteer with the Victorian AIDS Council in the mid-1980s. He has degrees in law and arts from the University of Melbourne, and has worked as a solicitor for community legal centres in Victoria and New South Wales. He was involved in establishing the HIV/AIDS Legal Centre (Victoria) and is a former Principal Solicitor of the HIV/AIDS Legal Centre at the AIDS Council of NSW. From 1996 to 2002 Chris worked as a policy analyst with the Australian Federation of AIDS Organisations (AFAO), and in 2003 began working on HIV legal and policy projects with governments and NGOs in south and southeast Asia. He is now a full-time consultant based in Sydney.

John de Wit (CO-AUTHOR CHAPTER 7)

John de Wit (MSc, PhD) is Professor and Director of the National Centre of HIV Social Research at the University of New South Wales, Sydney. John has a longstanding involvement in research in the field of HIV, STI, viral hepatitis and sexual health that spans two decades. His research is concerned primarily with contributing to a theory-based understanding of sexual and risk practices that inform effective programs and policies. His work encompasses both applied and more basic social sciences research, and has broadened to include viral hepatitis, STIs, teen-pregnancy and unwanted sex. A central current theme in John's work is to understand how individuals self-regulate their practices in social and physical contexts that are not always supportive and may even promote risk. This research emphasises the importance of feelings, personal and social motives and implicit rather than reasoned processes.

Melissa Woodroffe (CHAPTER 4)

Melissa Woodroffe is a solicitor and project officer at the HIV/AIDS Legal Centre (HALC) in Sydney. HALC was established in 1992 and is a specialised Community Legal Centre. It is staffed by three full-time solicitors and a number of volunteers, and provides free, practical legal advice to clients presenting with HIV-related matters, as well as participating in community legal education, policy work and law reform in HIV/AIDS related issues. HALC is the only full-time funded HIV/AIDS specialist legal centre in Australia and has recently produced a guide for legal practitioners on the Criminal Transmission of HIV in NSW, and is currently working on a similar guide that covers the criminal laws in all the states and territories.

Iryna Zablotska (CO-AUTHOR CHAPTER 7)

Dr Iryna Zablotska has worked as a Research Fellow at the National Centre in HIV Social Research since January 2006. She received her PhD degree at the Bloomberg School of Public Health, Johns Hopkins University, USA, and her primary areas of interest are epidemiology, HIV, sexual behaviours, and impact of human behaviour on health. During her research career, Iryna also worked on issues such as health consequences of risky sexual behaviour, HIV, utilisation of delivery services in resource-poor settings, evaluation of health communication programs, and health consequences of partner violence against women. She provided consulting services in the US and helped the Ministry of Health of Ukraine to design evaluation programs for HIV prevention efforts. In her current position, Iryna is a Chief Investigator on the Australian Gay Community Periodic Surveys, Positive Health study, Respondent Driven Sampling Pilot and other studies of HIV-related behavioural factors.

President's message

Robert Mitchell

NAPWA and its membership have a strong commitment to articulating the impacts of HIV at a personal level, as well as across a population experience. The engagement of HIV-positive people with prevention strategies and education messages has been a critical part of the Australian HIV response from the beginning of the epidemic.

In this monograph the authors have described aspects of the recent trend in Australia of HIV exposure or transmission being pursued within a criminalisation framework. They have also documented how these cases have been prosecuted inconsistently across the country, and also how the cases have been represented in the broader public domain by various, and often inappropriate media coverage.

NAPWA has supported the development of this work, initiated by people living with HIV, bringing together a collection of multidisciplinary papers, under the expert coordination of Sally Cameron and John Rule. The monograph includes several HIV-positive and community voices observing these events, alongside other authors from academic and legal sectors. I would like to thank all of the contributing authors for their involvement and support.

The end result is a collection of papers which provide rigorous analysis, and are relevant to the current environment in Australia, and other parts of the world, where increasingly there is a public intersection between personal behaviours, intimate encounters, moral judgements, public health positions and various legal instruments. This intersection has effectively created a complex and confounding set of realities not only for individuals, but also agencies across a national HIV response that has been based in health promotion and is now being pulled towards a health protection paradigm. The intention of this work is to start a dialogue across the HIV sector and with broader public health and legal sectors, to talk about the issues raised and the impacts of these events on the HIV-positive community in Australia. The notion of criminal law being directed against a person on the basis of HIV status is considered by many to be discriminatory, and to undermine the very principles behind two decades of promoting messages of shared responsibility and safe consenting sexual practice. The notion of blame and persecution directed towards HIV-positive people is unacceptable and NAPWA is calling for laws that require mandatory disclosure of HIV status, and laws that are targeting a specific disease status, to be reviewed. It is imperative that a nationally consistent legal framework be adopted that supports public health policy and population health outcomes, as well as protecting notions of fairness and equal rights under the law.

This is the beginning of what could become a body of work analysing the issues raised, including other areas not covered adequately in the monograph. For example, women and gender discussions have a set of unique parameters within the way HIV transmission is described in the Australian context, and notions of consent and cultural influence need to be explored in contexts other than the gay male experience.

NAPWA is also keen to progress a thorough review and reflection of legal and ethical implications surrounding the development of new technologies and laboratory analysis. These developments have been applied increasingly to HIV population surveillance and clinical patient focus, but attempts to position this data within a legal discussion has been widely resisted both internationally and nationally, quite rightly for compelling scientific reasons. NAPWA believes this is an increasingly important place for consistent governance and protocols to be developed and applied on a national level. It is critical that those operating within the legal system have an appreciation of the limitations of current scientific reliability for such purposes.

Finally, NAPWA hopes that this monograph is able to spark interest and support from other sectors to collaborate on future work towards resolving differences and contradictions inherent in the way HIV transmission is currently being described and dealt with across various state legal systems. NAPWA is committed to improving the current situation in Australia, where people living with HIV are being affected either directly or indirectly by adverse legislation, inappropriate legal procedures, and associated public media responses.

Sydney October 10, 2009

Foreword

The Hon. Michael Kirby AC CMG

This monograph addresses a subject that has engaged the national and international community for some time; but with growing urgency in recent years. It concerns the operation of the criminal law in the case of the deliberate or reckless transmission of the human immuno-deficiency virus (HIV), generally during consensual adult sexual relations.

This subject has assumed significance in Australia in recent years because of a number of highly publicised cases involving allegedly intentional transmission of HIV. When such cases get into the hands of tabloid media, they are presented as everyone's nightmare: an infected person with a special capacity to spread an extremely dangerous virus to innocent victims whose lives are then changed dramatically (either actually or potentially) by such wrongful and dangerous action on the part of the perpetrator.

As the chapters in this book indicate, in Australia, the invocation of the criminal law, with the objective of altering human conduct so as to reduce the risk of transmission of HIV from infected persons to the uninfected, will only ever be of tiny significance in the control of the epidemic as a whole. Nevertheless, prosecutions do occur. A question is: should they?

The prosecutions are based upon penal statutory provisions. And they are sometimes attended by high-profile, emotional reporting. A feature of a number of cases is that they have involved African or other foreign men, gay men with several partners, and often heterosexual sex, sometimes in the circumstances of commercial sex work. In comparison with the numbers of persons infected with HIV overall, the fraction of those prosecuted is extremely small. The possibility that an individual might be prosecuted for transmitting the virus is so slight and remote that it appears unlikely that that risk (and the imposition of criminal punishment) would have played a large part (or any part) in the decision-making by the sexual partners at the moment of their decisions to engage in unsafe sexual conduct.

In the early years of the HIV epidemic in Australia, such was the impact of the epidemic upon gay men, so many were the friends who became infected and so frequent were the funerals that we attended, that an urgent message of the need for responsible self-protection arose. The strategies designed to promote prevention of the spread of HIV were concentrated, initially, largely upon the sector of men who have sex with men (MSM). However, strategies were also designed to promote safety amongst injecting drug users (IDUs), commercial sex workers (CSWs) and their clients, and other at-risk groups. The consequence was not only a significant drop in the number of persons becoming infected with HIV in Australia, it was also a large community movement to promote generally safer sexual activity and to discourage, or diminish, unsafe activities through which the virus could spread to individuals and, by them, to entire populations.

The basic need for widespread education and enlightenment that lay at the heart of the endeavours to promote safer sexual and other behaviour at that time in Australia emphasised self-empowerment and mutual responsibility. The epidemic has taught, particularly sexual minorities, that it was not good enough, or safe enough, to blame others for the transmission of the virus. If the transmission were to be reduced, it was essential for each and every person, particularly those at special risk, to be familiar with the risks; to be acquainted with the risky modes of transmission; and to take personal responsibility to ensure that precautions were taken aimed at eliminating or minimising the chances of transmission. These precautions might include:

- The proper use of condoms, especially for penetrative sexual activity;
- The switch to, and promotion of, non-penetrative sexual behaviour;
- The empowerment of CSWs so that they would insist upon the use of condoms and safer sexual practices by their clients;

- The invariable use of sterile needles by IDUs;
- The promotion of knowledge about the virus, particularly amongst the cohort of new entrants into the categories of MSM, CSWs, and IDUs;
- The promotion of all of the above across the board throughout the entire Australian community by educational programmes so as to bring the messages home to the heterosexual majority as well as to minority groups; and
- The enactment of laws designed to reduce stigma, alienation and ignorance, and to promote empowerment, knowledge, self-protection and thus, the protection of others.

The foregoing strategies undoubtedly had a very large effect on the rates of sero-conversion to HIV in Australia. A similar pattern was detected in other countries of the developed world. Occasional prosecution for general or specific offences arising out of HIV transmission would occur. But, substantially, they were a side-show in the large enterprise of containing the virus and preventing, or discouraging, its spread.

In more recent years, in Australia, there has been some evidence, in particular states, of a falling away from the foregoing strategies. Uncomfortable indications have emerged that the tried and true strategies were no longer working, or working as well, amongst those persons who were at special risk of acquiring HIV. Doubtless, there are many causes for those interruptions in the previously steady decline of HIV infections. Amongst the possible causes for the variations have been:

- A decline in the alarm level, previously reinforced by the death of friends and attendance at their funerals, which the earlier stages of the epidemic presented to the MSM community in particular;
- After the advent of anti-retroviral drugs (ARVs), an increase in the belief in some quarters, erroneous though it may be, that HIV was 'cured' and that acquiring the virus was no longer as serious an outcome as it had previously been;
- A reduction in the educational messages and, in some cases, in the spending of public moneys to promote awareness of HIV and of its still gravely serious consequences for those who become infected; and
- The presentation of 'horror stories' by the tabloid media designed to promote alarm, by exceptional cases of irresponsible behaviour, resulting in demands for criminal sanctions to restore the previous attitudes providing protection of oneself and of others in identified risky behaviour.

As Professor John de Wit and colleagues note in chapter 7, the present period has been marked by naive and ignorant reliance by sexual partners upon assertions (or the appearance) of healthiness on the part of an infected person as justifying the abandonment of safer sexual practices. These developments, and the resumption of 'bare-backing' (and even cases of 'gifting' HIV) may have contributed to an increase in sero-conversion in recent times by conduct that would have specially alarmed those who lived through the first phase of the HIV epidemic. But it also alarmed politicians, media and sections of the general public.

Is the proper response to these new problems the introduction of new criminal laws targeting deliberately unsafe sexual and other practices? Is it likely that such laws would have a salutary effect on the epidemic? Would an occasional high-profile conviction, on the front page of the tabloids, impact on the mentality of those who expose themselves and others to unsafe behaviour? Or is the proper response to such conduct an insistence that, as at the start, everyone engaging in sexual behaviour, injecting drug use and other potentially risky activities must protect themselves and always take responsibility for doing so?

Views on these subjects differ in our community. Indeed, they differ both in the general community and in the gay community which, from the start, has felt the brunt of HIV on its members. Whereas there are some in the community of MSM who complain that criminal law is a very blunt instrument of no significance from an epidemiological point of view, there are others who have reached a different conclusion. They know, or remember too vividly, the impact which HIV has had over time on those who are infected. They recognise the life-changing character of the infection. They are aware of the side effects of the ARVs. Some are aware of the uncertain potential of such drugs to have long-term effectiveness. Moreover, they are conscious of the expense and inconvenience of such therapies. They therefore regard at least deliberate or reckless infection of others with HIV as such a seriously wrongful act that it calls for a response from the community as a whole. Such a response is normally expressed in terms of the criminal law.

Whilst the criminal law may be heavy-handed, it is intended to reflect the moral judgment of society that deliberately or recklessly spreading a life-threatening infection should not be ignored but should be punished if the prosecution can convince a judge or jury, beyond reasonable doubt, that what has occurred was done with the necessary intent or with reckless indifference to the grave consequences.

These are the debates that are recounted in these pages. Not only are they important debates for Australia. They are of great significance for the entire world.

From the point of view of epidemic control, the best steps that could be taken in many of the countries which are on the front line of the HIV epidemic (especially in Africa, Latin America and South-East Asia) would be to *repeal* the old colonial laws against MSM and many of the more recent harsh laws against IDUs and the traditional statutes targeting CSWs. However, a glance at the recent legislative responses of developing countries indicates that most of them are not willing to take such useful measures. In 41 of the 53 countries of the Commonwealth of Nations, formerly the British Empire, the old anti-sodomy laws remain resolutely in place. It is these countries that refuse to remove the old laws. Instead, they salve their consciences by *enacting* new laws to criminalise and penalise those who are found responsible of infecting another person with HIV. On a global level, this wave of criminalisation is not only an ineffective strategy. It is positively undesirable because it often distracts the countries that initiate such laws from the strategies that might help empower those at risk and promote preventative conduct to diminish the scale of the epidemic.

In short, from an epidemiological viewpoint, what is needed in most countries is the *repeal* of criminal laws on MSM, CSWs and IDUs. Instead, such countries are *enacting* new laws on criminal transmission. In this, they are moving in what is generally the wrong direction. So much has been said by UNAIDS, by WHO, by UNDP and other agencies of the United Nations. However, securing *repeal* of criminal laws is difficult for social, religious and political reasons. *Enacting* ineffective laws, targeted at HIV transmission, is so much easier. It looks to be doing something, however ineffective that something may turn out to be.

This, then, is the debate considered in this monograph. It is one of liveliest debates in the international response to HIV at this time. I congratulate the National Association of People Living with HIV (NAPWA) on the publication of this work. NAPWA has collected knowledgeable and informed commentators who have a great awareness of the epidemic in Australia. Without exception, the chapters are thoughtful, balanced and informative. I hope that they will be read in Australia. Indeed, I hope that they will be available overseas to bring enlightenment that is the first step in an effective response to the epidemic.

It remains true as Jonathan Mann taught in the earliest years of HIV, that paradoxically, the best way of fighting the HIV/AIDS epidemic is by empowerment of the people who are most at risk. Until we have a cure and a vaccine, knowledge and education are the best ways of preventing the spread of HIV. The role of criminal law is much more confined. Whether there is a limited role and what it should be is the proper subject of informed debate. And that is the debate that is recounted in these pages.

Sydney October 1, 2009

Outside the HIV strategy: challenges of ‘locating’ Australian prosecutions for HIV exposure and transmission

Sally Cameron and John Rule

Introduction

This monograph has been prepared by the National Association of People Living with HIV (NAPWA) to develop an informed analysis from a range of professional fields and advocacy positions on the criminalisation of HIV transmission in Australia. It reflects a strategy to facilitate broad engagement by those with diverse expertise on this issue, so that it may be more fully understood, and appropriate responses devised.

The exact number of people prosecuted for transmitting or exposing others to HIV in Australia remains unknown as there is no centralised (or state-based) mechanism for identifying and recording criminal cases involving HIV exposure or transmission.¹ Best efforts to date put the number of prosecutions for HIV transmission/exposure through sexual contact at 22, with three additional cases involving charges laid, but either dropped pre-trial or dismissed. Given the more than 27,000 people diagnosed with HIV between the first diagnosis of an Australian in April 1993² and the end of December 2007,³ individuals prosecuted represent a tiny fraction of those living with HIV in Australia.⁴ While the vast majority of HIV-positive people are unlikely to come into contact with the criminal justice system in relation to their HIV status, prosecutions are no longer ‘rare’.⁵ Edwin Bernard estimates Australia now ranks eighth in the world in terms of HIV prosecutions per capita.⁶

Prosecutions for HIV exposure or transmission, the probability of future prosecutions, and the context within which such prosecutions arise, have become issues of concern across the national HIV partnership. This is arguably nowhere more so than within HIV-positive people’s representative organisations. The small, but increasing, number of prosecutions for HIV exposure or transmission appears to represent a cultural shift with the potential to undermine Australia’s internationally esteemed HIV response.

Some major emerging questions include:

- Do Australia’s HIV-related laws, and the laws we now understand might be applied to HIV, provide the best framework for Australia’s HIV response to HIV transmission – including each individual case of HIV transmission? While the lack of consistency across jurisdictions is detrimental to a ‘best practice’ legal response, HIV-related prosecutions mean possibilities for law reform must extend beyond jurisdictional uniformity, must revisit laws of previous (often theoretical) concern, and must consider other previously unexamined laws as they relate to HIV. In addition, law reform must question prescribed sentencing.
- Why does criminal law treat HIV differently from other diseases? What social or cultural ‘filtering’ of the ‘meaning’ of HIV infection informs the decisions of complainants to complain, police to investigate, prosecution offices to pursue, and judicial officers to hear these cases and not cases of other disease transmission (hepatitis, syphilis, herpes, chlamydia, measles, swine flu, for example)? This question must also be examined in light of the increase in HIV-related prosecutions occurring at a time when the

'harms' of HIV infection at population level might be generally understood as having decreased when compared to the harms associated with HIV diagnosis in the early 1980s (defined by the absence of effective treatment and complete ostracism) when no prosecutions occurred.

- How do criminal prosecutions fit within Australia's official National HIV Strategy? Criminal prosecutions for HIV exposure or transmission might best be understood as undermining Australia's National HIV Strategy, based as it is on a public health framework. Criminal prosecutions, and particularly reportage of those prosecutions by an unaccountable media, are inconsistent and counter-productive in terms of HIV prevention initiatives and fail to encourage a supportive environment for the care and treatment of people living with HIV.
- How might the disparate actors working across Australia's HIV response best engage and respond to increasing prosecutions for HIV exposure and transmission? Despite the extraordinary levels of expertise located across law, behavioural and scientific research, academia, governance and community, the HIV sector is only beginning to develop a targeted response on this particular issue. Understanding the criminal law process and the roles and responsibilities of the various actors therein poses new challenges for the HIV sector.

It is hoped that the collection of articles presented in this monograph will provide a timely and useful addition to the debate surrounding these questions.

Development of the Australian HIV response

The HIV sector's resistance to criminal prosecutions for HIV exposure or transmission through sexual activity is best understood in the context of Australia's HIV response: a response developed, negotiated, managed, and implemented over some 27 years.

Following the identification of AIDS⁷ in the early 1980s, Australian federal and state governments responded to HIV with surprising acuity. They were informed by, and soon working with, affected communities, particularly well-educated and networked advocates of urban gay men. (In chapter 6, Tomsen provides closer consideration of the social movements that had an impact on community response.) Governments, in partnership with HIV-positive people and affected communities, moved quickly and determinedly, often against broad, conservative public sentiment. Their actions included the roll-out of condom-vending machines, needle-and-syringe disposal bins, needle-and-syringe exchange programs and, most importantly, public campaigns (broad and targeted) which talked about the risk factors of HIV transmission: a brave feat given the taboo of public discussions of sex and drug use.

Within this developing 'partnership approach', government and community rejected archaic (although quite recent) public health management measures such as compulsory HIV testing and quarantine, and, instead, adapted an emerging model of public health management which recognised that the key to limiting HIV transmission lay in behaviour modification in an enabling environment. 'Enabling' meant engaging with at-risk and affected communities, listening to them, providing support for nascent community-based organisations to develop, and offering protection from stigma and discrimination. In short, ensuring that human rights were protected. That process facilitated genuine engagement by those communities most affected by HIV and an impressive community response, which has in turn led to vital and ongoing discussions facilitating improved official responses (Cameron 2009).

Key to the Australian HIV response has been the location of HIV as a public health issue. Consecutive national HIV/AIDS strategies have formalised and guided the response.⁸ Substantial infrastructure has been developed. Detailed HIV surveillance data is collected and analysed to inform HIV prevention, care and treatment. Behavioural and social research enables nuanced understanding of the circumstances in which HIV is transmitted. Community-based agencies develop policy and deliver education, advocate for grass-roots understandings, and work with government. Early public health response to HIV recognised that type of behaviour modification required to prevent HIV transmission would only be effective through the active engagement of affected communities. Gay men, people who inject drugs, and sex workers carried out peer-based education activities which provided information about why behaviour modification

and changes would be necessary. HIV continues to impact sexual relationships, most notably in Australia's gay communities where there is a strong and continuing commitment to HIV prevention (see chapter 7). Safe-sex messages have not had the same degree of impact on heterosexual relationships: an issue with ongoing implications.

Criminal prosecutions for HIV exposure and transmission must be included as a central part of national HIV policy considerations because the application of criminal laws to sexual behaviours involving HIV-positive people conflicts with the evidence of what constitutes an effective response to HIV. For a start, prosecutions focus significant attention and resources on a few individuals, thus misrepresenting HIV risk as:

the problem of HIV transmission through sexual behaviour . . . is one of relatively small risks accumulating over a population into a significant epidemic, not a small number of reckless transmitters. (Burriss et al. 2006)

The public health approach, arguably implemented in Australia more effectively than almost anywhere else in the world, has been supported by a series of National HIV Strategies. That public health approach acknowledges that HIV-positive and HIV-negative people will continue to have sex, and that this is not innately problematic given the positive value of human sexual expression (Wolf 2004). An effective HIV response considers sexual relationships as occurring between partners, with behaviours considered in terms of agency and shared responsibility regardless of sero-status. Criminal law sets up an adversarial relationship between an aggressor and a victim, and regards sexual relations in terms of endangerment and intent. In fact,

the way in which the 'harm' of HIV is constructed and reproduced through law . . . is no different from being beaten or poisoned. And yet is this the experience of infection? (Weait 2007)

Public health responses consider the norms of human behaviour and the context in which sexual relationships occur. Criminal law largely removes context and the 'meaning' of those sexual relationships to both parties in its consideration of harm. Public health talks of mutual responsibility: Criminal law attributes blame to one party only.

While the public health and criminal law responses to HIV might be understood as being informed by different (at times opposing) rationales, the prosecution of individuals for HIV exposure or transmission has brought the intersection of these two approaches into stark relief – and those points of intersection are problematic. For example, What of a person's decision to have an HIV test being used against them later in a criminal trial as proof of their HIV status and (given requirements on GPs to inform patients of their responsibilities) their awareness of their obligations to prevent HIV transmission? What of therapeutic/treatment notes being subpoenaed and used as evidence against a former (or 'current') patient? What of people's fear of prosecution reducing their honesty with health care providers, and subsequently reducing the effectiveness of their treatment? Criminal prosecutions undermine public health's HIV prevention and treatment response and, conversely, public health procedures undermine the appropriateness of a criminal law response except in very unusual circumstances.

Overview of Australian criminal law cases

Simultaneous to the roll-out of Australia's HIV public health response, some 22 criminal prosecutions have occurred.⁹ The first HIV transmission/exposure case to proceed through a committal hearing was that of a man charged in November 1992 (*Queen v PD*): notably, some 10 years after the first diagnosis of HIV in Australia. The man was charged under reckless endangerment offences for having unprotected sex with a woman without disclosing his HIV status. The accused was ordered to stand trial but died from an HIV-related illness before the trial commenced (Ward 1994). The first decision relating to HIV exposure risk was that in *R v B*, concluded in 1995. The first decision on HIV transmission was in *DPP v F* in 1998. All three cases were in Victoria.

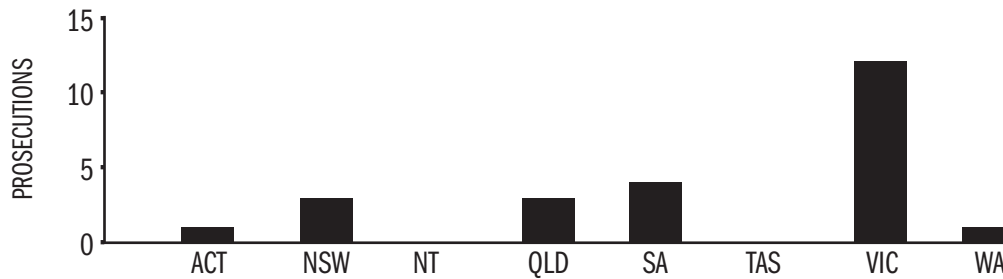
Until recently, prosecutions for HIV exposure and transmission may be best characterised as having occurred infrequently, with the first cases resulting in ‘not guilty’ verdicts or acquittal on appeal (*R v B*, *R v D*, and *Mutumeri v Cheeseman*) (Groves 2008). While individual cases evoked concern, the HIV sector offered limited response, perhaps because cases largely appeared to be ‘one offs’, and there were no links to police and justice departments that may have facilitated further discussion. Moreover, the fact that all prosecutions before 2002 occurred in one Australian state (Victoria) meant the issue was of some interest nationally, but did not become an issue of national concern¹⁰ until a confluence of events in recent years. All known criminal prosecutions for HIV exposure or transmission through sexual relations in Australia are presented in Table 1 below.

TABLE 1 Known Australian criminal prosecutions for HIV exposure or transmission through sexual relations

YEAR	STATE	CASE	OFFENCE	OFFENCE AGAINST	VERDICT
1993	Vic	<i>Queen v PD</i>	Transmission	Female (1)	None returned ¹¹
1995	Vic	<i>R v B</i>	Not Known	Male (1)	Acquitted
1996	Vic	<i>R v D</i>	Exposure	Female (2)	Acquitted
1998	Vic	<i>Mutumeri v Cheeseman</i>	Exposure	Female (1)	Guilty/Overturned on appeal
1998	Vic	<i>DPP v F</i>	Transmission (2), Exposure (1)	Male (3)	Guilty
1999	Vic	<i>R v Dirckze</i>	Exposure	Female (1)	Guilty
2001	Vic	<i>R v Thomas</i>	Transmission	Male (1)	Guilty
2002	WA	Houghton	Transmission	Female (1)	Guilty
2004	NSW	Kanengele-Yondjo	Transmission	Female (2)	Guilty/Upheld on appeal
2005	Qld	Reid	Transmission	Male (1)	Guilty
2006	SA	Parenzee	Transmission (1), Exposure (2)	Female (3)	Guilty/Upheld on appeal
2007	Qld	Richards	Transmission	Male (1)	Not guilty
2007	Vic	Kuoth	Exposure	Female (1)	Guilty
2008	Vic	Name suppressed		Male (1)	Not guilty
2008	Vic	Mwale	Transmission	Female(1)	Not guilty
2008	Vic	Neal	Exposure	Male (numerous)	Guilty
2008	Vic	Name suppressed	Transmission	Female(1)	Guilty
2008	NSW	Montgomery	Transmission	Female(1)	Guilty
2008	ACT	Scott (sex work)	Working with an STI		Guilty
2009	SA	McDonald	Transmission	Male (numerous)	pending
2009	SA	Chan	Exposure	Female (multiple)	pending
2009	SA	Unnamed	Exposure	Female (2 minors aged 13 and 15)	pending

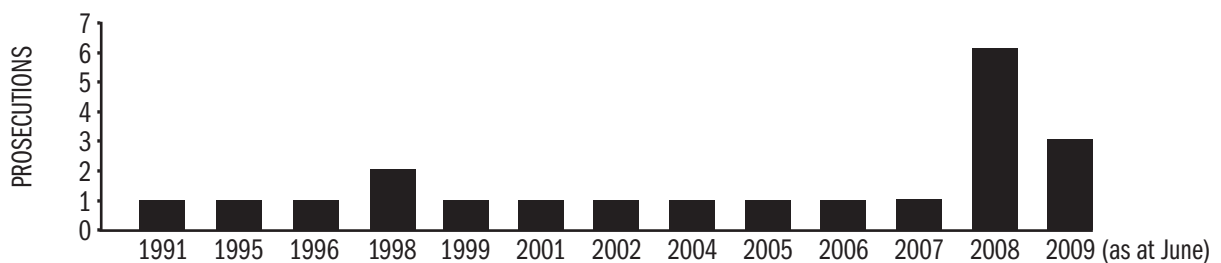
A disproportionate number of Australian cases (more than half) have been heard in Victoria over some 16 years: all seven prosecutions occurring prior to 2001¹² and a further five since 2007 (inclusive). However, prosecutions have now been held in six of eight jurisdictions, many occurring for the first time recently: 2004 in NSW, 2005 in Qld and 2008 in the ACT.¹³ In those instances, state laws which had not been applied (or tested) against HIV transmission/exposure were applied for the first time. For most states, the issue of HIV criminality linked to sexual acts moved from being ‘theoretical’ to actual.¹⁴

FIGURE 1 **Australian HIV Exposure/Transmission Prosecutions (by state)**



Since 2004, cases have occurred more often, with a notable national increase in prosecutions since 2007. Most states which had no history of prosecutions have recently experienced two or more (NSW, Qld, SA). As stated above, Victoria has conducted five since 2007.

FIGURE 2 **Australian HIV Exposure/Transmission Prosecutions (by year)**¹⁵

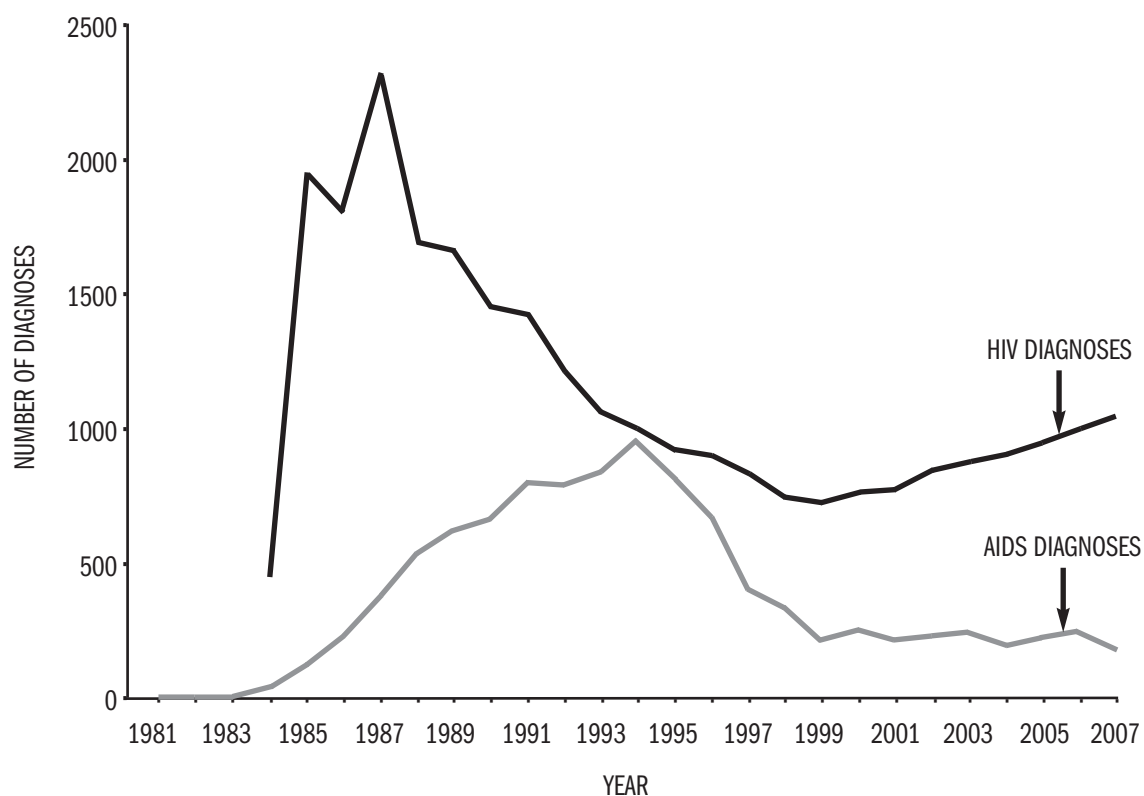


As the total number of prosecutions has increased, so too has the range of circumstances in which criminal charges have been laid. All accused have been men, but ‘victims’¹⁶ have included men and women in casual and committed sexual relations. Some men have been charged in relation to a single sexual partner, others in relation to more than one partner. Recently, two cases were pursued involving transmission that had occurred a decade ago or longer: Montgomery in NSW and an unnamed man in Victoria.¹⁷ The Victorian man was convicted despite the two parties having married five years after the woman had been infected and diagnosed.¹⁸ Two recent cases (Neal in Victoria and an unnamed man charged in South Australia in May 2009) involve HIV offences and sex offences against minors. This broadening of cases has raised the possibility that prosecutions may be pursued against individuals in an ever-increasing set of circumstances.

Changes in the social and political context

Although there is no direct correlation between increasing rates of diagnosis of HIV infection and prosecutions for HIV transmission/exposure, recent increases in HIV diagnosis rates have contributed to a heightened concern around HIV transmission. The annual number of HIV diagnoses in Australia peaked in 1987. Then following twelve years of decline, the annual number of new HIV diagnoses in Australia began to increase: an increase that has continued over the past eight years from 718 cases in 1999 to 1051 in 2007 (Figure 1): a significant increase of 41% over the preceding five years (NCHECR 2008). At the same time, AIDS diagnoses between 1999 and 2007 have remained relatively constant.

FIGURE 3 **Diagnosis of HIV infection and AIDS in Australia** (NCHECR 2008)



Note: AIDS diagnoses adjusted for reporting delays. **Source:** State and territory health authorities

Rates have varied across Australia. In New South Wales, the rate of HIV diagnosis per 100 000 population declined from 6.1 in 1998 to 5.1 in 2001 and then increased to 6.2 in 2007. The rate also increased in Queensland, South Australia and Western Australia, from 2.9, 2.4 and 2.8 in 1998, to 4.6, 3.6 and 3.6, respectively, in 2007. The rate of HIV diagnosis in Victoria almost doubled from 2.8 in 1998-99 to around 5.5 in 2006-07 (NCHECR 2008).

Broad sectors of the Australian media have reported widely on increases in HIV diagnoses and it is clear that in 2007 such reportage put the issue of HIV transmission in Victoria on the political agenda. A series of events morphed the issue of increased HIV diagnosis in Victoria into calls from the then prime minister to limit immigration of HIV-positive people to Australia (Cameron 2007). The issue of HIV had become re-politicised and included a questioning of the effectiveness of the public health measures that were in place. Because of the number of cases and substantial media coverage in Victoria, those working in HIV community-based organisations in that state were particularly concerned about the manner in which issues were conflated in media reports.

Given that criminal prosecutions for HIV transmission/exposure through sexual contact usually involve specifics about sex, fidelity, deception, sexual minorities and/or sexual activities 'on the fringe', it is not surprising that individual prosecutions have triggered more media reportage than others. These have included cases involving gay men with multiple sex partners (see, for example, Hurley and Croy's analysis of media coverage in Neal, chapter 8); African men (Persson and Newman as referenced in Menadue, chapter 11); and sex workers (see Jeffreys, chapter 9). While media reportage has varied from restrained to sensationalist and alarmist, the vast majority has contained an implicit message that one person is solely responsible for (an instance of) HIV exposure or transmission. That message is contrary to the public health approach and key HIV prevention education messages of shared responsibility.

The stigmatising effects of such media coverage on the broader population of HIV-positive people have been noted by Kidd (2005), Canavan and Rule (2007), and are considered by Menadue later in this monograph. Media reporting has only served to reinforce that the responsibility for preventing transmission lies solely with HIV-positive people and has therefore added a considerable sense of burden to those living with an already stigmatised disease. Mainstream media reportage has been about a minority of individuals in the context of legal action, but the potential is for HIV-positive people generally to be further stigmatised and stereotyped as having the potential to fall foul of the law.

Lastly, and perhaps most significantly, two high-profile cases (Neal in Victoria and McDonald in South Australia) have undermined faith in public health's capacity to work with those who put others at risk, and have ensured the criminalisation of HIV transmission/exposure has become a political issue. These two cases are discussed in some detail in chapters 8 and 11.

In this volatile political environment, a number of actions were undertaken, including no less than four reviews of guidelines on the management of HIV-positive people who place others at risk. Those reviews triggered the development of nationally consistent guidelines for management of people with HIV who knowingly place others at risk. The guidelines were approved by the Australian Health Ministers' Council (AHMC) and are being implemented across all jurisdictions.

The issue of managing those who put others at risk of HIV, and prosecutions for HIV exposure and transmission is now on the agenda of all those involved in Australia's HIV response. As yet, there is no agreed direction for policymakers in response to the increasing trend towards criminal prosecutions. The preparation of this monograph aims to educate policymakers about these complex issues and to inform an appropriate and sensitive policy response.

Why criminalisation is problematic

In recent publications, numerous authors have examined, and been critical of, the trend towards criminalisation of HIV.¹⁹ While few would argue against the prosecution of those who intentionally or deliberately harm others, most prosecutions are for 'recklessness' or 'negligence'. In some individual cases, criminal laws' consideration and response to the particular circumstances of the case and the sentences handed down raise concerns. However, greater harms arise simply through the location of HIV transmission in criminal law which 'fails to capture the various and complex meanings of HIV infection' (Weait 2007). As shall be argued here, prosecutions undermine public health prevention efforts and unnecessarily stigmatise HIV disease and HIV-positive people.²⁰

The media has generally spurned individuals for not disclosing their HIV status, thus communicating a strong message that individuals should expect HIV-positive people to disclose their status prior to sex, seemingly regardless of the level of 'safety' of the sexual act. This message is deeply problematic and places inappropriate pressure and expectations on HIV-positive people. Moreover, it is estimated that around one-third of new infections in Australia are the result of transmission from partners who are undiagnosed (Wilson et al. 2008). In these cases reliance on disclosure is obviously not an effective prevention strategy.

This issue is particularly important given recent findings from the *E-male Study* (Rawstorne et al. 2009) that condom use with casual sexual partners is more likely if there is no disclosure. Behavioural research into 'sero-sorting'²¹ has identified instances of 'miscommunication', where one HIV-positive person believes an HIV-negative person has communicated their HIV-positive status (and vice-versa) (Zablotska 2009). Some people are unwilling to disclose their HIV status, as confidentiality is often not maintained and respected. (HIV Futures 5 reports that 52% of HIV-positive respondents had had their HIV status disclosed without their permission²²). Some people do not disclose due to fear of rejection: unpublished data from the Positive Health study shows that as many as 27% of HIV-positive men surveyed have been sexually rejected due to their HIV serostatus (Zablotska 2009). The decision not to disclose may, legitimately, be informed by other decisions to use safer sexual practices or knowledge of having a low viral load and hence reduced risk of transmission. For a fuller discussion, see chapter 7.

Successive National Strategies have supported a range of prevention initiatives and have successfully positioned the concept of mutual responsibility as a cornerstone of the prevention effort. Notions of blame, culpability and fault threaten the mutual responsibility message fundamental to Australia's HIV response. Little is known about why some cases proceed to litigation and others do not.²³

Media coverage has the potential to misrepresent HIV transmission and exposure risk in many ways. In some jurisdictions outside Australia, HIV-positive people have been charged for spitting, scratching or biting, despite the fact that these behaviours carry an extremely low or no risk of transmitting HIV (Bray 2003). While no specific charges have been laid, the association of biting with HIV transmission was recently raised and reported in a Brisbane court (Cameron 2008).²⁴ Similarly, the reporting of unsubstantiated testimony as 'fact' potentially misrepresents scientific knowledge of HIV and HIV transmission.

The reporting of HIV-related prosecutions has the potential to reinforce the notion that HIV is contracted from certain people (gay men, sex workers, African men, etc.) as opposed to particular behaviours: 'sexually active gay man' becomes 'HIV man' – in no less than seven headlines (see chapter by Hurley and Croy), sex worker working while HIV-positive becomes 'Sex worker purposely spread STD' (Jenkins 2008) and 'Police search for victims of HIV prostitute' (Benson 2008). This misinformation may also lead to increased vilification of groups of people and to increasing the stigma and discrimination already experienced by particular marginalised groups in society.

Media coverage of sporadic criminal prosecutions for HIV transmission and exposure may create a false expectation among those who believe themselves to be HIV-negative that criminal laws offer the individual and the community protections.²⁵

Prosecutions of HIV-positive people for transmitting HIV reinforce stigma based on the 'othering' of all HIV-positive people. Media coverage has unambiguously stressed notions of risk-taking and deceit in their portrayal of the accused. There is an unfortunate irony that in the publication of these stories that take as their subtext 'the dire consequences of HIV transmission', the logic and language of public health is absent, when it is that approach that has most effectively driven the successful HIV response in Australia and has ensured the greatest protections to HIV-positive and HIV-negative people alike. As Hurley and Croy outline in chapter 8:

Media articles can rarely be considered objective, and consequently 'the media' . . . wields enormous power. Not only do journalists choose 'the facts' they report and the style of reportage, media research indicates that news can frame and cue 'issue regimes' and structure public response.

It is the way in which a public response is 'structured' that causes the greatest concern for HIV-positive people. As explored by other authors in this monograph, the potential is for all HIV-positive people to be stereotyped and further stigmatised. Stigmatisation is abhorrent per se, but it also has an impact on people's preparedness to be HIV tested, to seek support and treatment (including openly discussing risk behaviours), and to disclose HIV status. Stigmatisation also leads to individuals feeling isolated with resulting psychological and physical effects.

Principles of a best-practice response

The chapters that follow in this monograph lend support to what is being described as a 'global movement' against the criminalisation of HIV transmission, which argues that legal intervention is an appropriate and warranted intervention in cases of wilful transmission,²⁶ but that HIV transmission must remain a public health concern and not a matter for the courts.

Basic human rights must be protected and the core principles of the national HIV response maintained. These include a right for all adult Australians to have a safe, active and fulfilling life (including a sexual life) free from discrimination and stigma, regardless of HIV status. Community education and support for primary HIV prevention efforts must continue in a manner which encourages all people to be informed and supported in practising safer sex. This must include making available accessible and culturally

appropriate information and resources to assist understanding and effective management of the risk of HIV transmission. Community education and health promotion, alongside culturally appropriate and sensitive public health interventions, are effective tools for preventing the spread of HIV. Criminal law can play no role in preventing HIV, as punitive or blame-oriented interventions are ineffective at changing sexual practice or behaviour.²⁷

Policy responding to criminal prosecutions must be a key focus of the development of the Sixth National HIV/AIDS Strategy. That requires the application of some thought to our curious predicament of a National Strategy undermined, interrupted and challenged by actions of the criminal legal system (police, prosecutors and the courts). Would the development of police and crown prosecution service guidelines²⁸ for HIV transmission cases be of assistance in reconciling criminal law rationales and the public health imperative? Is law reform required, as is suggested in the international response to HIV criminalisation?²⁹ For example, there remains a great deal of scepticism about laws requiring disclosure before sex (Buchanan 2009) and significant doubts about reliance on disclosure as a safe-sex strategy, yet there are a range of legal requirements of people with HIV to disclose their status to sexual partners.

At the level of service-provision, HIV services must be resourced to better understand their role and the positioning of their staff in relation to this issue. Cross-agency linkages must be promoted and developed,³⁰ and partners in the Australian HIV response, familiar with HIV and public health policy, must develop strategies to engage with criminal law and those working within the legal frameworks. Further research on this issue is urgently required to ensure the Australian HIV response remains evidence based. Further consultation and dialogue is needed between agencies and jurisdictions in applying the *National Guidelines for the Management of People with HIV who Place Others at Risk*, to ensure public health procedures are fully equipped to address those rare instances when individuals knowingly or recklessly place others at risk of HIV infection. But mostly, there must be ongoing commitment to enforce and deliver the many and varied public health laws, policies, guidelines and procedures that provide Australians the international best-practice response to HIV.

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Endnotes

- 1 Note:** people have been prosecuted for transmitting HIV to a sexual partner, and also for exposing a sexual partner to HIV (i.e., where transmission has not occurred).
- 2** That diagnosis related to an Australian returning after living overseas for some years. An earlier Australian diagnosis (December 1982) was of a tourist visiting Australia. For a full breakdown of HIV population statistics, see the *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report* by the National Centre in HIV Epidemiology and Clinical Research
- 3** The most recent available data until September 2009
- 4** Estimated at December 31, 2007 at 16,692
- 5** See articles on criminalisation of HIV in *HIV Australia* Vol 6 No 4
- 6** See <http://criminalhivtransmission.blogspot.com/2009/06/global-prosecutions-league-table>
- 7** It was some time before the HIV virus was identified.
- 8** Currently the fifth national strategy, *National HIV/AIDS Strategy – Revitalising Australia's Response 2005-2008* (Australian Department of Health and Ageing 2005), which has been extended into 2009
- 9** This chapter does not consider legal issues raised in those cases. For an overview, see Groves A and Cameron S (2009) 'Criminal prosecution of HIV transmission: the policy agenda', Australian Federation of AIDS Organisations.
- 10** Australian policy development is often hindered by the difficulty of coordinating across eight jurisdictions spread over a large geographic area: a problem compounded when there is more than one key agency in each jurisdiction.
- 11** Committed to stand trial but died before hearing
- 12** Please note, this does not include two sets of charges laid in 1991 that were dismissed.
- 13** The prosecution of Scott for sex work offences is included here.
- 14** And in the case of NSW, arguably led to the never-used HIV specific offence being revoked and the Criminal Code (Act) redrafted after the offence was shown to be largely unworkable.
- 15** Dates generally refer to the judgment on the initial prosecution (not to appeals which were decided later), except for the 1991 case where committal proceedings were concluded but the person died pre-trial, and the 2009 case of McDonald in SA which has not yet been decided.
- 16** The term 'victim' is used here because that is the way in which criminal law characterises those parties in the sexual relationship.
- 17** There is no statute of limitations on serious crimes (generally those to which jail terms apply) so persons may be prosecuted for acts of HIV transmission that occurred many years previously.
- 18** So the offender was known to the 'victim' throughout that period. In fact, the offence was not enough to destroy the relationship or stop the woman from marrying her 'assailant'; again making the point that simple notions usually associated with crimes may not be easily applicable to HIV-related cases.
- 19** These publications include but are not limited to *Intimacy and Responsibility: The Criminalisation of HIV Transmission* (Weait M 2007), *Do Criminal Laws Effect HIV Risk Behavior? An Empirical Trial* (Burris et al. 2006), *Policy Brief: Criminalization of HIV transmission* (UNAIDS/UNDP 2008), and *Ten Reasons to Oppose the Criminalization of HIV Exposure or Transmission* (Open Society Institute 2008). GNP+'s Global Criminalisation Scan aims to map the issue across the globe, while E Bernard's website <http://criminalhivtransmission.blogspot.com/> provides a sense of the increasing number and range of recent prosecutions across countries.
- 20** These two points have been clearly argued in the Open Society Institute's *Ten Reasons to Oppose the Criminalization of HIV Exposure or Transmission* (2008) but the arguments are expanded here in the Australian context.
- 21** Where HIV-positive or HIV-negative people endeavour to identify sexual partners based on shared HIV status.
- 22** And while many of these disclosures were not by people with whom they'd had a sexual relationship, it certainly informs positive people's understanding that information about their HIV status cannot be controlled once disclosed.
- 23** Questions remain under-researched, including who makes a complaint to police or agrees to act as a witness

against an accused when approached by police, who feels victimised and why?

24 In Brisbane in January 2008, an HIV-positive man struggled and bit a police officer during an arrest for public drunkenness. The man was charged with serious assault to which he pleaded guilty. Despite the bite not breaking the police officer's skin, the judge handed down a 12-month sentence, stating: 'When I first became a judge . . . it was unheard of for anyone to bite or spit on a police officer but in recent years I have had to deal with many many cases . . . There are now diseases in the community which are spread like this.'

25 And at times some of those reports include fiction.

26 www.aidsmap.com/en/news/7B12A6C8-95DB-4AFE-B678-233BEC8E09CB.asp

27 Such positions are supported in the NAPWA Criminalisation and the sexual transmission of HIV Policy position – January 2007

28 Strategies discussed in Groves A and Cameron S (2009) *Criminal prosecution of HIV transmission: the policy agenda* Australian Federation of AIDS Organisations, Sydney

29 www.ippf.org/en/Resources/Guides-toolkits/Verdict+on+a+virus.htm

30 Strategies discussed in Groves A and Cameron S (2009) *Criminal prosecution of HIV transmission: the policy agenda* Australian Federation of AIDS Organisations, Sydney

Legality

International trends towards the criminalisation of HIV transmission UK, New Zealand and Canada: laws, cases and response

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Internationally, different jurisdictions have taken a variety of selective approaches to addressing 'problematic' instances of HIV exposure and transmission: some writing HIV-specific criminal laws or broader disease transmission laws, others re-interpreting more general criminal statutes to include HIV transmission during acts of consensual sex.² For the most part, global campaign efforts have focused on dissuading governments from drafting HIV-specific legislation, arguing that HIV-specific laws are both stigmatising of people with HIV, and unnecessary as broad criminal laws should be applied to particular instances of a person deliberately or recklessly inflicting harm on another person (e.g., UNAIDS/UNDP 2008). That argument is consistent with the UN High Commission for Human Rights and the Joint UN programme on HIV/AIDS (1996) *HIV/AIDS and Human Rights International Guidelines*, which state that 'criminal and/or public health legislation should not include specific offences against deliberate and intentional transmission but rather should apply general criminal offences to these exceptional cases.' Unfortunately, that argument has had unexpected consequences.

While some lawmakers are considering or have introduced HIV-specific transmission criminal laws, notably those in 28 US states (American Civil Liberties Union 2008 and GNP+ 2009) and at least a dozen in West and Central African countries (Pearshouse 2008), most other jurisdictions have seen their general criminal laws applied to HIV transmission (including transmission lacking 'intent') with increasing frequency: a relatively remote possibility only a decade or so ago.

It is far beyond the scope of this paper to consider HIV laws and their implementation in countries throughout the world,³ so instead it focuses on three jurisdictions: the United Kingdom (particularly England and Wales), New Zealand and Canada. While those HIV epidemics share some similarities, it is the systems of governance and specifically the legal systems based on shared Commonwealth history, that are of particular relevance to each other and to Australia. Numerous cases have been included because it is in the details of the many and varied cases that a broad range of intersecting issues become apparent.

United Kingdom

UK prosecutions for transmission of HIV (and also other serious health conditions such as hepatitis B and C) have taken place in Scotland (which has an independent legal system) since 2001, and in England and Wales (which share a legal system) since 2003. Until that time, it was widely believed that such prosecutions could not take place. However, old and generic assault laws were unexpectedly extended by the courts to apply to disease transmission. The following concentrates on the law and cases in England and Wales, where most UK cases have occurred.

People are charged under the *Offences Against The Person Act 1871*: s18 'wounding with intent to do grievous bodily harm (the intentional provision)⁴ or s20 'inflicting bodily injury, with or without a weapon' (the recklessness provision).⁵ The first person charged in England (2003) was initially charged under the intentional provision, but those charges were reduced to the recklessness provision given the difficulty of proving sexual HIV transmission with intent. All subsequent cases in England and Wales have been tried using s20. There is no offence of recklessly exposing someone to HIV in England and Wales.

There have been 15 prosecutions for 'reckless' HIV transmission in England and Wales as at April 2009 (and one each for hepatitis B, herpes and gonorrhoea⁶). Of these, 11 HIV defendants (and the gonorrhoea and the hepatitis B defendants) were found guilty and sentenced to between one and ten years⁷ imprisonment. Generally, those convicted have been sentenced to around three years, which is considerably above the average sentence for the same offence when not related to HIV transmission (James 2008).

Each case raises its own particular issues. However, the following raise particular points of relevance to this paper.⁸

- The first English prosecution⁹ did not run smoothly. In 2003, an African man with refugee status was convicted for infecting two women with HIV. It was alleged that condoms were abandoned as he had told the women he did not like using them. As noted above, he was originally charged with intentionally inflicting grievous bodily harm but that charge was reduced to recklessly causing grievous bodily harm. Even so, his conviction was overturned on appeal in 2004 and he was retried. Finally, after four trials and two appeals, he was found guilty of infecting one of the original two women, and was sentenced to four and a half years in prison (which the judge stated would have been a longer sentence if he were able to make it so). An attempt to deport him at the end of his sentence did not succeed.
- In 2004 a man, reportedly seeking asylum from the Ivory Coast, was convicted in Liverpool after pleading guilty to infecting a woman.¹⁰ He was sentenced to six years (including time for 20 other non-HIV-related offences), with a recommendation that he be deported after serving his sentence. This case was notable because the man was convicted despite not having been diagnosed HIV-positive at the time of the offence, although the intricacies of that have been misreported. Evidence was presented that a doctor who treated him in Africa for sexually transmitted infections told him he was at 'high risk' of HIV infection and recommended he take an HIV test. However, the prosecution and judge agreed that did not constitute knowledge of his HIV-positive status. Rather, the court found the man knew he had HIV after his monogamous wife told him she had been diagnosed HIV-positive. He was convicted of infecting another woman after that time. This case led to the notion of 'wilful blindness' included in the 2008 Crown Prosecution Service (CPS) policy and guidance to prosecutors (referred to below).
- In 2004 a man, originally from Malawi and settled by an asylum service, was convicted of infecting three women.¹¹ He was sentenced to 10 years, with deportation recommended on completion of his prison term. His conviction was upheld on appeal in 2005. This case was important for two reasons. Firstly, it came to the attention of the police following a complaint from the GP of one of the women who was 15 at the time of the offence. Secondly, a key outcome of the appeal related to the notion of consent. The Court of Appeal rejected the argument that by agreeing to unprotected sex the women had consented to the risk of HIV transmission. The Court considered the women's consent to be invalid as they were unaware their partner had HIV, meaning they did not give informed consent. This judgment effectively means that people with HIV who do not tell their sexual partners they have HIV before sex are liable to prosecution if an infection then follows.
- In 2005, a 20-year-old woman from Newport (18 years at the time of the offence) was the first person prosecuted in Wales.¹² She pleaded guilty to infecting her heterosexual partner (claiming it was during attempts to become pregnant). She was sentenced to two years in a young offenders' institute. Of note, the woman stated during court proceedings that health department staff had advised her that it was very difficult for a woman to infect a man, and that she didn't know how to disclose her HIV status to her partner.

- The first conviction of a man for transmitting HIV to another man was in 2006. Although news reports (including Carter 2006) stated the man pleaded guilty because the defence barrister was advised by the prosecution barrister that the phylogenetic analysis evidence was conclusive, this was not the case. Court transcripts reveal that phylogenetic analysis evidence was not described as conclusive by defence, prosecution or judge, and was instead considered only one element of evidence which included HIV testing and the sexual history of the complainant. Transcripts also suggest the defence did not rely on the advice of the prosecution. The reliability of phylogenetic analysis was not tested as a result of his guilty plea. Following his conviction and a refusal to retry the case, the man disappeared and was not present in August 2006 when he was sentenced to four years and three months in prison for reckless transmission of HIV. He remains at large.
- In June 2006, a woman pleaded guilty to recklessly transmitting HIV to a man, and was sentenced to 32 months in prison.¹⁴ A worrying feature of this case was the way in which the investigation was carried out. The ex-partner who originally complained to the police that the woman had HIV and was having unprotected sex, was not HIV-positive. However, on discovering that the defendant had HIV, the police appear to have actively investigated her previous sexual partners, one of whom agreed to make a complaint against her despite having previously declined to do so. Press reporting of this case was highly sensationalist and largely inaccurate. Despite the conviction being for reckless transmission, tabloid newspapers were particularly irresponsible, speculating (among other things) that the infection was 'deliberate' and that the woman was 'seeking revenge'.
- In 2006, a London man was acquitted of transmitting HIV to his male partner.¹⁵ The judge directed the jury to find the defendant not guilty after evidence given in his defence by an expert virologist. The defence case successfully argued that it was impossible to prove whether or not the man had passed HIV to his partner because the complainant had a clear history of unprotected sex with others without regularly testing for HIV. This was the first prosecution for HIV transmission to end in a not guilty verdict. It is a particularly important case because it is this case which challenged the erroneous belief that virological evidence could provide a level of proof similar to DNA or fingerprint evidence: changing the way phylogenetic analysis is understood.

Response

A feature of the UK prosecutions has been the vigorous challenges from relatively early on by a range of legal and public health experts and HIV support and policy groups, of the use of criminal law, the evidence used to establish guilt, and the manner in which cases have been conducted and reported.

All four acquittals, and many investigations that have not made it to court,¹⁶ relied heavily upon a combination of scientific evidence and sexual health records to fend off the charges. Notably, the 2006 case in Kingston Crown Court established that phylogenetic evidence of similarities or differences in the viruses of the two parties in a case could rule someone out as a suspect but were not, alone, enough evidence for a conviction where sexual histories showed that other parties could have been responsible for transmission (Bernard et al. 2007). This understanding was subsequently accepted by the CPS and incorporated into their guidance to prosecutors.

UK HIV organisations have succeeded to some degree in rolling back the mounting number of prosecutions in England and Wales (though not, so far, the number of accusations and investigations) by a proactive approach to working with the authorities on both policy and practice (Azad 2008). Instigated by the National AIDS Trust (NAT) and Terrence Higgins Trust (THT), HIV NGOs, PWHIV and clinicians worked with the CPS to produce relatively clear policy on prosecutions for sexual transmission of infection. This policy has greatly clarified the issues and risks for people with HIV and those working with them and shortened the misery of certain investigations when police are aware (or made aware) of CPS policy.

The same NGOs have subsequently gone on to challenge policing tactics for these offences (Terrence Higgins Trust 2008), with THT producing a review of police handling of cases, in collaboration with the Association of Chief Police Officers (ACPO), the Metropolitan Police (London's force) and community groups (Terrence Higgins Trust 2009). NAT is now engaged with ACPO to turn this review into guidelines for English and Welsh police forces.

NAT has also analysed transcripts of HIV transmission trials to show how the judicial process interacts with HIV stigma and poor understanding of the virus by the legal professions (Azad 2009), and has actively worked with the National Union of Journalists to reduce stigmatising coverage of cases in the media (NAT/NUJ 2007).

Alongside the above work, THT and other HIV service organisations, such as Manchester's George House Trust, have been closely involved in supporting people with HIV in all aspects of criminal cases as defendants, accusers and witnesses. THT has maintained records of all known cases and information on how they have been conducted. This close practical knowledge has enabled a body of experience which means that those people accused who are well informed and contact THT or others for expert help at an early stage, have a far greater chance of a fair trial than they had earlier in the decade.

Unfortunately, not all people with HIV know how to contact HIV support services, and it is notable that successful prosecutions have disproportionately been of migrants and people with poor mental health or other forms of social disadvantage. Acquittals and dismissals are more likely to be achieved by white gay men, especially those with financial independence. That being said, gay men are subject to more proactive policing around HIV, and there have been a number of cases where they have come to the attention of the police for other offences and ended up being intensively questioned about their sex lives, or forced to call previous partners and disclose their status. There is a clear need for police guidance to cover not only the conduct of transmission cases, but also the treatment of suspects with HIV for any offence.

Concurrent with these actions, an enormous amount of debate has taken place within the UK's HIV and sexual health sector on the use of the criminal law to regulate public health and the difficulties and dangers of such a course. It would be fair to say that the situation has gone from one where it was extremely difficult (in 2003-4) to stand against the clamour for vigorous and frequent use of the law, to one where even senior politicians are beginning to question the appropriateness of its use.

The English and Welsh experience shows that proactive engagement with the authorities, combined with vigorous support for all people with HIV involved in cases, can mitigate some of the negative impacts of the use of criminal law. Still, much more needs to be done to put public health before punitive, ineffective use of the criminal law.

New Zealand

The laws used to prosecute HIV exposure and HIV transmission in New Zealand are not HIV or disease specific. Prosecutions have been based on four sections of New Zealand's *Crimes Act 1961*, summarised below (for the full text of the sections please refer directly to the *Crimes Act*).

S145 Criminal nuisance

A person commits criminal nuisance if they do something unlawful or fails to discharge their legal duty and that endangers another person's health, safety or life. They may be imprisoned for up to one year.

S156 Duty of persons in charge of dangerous things

HIV-positive people's infectious bodily fluids are considered something HIV-positive people can control, so they are under a legal duty to take reasonable precautions to avoid transmitting HIV to people so that another person's life, health or safety is not endangered.¹⁷

S188 Wounding with intent (2)

If HIV is transmitted by the accused with intent to injure or with reckless disregard for the safety of others, the positive person will be criminally liable and may be sentenced to up to seven years jail.

S201 Wilfully infecting with a disease

An HIV-positive person may be found guilty of wilfully infecting another person with a disease if they are found to have wilfully and without lawful justification or excuse, caused or produced a disease or sickness in any other person. The person may be imprisoned for up to 14 years.

There have been ten cases of HIV-positive people (all male, with one man charged twice in two separate prosecutions) prosecuted for having sex without disclosing their HIV status. Eight cases resulted in a guilty verdict. One is pending as at June 1, 2009. The first person, Mwai, was convicted in 1995¹⁸ for having unprotected sex with five women without disclosing his HIV status or using a condom. Two of the women became HIV-positive. On appeal, the defence attempted to challenge the application of section 156, arguing there were many biological factors that influenced whether or not a single sexual encounter might result in HIV transmission, and consequently the defendant could not 'control' the virus so had not failed to discharge his legal duty. This argument was flatly rejected by New Zealand's Court of Appeal.

The Mwai case generated significant media speculation and comment (much of it prurient and racist) with a focus on the accused's identification as a 'Kenyan migrant'. Ensuing debate challenged strategic HIV policy development, with calls for the New Zealand government to tighten immigration policy, including introducing mandatory HIV testing¹⁹ and a proposition that mandatory testing be applied to women who had become pregnant after having sex with men from Africa, Asia or the US. New Zealand AIDS Foundation (NZAF) worked with other key stakeholders to ensure those demands were not implemented as a knee-jerk reaction to the case.²⁰

The concerns that HIV in New Zealand would become a heterosexual epidemic were still apparent in the mid-1990s. However, of the HIV diagnoses reported to have occurred in New Zealand in 2008, 83% were between men who have sex with men (MSM) (AIDS Epidemiology Group 2008). Despite the high proportion of MSM transmissions, only three of the eight convictions have involved male-to-male transmission. Further, of the five heterosexual men prosecuted, two were African, and three of the eight suffered from a diagnosed mental illness or low intellectual ability (New Zealand AIDS Foundation 2009).

Since the first conviction in 1995, six other men have been convicted of criminal nuisance. One of those was Dalley, who was found guilty of criminal nuisance for having unprotected sex with a female partner over a period of time but failing to inform her he was HIV-positive. Police requested a nine-month jail term but the judge sentenced him to 300 hours' community work, six months' supervision and told him to pay \$NZ100 reparation to the woman to cover her counselling costs and expenses.

In 2005, a second prosecution of Dalley resulted in a landmark decision on the centrality of condom use as an HIV prevention tool.²¹ Dalley was charged under sections 145 and 156 for endangering a female sexual partner's health by exposing her to HIV (i.e., not transmitting HIV) after failing to inform her that he was HIV-positive. The first charge concerned oral intercourse (by both parties) without a condom. The second charge related to vaginal intercourse during which Dalley used a condom.

Oral intercourse The woman testified that Dalley did not ejaculate during oral intercourse and that there had been only a 'tiny bit' of pre-ejaculation fluid. The judge accepted the defence evidence of one of the expert witnesses, an infectious disease clinician and Chair of the Ministry of Health's AIDS Medical and Technical Advisory Committee, Dr Meech, who cited a ten-year Spanish study finding no case of transmission through oral sex. Meech suggested best-guess estimates put the risk as somewhere around a 1 in 10,000 to 1 in 20,000 risk. The judge found '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 it does not register as a risk'.

Vaginal intercourse The judge referred to the Mwai²² case, which had found that reasonable precautions and reasonable care require condom use. She then considered whether the use of a condom was sufficient to constitute reasonable precautions against and reasonable care to avoid the transmission of the HIV virus. Judge Thomas noted that the risk of transmission from an HIV-positive man to a woman during vaginal intercourse was 'relatively low', finding that expert evidence was relatively consistent: the prosecution putting that risk at approximately 5.75%, the defence putting the risk at between 8-20 per 10,000 exposures or alternatively at 0.1%. The judge decided 'the evidence for the defence was extensive, comprehensive and persuasive on this point.'

The judge then tested evidence on the reliability of condoms, dismissing prosecution's evidence of high levels of condom slippage and breakage, finding condoms to be 80-85% effective, 'thus significantly reducing the risk of HIV transmission during vaginal intercourse which, even using the prosecutions figures, is low'.²³ Expert doctors were asked what advice they gave to patients to prevent HIV transmission: their advice confirming their emphasis on safe sexual practice, not disclosure.

The judge relied heavily on medical and scientific evidence, and decided that Dalley had taken reasonable (as required, rather than 'failsafe') precautions and was not guilty of criminal nuisance, also noting:

It seems to me that most people would want to be told that a potential sexual partner was HIV-positive. There may well be a moral duty to disclose that information. There is, however, a difference between a moral duty and a legal duty, the legal duty in this case being to take reasonable precautions against and use reasonable care to avoid transmitting the HIV virus.

This case established that for an HIV-positive person to discharge their legal duty to take reasonable precautions, it is not necessary for them to disclose their HIV-positive status to heterosexual partners if a condom is properly used for vaginal intercourse. While the case did not consider the higher risks involved for anal intercourse, the new public health message was significant for all people living with HIV. For the first time, criminal law supported the use of a condom as a reasonable precaution suitable to discharge the duty to take care, rather than the emphasis being on disclosure of HIV status. Clarity on legal obligation/risk in relation to oral sex without a condom was also welcomed.²⁴

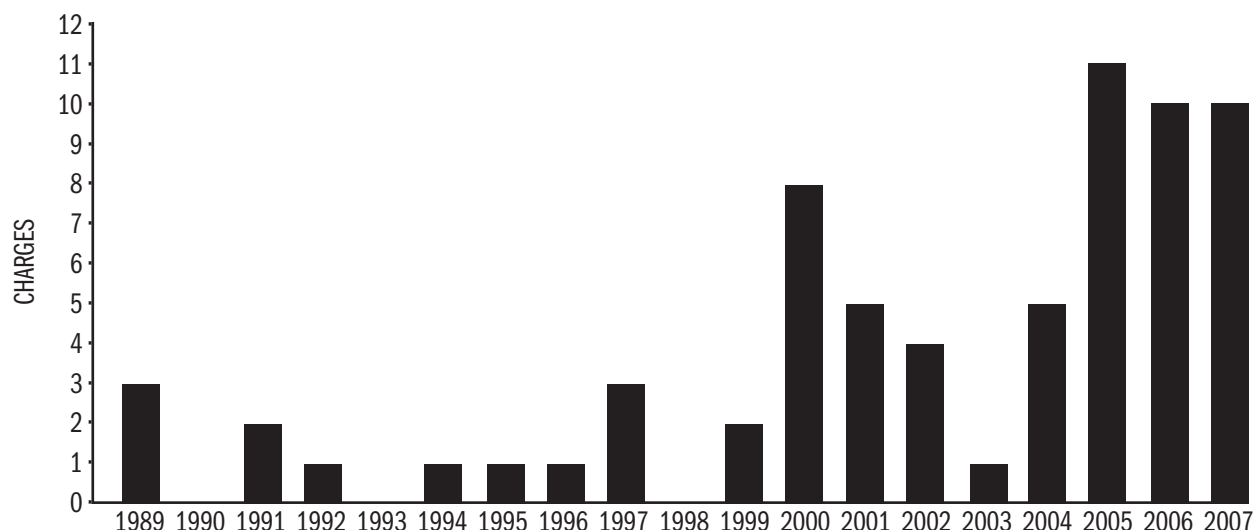
Response

During the second Dalley prosecution, NZAF and Body Positive Inc (the largest PLWHIV organisation in NZ) worked hard to ensure both prosecution and defence were well informed of the scientific evidence on the actual risk of transmission. Both the convicted man and the witness were supported through the trial. Non-government organisations working in HIV prevention and care and support for people living with HIV welcomed the decision, making the point that while disclosure may be deemed by many as ideal, it does not necessarily ensure HIV transmission does not occur and has resulted in violence, stigma and damning rejection of individual people living with HIV, and PLHIV generally. The ultimate goal of a public health approach must be for the law to support the principle that the prevention of HIV transmission is in the best interest of public wellbeing. At the time of the decision, NZAF stated that 'relying on HIV-positive people to tell you, and assuming that unprotected intercourse is safe if HIV is not mentioned, is a much riskier strategy [than routinely practising safe sex], especially as approximately one third of people with HIV in New Zealand don't know they have it' (Le Mesurier 2005).

Canada

As in the UK and New Zealand, Canada does not have specific HIV exposure/transmission laws; however, to date almost 90 people have been criminally charged under Canada's *Criminal Code* for HIV exposure or transmission,²⁵ with the annual number of prosecutions having increased dramatically since 2000. The vast majority of charges and convictions have been against HIV-positive men who have had unprotected sex with a woman or women. There have been a number of cases of HIV-positive women who have had sex with a man or men, and some 12 cases²⁶ against HIV-positive men who have had sex with a man or men.

FIGURE 1 **Charges laid for HIV Exposure or Transmission** (Canada, 1989-2007)²⁷



S180 Common nuisance

As in New Zealand, ‘nuisance’ charges have been laid against HIV-positive people accused of exposing others to HIV through sexual contact (termed ‘criminal nuisance’ in New Zealand and ‘common nuisance’ in Canada). Section 180 of Canada’s *Criminal Code* states that any person who ‘does an unlawful act or fails to discharge a legal duty’ and, as a result, ‘endangers the lives, safety or health of the public’, commits the offence of *common nuisance* which carries a maximum sentence of two years’ imprisonment (one year in New Zealand). The first HIV application of this charge related to an HIV-positive man charged for donating blood. All other prosecutions for common nuisance have involved sexual activity by HIV-positive persons (Canadian HIV/AIDS Legal Network).

S219 and S221 Criminal negligence

A person may be charged with criminal negligence if they do anything or omit to do anything thereby showing ‘wanton or reckless disregard for the lives or safety of others persons’ (s219). The person’s actions must represent a ‘marked and substantial’ departure from the care that would be exercised by a ‘reasonable person’ in the circumstances.²⁸ If the negligent conduct causes bodily harm to another person, it is a criminal offence, carrying a maximum penalty of 10 years.

Assault

Since 1989, HIV-positive people prosecuted for transmission cases have been charged with *assault* (s265), *assault causing bodily harm* (s267), and *aggravated assault* where an assault ‘endangers the life of the complainant’ (s268), *sexual assault* – an assault committed in circumstances of a sexual nature such that it violates a person’s sexual integrity s271), *sexual assault causing bodily harm* (s272), and *aggravated sexual assault* that endangers the life of the complainant (s273).

In some respects, the application of assault charges reflects Canadian criminal prosecutions having taken a different path from that taken in the UK, New Zealand and Australia, enabled by a 1998 Supreme Court ruling on ‘consent’ (*R v Cuerrier*). Under Canadian criminal law, an HIV-positive person has a duty to disclose his or her HIV status before engaging in conduct that poses a ‘significant risk’ of transmitting the virus to another person.²⁹ When such a risk exists, lying about or not disclosing HIV-positive status is treated as a ‘fraud’ that makes the other person’s consent to sex legally invalid.³⁰ One partner cannot give consent for sexual relations if the other fails to disclose an HIV infection (Elliott R 2002 and Groves M 2007), which means the sexual act becomes an assault.

One of the unfortunate consequences of Canada's approach to HIV transmission prosecutions through sexual contact is that those found guilty are labelled 'sex offenders', which, given the seriousness of both the crimes of sexual assault and the public's understanding of the associated label, will in many cases be inaccurate, inappropriate and/or extremely stigmatising, i.e., in the general public's thinking, those found guilty are effectively labelled 'rapists'. Another unfortunate consequence has been the lengthy sentences applied to those convicted: sentences based on understandings of harm caused by assault and sexual assault, rather than HIV transmission: Maximum sentence for assault – 5 years; assault causing bodily harm – 14 years; aggravated assault – 14 years; sexual assault – 10 years; sexual assault causing bodily harm – 14 years; and aggravated sexual assault – life.

Another significant Canadian case, *R v Williams* (decided by the Supreme Court in September 2003), considered the possibility of an HIV-positive person infecting someone before the 'accused' had been tested for HIV. Williams began an 18-month relationship in June 1991 with a woman who would eventually become the complainant. They had unprotected sex on numerous occasions. In November 1991, Williams received HIV test results stating he was HIV-positive. The complainant received a negative test result a few days later. The Court acknowledged she may have already been infected but still in the 'window period' between infection and seroconversion. Williams did not disclose his HIV status and the relationship, including unprotected sex, continued for another year. Williams was counselled on three different occasions by two doctors and a nurse about HIV, its transmission, safer practices and his duty to disclose his HIV status to sexual partners.

In *R v Williams*, the court found that a person could be convicted of 'attempted aggravated assault' and 'common nuisance' if aware there is a risk they may be HIV-positive but do not disclose that risk to their prospective sexual partners, i.e., before an HIV test is conducted (or considered). No such charges have been laid to date.

The Williams case also presented medical evidence raising the possibility that even if the complainant was already HIV-positive, they may have been re-infected with a different and possibly drug-resistant strain of HIV through continued unprotected sex. Although the argument was not applied in the decision, the Supreme Court ended its judgment by expressly noting that in future cases, this line of legal argument could be pursued, and that a court might conclude that even if a person were already infected with HIV, the possibility of re-infection with another strain could represent a 'significant risk of serious bodily harm' and therefore there might still be a duty to disclose (Canadian HIV/AIDS Legal Network 2006). (Of note, the 'super infection' thesis was recently considered but not pursued in Australia in *Mwale*.)³¹

Canada's HIV transmission cases are now many and varied, with cases frequently raising issues of some considerable concern. Consider a few recent cases:

- **Handy (2008)**,³² a young man with a diagnosed mental illness (schizoid-affective disorder³³), met a 55-year-old gay man in an internet chat room, and later had two unprotected sexual encounters. Handy did not inform the man he was HIV-positive. Handy testified that he believed he had sweated out the virus, but had moments of clarity, prompting him to phone the man and inform him of his HIV-positive status some hours after the second encounter. Despite the judge recognising Handy had a mental illness affecting his judgment and that Handy had genuinely expressed his remorse, the judge sentenced Handy to eight months in jail (with additional conditions). The 'victim' remains HIV negative.

- **Leone (2008)**³⁴ pleaded guilty (changing from an earlier 'not guilty' plea) to 15 counts of aggravated sexual assault for not disclosing his HIV status to 15 women, five of whom tested HIV-positive. According to press reports, following a single complaint, investigators 'feared there might be other victims and released his photo to the public,³⁵ urging his sexual partners to get tested. More than 200 people flooded the local health unit for testing.³⁶ Psychiatrist for the defence testified that Leone had been in extreme denial of the seriousness of the disease he had been diagnosed with,' and had come 'to the conclusion that the [HIV] test must have been a so-called false positive.' Leone had developed no overt symptoms relating to HIV and had never sought treatment. Three of the women have now commenced civil action for damages.

● **Kelly (2003/8)**³⁷ was convicted of aggravated sexual assault because he did not disclose his HIV status to his female sexual partners. After serving almost three years in prison, he was charged again for the same offence with a different woman.

● **Hinton (2008)**³⁸ was charged with attempted aggravated sexual assault for allegedly exposing another man to HIV two years earlier without first disclosing his HIV status. During cross-examination, the complainant admitted that HIV was not a concern to him before he engaged in 'moderately high-risk' unprotected sexual activity with previous sexual partners. The Crown conceded they were unable to prove the allegation that Hinton had infected the complainant beyond reasonable doubt, and charges were dropped. Subsequently, Hinton publicly stated he had never had sex with the complainant, and noted that despite police releasing his photograph and publicly seeking anyone who had a sexual relationship with him to call the sexual-assault section; no one had come forward to say they had been infected by him.

● **DC (2008)**³⁹ met a man who was to become her partner when she was in her early 40s. When they first began a sexual relationship she did not tell him she was HIV-positive but she testified she had insisted he use condoms. He testified they engaged in unprotected sex at least once. When DC revealed her HIV status, her partner accepted it and they continued their relationship for some five years. The relationship deteriorated, however, and DC's partner was arrested on various assault charges after he attacked DC and her son in their home. Following investigation of domestic violence, DC's partner took his allegations about DC's 'hidden' HIV status to police, although he remained uninfected. He was apparently given an unconditional discharge with no criminal record for his violence against DC and her son. DC was found guilty of aggravated assault (for HIV exposure) and given a one-year suspended sentence to be served in the community.

● **Mabior (2008)**⁴⁰ was convicted of six counts of aggravated sexual assault in relation to occasions of protected and unprotected sex with six women/girls (the youngest being 12 years old). The women/girls did not seroconvert, believed to be attributable to his low viral load. Police alleged Mabior had been luring runaway girls/young women to his home, with the judge noting Mabior had supplied quantities of alcohol and drugs. Mabior's defence team argued that at the time he had unprotected sex with the women, he did not believe he was infectious. Expert testimony concurred that was likely to be the case at least some of the time. In the first case dealing directly with viral load, the judge stated:

I am persuaded that the combination of an undetectable viral load and the use of a condom would serve to reduce the risk below what would be considered a significant risk of serious bodily harm. The facts and medical evidence in this case have brought me to the conclusion that consent would not, in this particular circumstance, be vitiated.

In short, Mabior was acquitted on charges where there were both condoms and a low viral load; convicted on charges where only one of those elements was in place; and also convicted of charges related to exploiting the girls. As this was only a lower court (trial level) decision, it is not yet clear how much influence it will have.

● **Iamkhong (2008)**, a Thai woman, came to Canada from Hong Kong on a work visa to perform at a strip club in 1995. She met her husband in 1996 and they married the following year. Iamkhong had previously tested positive for HIV in Hong Kong, but testified that she had believed she was HIV-negative because she had mistakenly understood she had been HIV tested in Canada for immigration purposes and that those test results did not show she was HIV-positive. In fact, those tests did not screen for HIV as Iamkhong entered Canada seven years before the HIV screening of immigrants was introduced (in 2002). Iamkhong received no HIV treatment until she learned she had AIDS in 2004, at which time she told her husband. Iamkhong was convicted of aggravated assault and criminal negligence causing bodily harm for failing to disclose her HIV-positive status to her husband and sentenced to two years in jail which would have meant, that despite being a 'landed immigrant', she would automatically be deported. A 2009 appeal reduced her sentence by one day, allowing her to appeal her deportation once she is released from prison.⁴¹ Her husband has filed a civil lawsuit against Iamkhong and the Immigration Department (reportedly for C\$33 million), alleging it did not take appropriate steps to screen her health when she entered the country.⁴²

● **Mzite (2009)**⁴³ was found guilty of four counts of aggravated sexual assault for having unprotected sex with four women between 2001 and 2005. Throughout his trial, Mzite vigorously denied knowing he was HIV-positive until late 2004. Mzite testified that he had six negative HIV tests in Zimbabwe, and also medical tests to facilitate his migration to Canada, believing they included an HIV test. They did not. A few months after arriving in Canada in 2001, Mzite was tested for STDs and HIV. The clinic phoned him and Mzite understood the caller had said his results were fine but he needed to come in for counselling. Although Mzite had tested positive for HIV, the clinic did not give him that information over the phone, and he did not go back for counselling so never picked up his positive result. Mzite testified that from the time he learned he was HIV-positive, either the women knew he was HIV-positive and/or they practised safe sex. The Judge found beyond a reasonable doubt that Mzite knew he was HIV-positive at the time of the relationships and sentenced him to ten years less three days in prison. He will not automatically be deported at the end of his sentence, however, due to his refugee status.⁴⁴

S231.5 Murder

Recently, Canadian prosecution for HIV transmission has moved to a whole new level with the trial of Ugandan migrant Aziga,⁴⁵ who was found guilty of two counts of first-degree murder after having unprotected sex without disclosing his HIV status with eleven women, seven of whom tested HIV-positive. The murder charges follow the deaths of two women from AIDS-associated cancers within two years of infection. That defence challenged evidence of the Director of National HIV and Retroviral Laboratories that Mr Aziga (and only Mr Aziga) could have infected the seven HIV-positive complainants since they shared a similar strain of the same HIV subtype, clade A, which is rare in Canada but endemic in Uganda (a challenge based on the work started in the UK, and applied in the 2006 case at Kingston Crown Court). At least two of the complainants shared another HIV-positive sexual partner from sub-Saharan Africa, and most of the women were part of a wider sexual network in Mr Aziga's hometown of Hamilton, Ontario. As a result of this case, two individuals accused of HIV exposure in Ontario have now been charged with attempted murder, rather than aggravated sexual assault.⁴⁶

Response

Amidst the recent onslaught of cases, Canadian HIV agencies have worked in a variety of ways to respond to the impact of the criminalisation of HIV. The HIV/AIDS Legal Network, Canadian AIDS Society and British Columbia Persons with AIDS Society intervened in the Cuerrier case to introduce public policy arguments and attempt to contain the law. Those agencies continue their efforts to intervene in other cases in an effort to 'rein in' the law, specifically around the definition of 'significant risk': to exclude protected sex or similar low-risk activities. The Coalition of Community Organizations Quebec Fight against AIDS (COCQ-SIDA) undertook significant fundraising and campaigning around the case of 'DC' (above). The Ontario Working Group on Criminal Law and HIV Exposure (CLHE) has mobilised on this issue and produced a 'Position Paper on the Criminalization of HIV Non-disclosure' which includes calls for a comprehensive evaluation of the way Canada's HIV-related criminal laws are being applied within Ontario (where a disproportionate number of HIV prosecutions have occurred). A major research study is being undertaken by the Ontario HIV Treatment Network and the University of Windsor to gather evidence on the impacts of criminalisation.

Numerous workshops, conferences, public forums and training sessions have been held for front-line workers and HIV-positive people, to inform people and increase public debate. Efforts are continuing to better inform HIV service organisations throughout Canada of their rights and obligations as a means to address the anxiety and confusion that exists around HIV criminalisation among people living with HIV, front-line workers and counsellors.

The HIV/AIDS Legal Network and partner organisations are involved in producing materials for defence counsel and AIDS service organisations (including suggesting medical experts, public health arguments, etc.) to assist in the development and delivery of good defence cases, which will hopefully narrow the scope of the application of the law.

Conclusions

There have now been many prosecutions for HIV non-disclosure, exposure and/or transmission across England and Wales, New Zealand and Canada. While the charges, sentencing and other individual circumstances vary enormously, some commonality of issues have emerged.

A significantly disproportionate number of prosecutions have been of men infecting women: perhaps because heterosexual populations have failed to adopt the 'mutual responsibility' ethos embedded in safer sex messages,⁴⁸ because women may more readily identify as victims in heterosexual relations, and/or because men have manipulated particular heterosexist power dynamics and have been particularly deceitful and exploitative, particularly in cases involving long-term relationships and sex with young women and girls.

A significantly disproportionate number of prosecutions have been of heterosexual migrant men,⁴⁹ implicating the above possibilities as well as complex cultural factors, xenophobic and class- and race-based assumptions that affect how those individuals come to be charged and the ways their cases are conducted.

The criminal law has shown a lack of capacity to recognise and deal effectively with mental health issues (e.g., diagnosed mental illness) and psychiatric factors (e.g., being in 'extreme denial'). It has also shown little facility to explore and take into account the reality that HIV disclosure is complex and often raises real and reasonable fears.

People have pleaded guilty (possibly because they are scared or feel guilty) without having their guilt tested by the stringent requirements of criminal law. In addition, others have been found guilty despite their not having been HIV tested or having been unaware they were HIV-positive at the time transmission occurred. Science has been used and misinterpreted as decisive evidence of guilt.

In many cases, the media's response has been inflammatory, often resulting in the vilification of HIV-positive people in general, particularly noticeable when reading the public's comments on news stories online. Sensationalist and sloppy articles have demonised individuals, misrepresented facts and confused 'reckless', 'deliberate' and 'intent'.

While Australia may not be suffering the same 'enthusiasm' for HIV transmission prosecution as Canada, it is clear that much more work needs to be done to mitigate prosecutions' harms, such as has happened in the UK as well as New Zealand and Canada (not to mention other jurisdictions such as The Netherlands, where the Supreme Court ruled in 2005 that reckless sexual HIV transmission could not be prosecuted since the per-act risk of sex was too low).⁵⁰ It is hoped this paper represents the beginning of focussed dialogue among HIV advocates from comparable social and legal systems so that the potential harms of HIV criminalisation may be minimised.

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Endnotes

1 With thanks to Robert James (National AIDS Trust), Rachael Le Mesurier (New Zealand AIDS Foundation) and Alison Symington (Canadian HIV/AIDS Legal Network) for their perceptive comments and assistance developing this paper.

2 Even though laws were likely not intended to be applied in those circumstances; for example, in the case of laws pre-dating the AIDS pandemic and others professedly targeting other modes of transmission (see Rush's notes on 'needle bandits' in chapter 5).

3 Those seeking information on developments in prosecutions for HIV exposure and transmission through sexual contact should, in the first instance, refer to GNP+'s Global Criminalisation Scan website at www.gnpplus.net/criminalisation/ and Edwin J Bernard's collection of resources at <http://criminalhivtransmission.blogspot.com>

4 Maximum penalty life imprisonment

5 Maximum penalty 5 years imprisonment

6 This is a line of prosecution not (yet?) pursued in Australia, and represents a challenge to those who dismiss arguments against HIV transmission prosecutions based on the possibility they may represent 'the thin edge of the wedge'.

7 The sentence of 10 years related to three separate charges.

8 Content for the following summaries is largely taken from the summaries provided by Terrence Higgins Trust at (www.tht.org.uk/informationresources/prosecutions/recentcourtcases/) More details of the first five cases in England and Wales are summarised in Dodds C et al. (2005) *Grievous harm: use of the Offences Against the Person Act 1861 for sexual transmission of HIV*, Sigma Research, UK, www.sigmaresearch.org.uk/files/report2005b.pdf

9 *R v Dica* (Unreported October 14, 2003), *R v Dica* (2004) 2 Cr App R 28, 3 All ER 593, EWCA Crim 1103, 77 BMLR 243, *R v Dica* (Unreported March 23, 2005)

10 *R v Adaye* (Unreported January 13, 2004)

11 *R v Konzani* (Unreported May 14, 2004), *R v Konzani* (2005) 2 Cr App R 198, EWCA Crim 706

12 The citation for this case is not available, although the prosecution is known to have occurred in Cardiff.

13 *R v James* (Unreported April 3, 2006)

14 *R v Porter* (Unreported June 19, 2006)

15 *R v Collins* (Unreported August 9, 2006)

16 Many are undocumented but they are 'most probably in the three figures' (THT poster at WAC, Mexico, 2008)

- 17** Sentence not prescribed
- 18** *R v Mwai* (1995) 3 NZLR 149.
- 19** A proposal with some resonance for Australia following former Prime Minister Howard's public comments on 'immigrants' in June 2006 (see Cameron 2007)
- 20** Following significant increases in new diagnoses of HIV amongst migrants, mandatory HIV testing was introduced some 10 years later for applicants for residency visas and visas exceeding 12 months' stay in New Zealand. As a result of an increase in mother to child transmissions, NZAF worked with the Ministry of Health and other health service professionals to introduce a system of antenatal HIV screening similar to the UK 'opt off' model (2007).
- 21** All subsequent quotes on the Dalley court proceedings are from *New Zealand Police v. Dalley*, Court of Wellington, Court File No. CRI-2004-085-009168 October 4, 2005
- 22** *R v Mwai* (1995) 3 NZLR 149
- 23** All quotes in the following section are from Decision of Judge S E Thomas in *New Zealand Police v Justin William Dalley* October 4, 2005 www.justice.govt.nz/judgments/decisions/police%20v%20dalley%20cri-2004-085-009168.pdf
- 24** Notably two years earlier, another significant milestone in public health supported legislation occurred in New Zealand through the *2003 Prostitution Reform Act* establishing safer sex as a legal right of a sex worker. In 2005, the same year as the second Dalley case, a New Zealand man was convicted and fined \$NZ400 for endangering a sex worker (the first case under the new law) for surreptitiously removing the condom she had insisted he wear.
- 25** Eighty-four cases were reported by November 2008 for the GNP+ scan, and a further five cases have been reported at criminalhivtransmission.blogspot.com to April 2009
- 26** Known to the Canadian HIV/AIDS Legal Network
- 27** Canadian AIDS Treatment Information Exchange and the Canadian HIV/AIDS Legal Network (2009) *HIV Disclosure Issues: criminal law, public health law and confidentiality*, presented at Pacific AIDS Network Skills Building 2009
- 28** See *R v Handal* (1993) 1 SCR 867 (Supreme Court of Canada)
- 29** See *R v Cuerrier* (1998) 2 SCR 371 (Supreme Court of Canada)
- 30** Consent (Criminal Code 265(3)(c)), For the purposes of this section, no consent (to physical contact) is obtained where the complainant submits or does not resist by reason of . . . fraud. Fraud vitiates consent.
- 31** *The Queen v Solomon Mwale* (2008)
- 32** *R v Handy* (Unreported March 27, 2008) See Bernard, EJ (2008) <http://criminalhivtransmission.blogspot.com/search?q=handy> and Canadian HIV/AIDS Legal Network (2008a) *Lifetime sex offender registration for man who failed to disclose his HIV status*, Vol 13 No 1
- 33** which apparently included symptoms of delusions of grandeur and impaired reality testing, including previously believing he was a messiah (Sims 2008)
- 34** *R v Leone* (Unreported April 8, 2008) See <http://criminalhivtransmission.blogspot.com/2008/04/canada-carl-leone-sentenced-to-18-years.html>
- 35** A practice of considerable contention. For example, heated debate erupted around Adelaide Magistrates Courts' suppression of South Australian McDonald's image in 2007, including calls from opposition and independent Members of Parliament, and the South Australian branch of the Australian Medical Association to release McDonald's image. See, for example, 'Calls to release photo of alleged HIV spreader' on ABC Radio's *PM* program (April 24, 2007) www.abc.net.au/pm/content/2007/s1905712.htm
- 36** *Man who spread HIV sentenced to 18 years* CBC News April 5, 2008 www.cbc.ca/canada/story/2008/04/04/leone-sentence.html
- 37** *R v Kelly* (unreported 2003, unreported 2008) See <http://criminalhivtransmission.blogspot.com/2008/09/canada-ontario-man-imprisoned-for.html>
- 38** See <http://criminalhivtransmission.blogspot.com/2008/02/canada-hiv-exposure-charge-dismissed.html>
- 39** *R v DC* (2008) QCCQ 629 See <http://criminalhivtransmission.blogspot.com/2008/05/canada-montreal-domestic-violence.html>
- 40** *R v Mabior* (2008) MBQB 201 See also <http://criminalhivtransmission.blogspot.com/2008/10/canada-mabior-sentenced-to-14-years.html>
- 41** *R v lamkhong* (2009) ONCA 478
- 42** Tyler T (2009) *Man blames Ottawa in HIV case* www.thestar.com/article/607828, and Bernard EJ (2009) <http://criminalhivtransmission.blogspot.com/2009/03/canada-man-sues-canadian-government.html>
- 43** *R v Mzite* (Bernard EJ (2009)) from <http://criminalhivtransmission.blogspot.com/2009/03/canada-yet-another-african-migrant.html>
- 44** See www.timescolonist.com/Health/Mzite+gets+year+sentence+sexual+assault/1450941/story.html
- 45** *R v Aziga* (unpublished 2009) See <http://criminalhivtransmission.blogspot.com/search?q=Aziga>
- 46** See www.xtra.ca/public/Toronto/Attempted_murder_the_new_aggravated_assault-6947.aspx
- 47** Mutual responsibility might be summed up as both persons in a sexual relationship having equal rights and responsibilities for their mutual pleasure and protection.
- 48** Conversely, the uptake of the mutual responsibility ethos in gay communities may also suggest why relatively few cases involving men infecting other men (the most prevalent route of HIV transmission in all three countries) have reached court, although there is also some anecdotal evidence of the police not taking complaints from gay men as

seriously as from heterosexual women.

49 For example, although they make up only 2% of the Canadian population, and 12% of the Canadian HIV-positive population, migrants from high prevalence countries (Uganda, Sudan, Zambia, Zimbabwe, Democratic Republic of Congo, Ethiopia, and Trinidad) made up almost half of all criminal sexual HIV prosecutions in Canada during 2008. See www.gnpplus.net/criminalisation/index.php?option=com_content&task=view&id=386&Itemid=64&limit=1&limitstart=2

50 *Prosecution Services v AA* (January 18, 2005), The Hague AR1860 02659/03 (Supreme Court of the Netherlands). Translated copy of the ruling at www.gnpplus.net/criminalisation/images/stories/judgment_20_supreme_court_of_the_netherlands_aa_2005_01_18_2nd.doc. See also Canadian HIV/AIDS Legal Network (2005) 'Netherlands: Supreme Court overturns HIV-positive man's sentence', *HIV/AIDS Law and Policy Review*, Vol 10 No 2

Public health laws and policies on the issue of HIV transmission, exposure and disclosure

David Scamell and Chris Ward

The protection and promotion of public health and the welfare of citizens has been characterised as one of the most important functions of the modern state.¹ At the heart of the concept of public health is the recognition that in order to maximise the health and wellbeing of individuals within society, it is necessary to address issues and threats relating to health at the population or community level. Effective public health responses are characterised by the monitoring and surveillance of disease and behaviour within populations (which can range in size from a handful of people, to groups across numerous continents), and the provision of programs and services which facilitate behavioural change in order to prevent the proliferation of disease and illness. In Australia, public health is informed by the critical concept that public health and human rights are *not* incompatible. In fact, the protection of human rights is critical to effective public health management of the HIV epidemic.

Public health has been at the core of Australia's response to HIV since the start of the local epidemic in 1982. In responding to the disease, governments at both the Commonwealth and state/territory levels have worked in partnership with a range of different stakeholders, including researchers, medical practitioners, scientists and, importantly, the communities affected by HIV. The basis for what was at the time a unique approach to public health, was the realisation in the early stages of the Australian epidemic that the groups within society that were becoming infected or were most at risk were highly marginalised. With these groups being legally and socially excluded, it was evident that governments alone could not provide the public health response to HIV. Consequently, through community-based representative organisations, gay men, sex workers and injecting drug users (IDUs) were made central in deciding and delivering on the most effective ways to prevent the disease.²

Underpinning the Australian response has been the principle that voluntary engagement of at-risk groups with health information and support services is a more effective means of preventing the spread of HIV than using coercive measures that have been associated with other communicable disease interventions, such as compulsory testing and isolation. As a result, policy frameworks around the management of risk of HIV transmission have generally favoured the use of public health mechanisms rather than criminal interventions. For example, the 2002 ANCAHRD paper, *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission*, states that 'punishment under public health or criminal law should be reserved for the most serious cases of culpable behaviour as a last resort'.³

The prioritisation of a public health response to HIV has brought with it new challenges for existing public health legal and policy frameworks. As Australian public health law and policy are within the jurisdiction of the states and territories, legislation, case law, and (until recently) public policy have developed differently in each jurisdiction. Some Australian jurisdictions have reviewed and amended their public health laws and policies to address the particular public health issues associated with HIV. In other jurisdictions laws and regulations concerned with disease control have continued to focus on the containment of infection spread by casual social contact or inadequate public hygiene. In doing so, they fail to address the intimate and mostly hidden behaviour by which the majority of HIV infections have occurred in Australia.

There are broad-ranging laws and policies influencing the HIV response in Australia, including those on testing, pre- and post-test discussion (previously called 'counselling'), notification of HIV infections, and confidentiality and privacy. All affect HIV management; however, an analysis of these is outside the scope of this chapter.⁴ This chapter provides an outline of key current public health policies and laws in Australia dealing with issues around HIV transmission and exposure. The first part of the chapter provides an exploration of the different policy and legislative frameworks across jurisdictions in relation to managing people who are at risk of infecting others with HIV. The second part discusses the offences created under public health law that relate to disclosure of status, knowing or reckless transmission of HIV, and exposure to the risk of transmission.

Managing people who are at risk of infecting others with HIV

Each state in Australia, either through statute alone or a combination of statute and departmental policy, has mechanisms in place to manage people infected with HIV who are at risk of infecting others. These mechanisms have been designed to facilitate behavioural change of specific individuals who have been identified as posing a risk of passing on HIV to others. As such, they represent a more individualised and coercive aspect of the public health response to HIV transmission than the health promotion and education activities that are directed towards at-risk population groups within society.

It is important to note that the number of individuals for whom these mechanisms apply, or may at some point apply to, is small. The overwhelming majority of people with HIV in Australia actively take steps to ensure that transmission of HIV to others does not occur. However, owing to a range of psychological, social and other factors, there are some individuals who engage in behaviour that could or does place their sexual partners or people with whom they are sharing injecting equipment, at risk of HIV infection. Public health mechanisms are enacted at the point where the public health system recognises that more than the provision of information and resources, such as condoms and lube or clean injecting facilities, is needed.

While public health mechanisms sit at the state and territory level, there has been a recent commitment to introduce consistent framework for managing people with HIV who risk infecting others. In 2007, Professor Robert Griew was commissioned by a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC) to undertake a review of policies for the management of people with HIV who risk infecting others. The Griew Review found:

the number of individuals whose behaviours require intervention utilising coercive public health management strategies is small and that these individuals do not drive Australia's HIV infection rate. The review noted that the continued effective management of HIV/AIDS in Australia is reliant on sustained investment in prevention education efforts based on the latest surveillance data and targeting high-risk populations as the highest priority.

The review contained recommendations:

- that states and territories continue to rely on public health law to manage those at risk of infecting others, with criminal law considered in the unusual circumstance that an individual's behaviour warrants charges of serious criminal offence;⁵
- that public health mechanisms should distinguish between those individuals who are 'unwilling' and those who are 'unable' to modify their behaviour, with different approaches needed for the two categories;⁶
- that where it is clear that an individual is engaging in behaviour that supports a criminal charge of intent to cause serious harm, they should be immediately referred to the police;⁷
- that where someone's behaviour may warrant a charge of recklessness or negligence, the public health authorities should assess their case further before engaging with the police.⁸

One of the other key recommendations from the review was the development of *National Guidelines for the Management of People with HIV Who Place Others at Risk* ('the National Guidelines').⁹ The National Guidelines were developed to inform, support, and harmonise approaches by the states and territories to the management of people with HIV who place others at risk of HIV infection.¹⁰ Having been approved by the Australian Health Ministers Conference, there is now an expectation that all states and territories will review their current policies and, where necessary, revise those policies, to ensure consistency with the National Guidelines.

The National Guidelines are based on the following principles and assumptions:

- except in special circumstances, testing for HIV should be conducted on a voluntary basis;
- people with HIV should not be quarantined, or excluded from social or sexual activities;
- every individual has a responsibility to prevent themselves and others from becoming infected and preventing further transmission of the virus;
- most people with HIV are motivated to avoid infecting others and the risk of transmission by most people with HIV is best managed through access to information, education, resources for the prevention of transmission and HIV treatment services;
- counselling and support services, including post-diagnosis counselling, should be provided to encourage behaviours that minimise the risk of infecting others;
- for people with HIV who place others at risk, a variety of increasingly interventionist strategies may be needed, with preference being given to that are least restrictive, as these will generally be the most sustainable and effective in the long term;
- the right to equitable, non-discriminatory and transparent dealing, including the right of review and appeal, should be preserved; and
- the roles of clinicians and local service providers with clients and of public health officials in surveillance and enforcement should be kept distinct.

The National Guidelines provide a public health framework based upon five levels of intervention. They are underpinned by the principle that 'for people with HIV who place others at risk, a variety of increasingly interventionist strategies may be needed, with preference being given to strategies that are least restrictive, as these will generally be the most sustainable and effective in the long-term';¹¹ however, levels need not be approached as chronological. For example, in a particular case, the most appropriate but least interventionist level may be level 2, or 3, etc. At level 1, an identified individual should be provided with comprehensive counselling, education and support. If it is clear that this level of intervention will not lead to the necessary change in behaviour, then the National Guidelines provide for the introduction of an HIV Advisory Panel to provide formal support to the individual's primary health care provider. At the third level of intervention the Chief Health Officer (CHO), on advice from the Advisory Panel, may make a behavioural order which requires the individual to undergo counselling, treatment, refrain from specific behaviour or be subject to supervision. At the next level (Level Four), the CHO, again on advice from the Advisory Panel, may make an order for the person to be subject to isolation or detention. The final level of the National Guidelines involves the referral of the individual to police.

Australian Capital Territory

In the ACT, the mechanism for managing people at risk of infecting others with HIV can be found in the ACT Health *Management of People With HIV Infection Who Knowingly Risk Infecting Others* and the *Public Health Act 1997* (ACT).

The guidelines were published in February 2007 and are designed for doctors, nurse practitioners, and those responsible for the care, support or education of a person with HIV. They set out a two-stage management process. At the first stage, an identified individual should be provided with counselling, education and support. If no significant behavioural change ensues, and the individual still presents a risk of infecting others, then stage two is enacted, with the primary care giver required to notify the ACT's CHO. It is at this point that the guidelines defer to the powers of the CHO assigned under the *Public Health Act 1997* (ACT).

Under the Act, the CHO is empowered to issue public health directions to any person to prevent or alleviate a public health hazard (*Public Health Act 1997* (ACT) s113). This power may be exercised where there are reasonable grounds for believing that a person is infecting or placing others at risk of HIV infection. Any or all of the following directions may be issued to a person:

- To refrain from behaviour or an activity that significantly contributes to, or could contribute to, the public health hazard;
- To cease performing work of a particular kind, or cease working in a particular place, while such work contributes to, or could significantly contribute to, the public health hazard;
- To undergo a medical examination;
- To undergo specified counselling (either a person with HIV or a contact of a person with HIV);
- To be confined to a particular place for a specified period, being the least restrictive confinement appropriate to the person's medical condition;
- Not to enter, or not to remain in a particular place for a specified time;
- To cease using a particular piece of equipment;
- To clean and decontaminate a particular place;
- To undertake, or refrain from undertaking, any other action, where the CHO has reasonable grounds for believing the requirement to be necessary for the purposes of preventing or alleviating the hazard.

The CHO must take the minimum action necessary to prevent or alleviate the public health hazard. The current ACT guidelines were written prior to the establishment of the national guidelines, and are due for review in 2009.

New South Wales

In April 2009, the NSW Health Department published its policy directive, *HIV – Management of People with HIV Infection Who Risk Infecting Others*. The purpose of the document is to explain 'the framework and process through which the health system may decide to infringe the liberty of an individual to protect the health of the public'.¹² That framework is divided into stages or management levels and the guidelines clearly outline the role of an Assessment Panel.

At the first stage, the client is managed by their treating clinician through counselling, education and support, with the opportunity to obtain advice from the Chair of the Assessment Panel. If there continues to be concern regarding the risk that the client presents to others, then the Chair of the Assessment

Panel can decide that the client should be managed with support from the Assessment Panel. This stage is the first level of formal management under the directive, and also allows for the CHO to provide the client with a letter of warning.

Level 2 under the directive invokes the range of powers given under the *Public Health Act 1991* (NSW) which can be used to force someone to undertake, or refrain from undertaking, a particular activity.

Section 23 (A) and (B) of the *Public Health Act 1991* (NSW) empower the Director General of NSW Health, or another authorised medical officer (including CHO), to make public health orders where reasonable grounds are made out, and which may require a person to do one or more of the following:

- Undergo medical assessment to diagnose whether the person has HIV infection or AIDS;
- Refrain from specific conduct;
- Undergo counselling;
- Submit to behavioural supervision;
- Undergo specified treatment, including detention for the purposes of treatment;
- To be further detained while a public health order is in force.

Level 3 is the final management level and provides for the option of placing a person under detention where the evidence clearly shows their ongoing behaviour is placing others at risk of being infected with HIV, and there are no other means considered likely to be effective.

The making of a public health order is required to take into account the principle that any requirement restricting the liberty of a person should be imposed only if it is the only effective way to ensure that the health of the public is not endangered or likely to be endangered. A police warrant may be issued in cases where a medical practitioner certifies in writing that a person is in contravention of a public health order.

Queensland

Queensland Health released its *Protocol for the Management of People with HIV who Place Others at Risk* in August 2008. The protocol sets out a five-stage policy framework for 'the management of HIV-positive persons whose reckless behaviour may place others at risk of HIV infection'.¹³ Stage 1 starts when a clinician or client service provider notifies in writing the Executive Director of Population Health in Queensland that they have reason to believe that a client is recklessly placing others or could place others at risk of HIV infection. The clinician or service provider has the responsibility under the protocol to carry out counselling, education and support, and at the same time an HIV Advisory Panel will convene to consider the circumstances of the case and advise on appropriate action. At the second level, Qld Health takes a more direct role in counselling, education and support, with the panel (with expanded membership) determining and overseeing the management of the client.

It is at the third and fourth levels that the *Public Health Act 2005* (Qld) is used. A public health order may be used to detain a person who is reasonably believed to have HIV, and who is reasonably believed to be placing others at risk of infection. A public health order may not be issued unless, where practicable, counselling has been provided or an attempt has been made to provide counselling (*Public Health Act 2005* s113). A public health order may be enforced by the head of the public sector health facility at which a person is to be detained, employing such assistance and force as is necessary for enforcing the order (see s114). A chief executive's order lasts not longer than 24 hours, or until a magistrate has ruled on an application for a controlled notifiable condition order in relation to the person (s115).

Applications for controlled notifiable condition orders are made by the Chief Executive and may request an initial examination order, a behaviour order, or a detention order (s116). An order may be made in the absence of the person to whom it applies if the magistrate is satisfied that this is necessary. Divisions 3 and 4 of the Act detail the conditions which may form part of a behaviour order or a detention order. A person can appeal against the decision of a magistrate either to make or to extend a controlled notifiable condition order.

The Queensland protocol also includes a fifth level which provides for the case being referred to the police for criminal prosecution under the *Criminal Code Act 1899* (Qld). This will occur when ‘the panel considers there is clear evidence that a person is unwilling to modify behaviour that recklessly endangers another person by exposing them to HIV infection, or if there is other clear evidence of criminal intent’.¹⁴

South Australia

The public health mechanism in South Australia for managing people who are at risk of infecting others can be found in the SA Health Directive, ‘Code for the Case Management of Behaviours that Present a Risk for HIV Infection’, and the *Public and Environmental Health Act 1987* (SA).

The South Australian framework consists of four levels. The first level relates to the obligation that an agency providing care and support to an HIV-positive person has to notify the Chief Executive of SA Health if they have reasonable grounds to believe that person’s behaviour poses a continuing risk of HIV transmission. Once notified, the Chief Executive may refer the case to the HIV Risk Behaviour Panel, which may decide on a range of outcomes listed in the directive. Level 2 involves formal engagement by the Chief Executive and the panel in managing the client and attempting to instill behaviour modification through education, counselling and support measures. If these measures do not result in behaviour change, and the person still presents a risk of infecting others, then the *Public and Environmental Health Act 1987* (SA) can be invoked to force the person to do certain things, or refrain from doing certain things in order to prevent HIV being passed on. At level 3, where the Chief Executive believes on reasonable grounds that a person has HIV, the Chief Executive may:

- require the person to present himself or herself for examination by a medical practitioner (s31);
- apply to a magistrate for a warrant for the apprehension and examination of a person (s33).

Where these coercive measures do not result in behaviour change, the management process moves to the final level, where the Chief Executive may apply to a magistrate for a warrant for the detention of a person in the interests of public health (s32). Initial detention under a warrant may not be for more than 72 hours. The Chief Executive may apply for an order extending the person’s detention under warrant for not more than 6 months. The period of detention may be extended for more than 6 months by an order of the Supreme Court. A person subject to an order of a magistrate may appeal against that order to the Supreme Court.

Powers of Authorised Officers

Officers authorised by the Minister for Health may exercise a range of powers set out in the *Public and Environmental Health Act 1987*, which may affect people with HIV. These include the power to require any person to answer any question that may be relevant to ascertaining whether the person has HIV or AIDS, to enter or inspect premises or a vehicle, to take samples of substances, and take other investigative measures (see s38). A person is not required to answer a question if to do so would tend to incriminate the person. Persons involved in investigating public health problems in South Australia may also be authorised by the Governor to have access to confidential information. An authorised officer may apply to a magistrate for a warrant to enter premises by force to carry out investigations. A person who hinders or obstructs an authorised officer exercising their powers under the Act commits an offence and may be fined. Authorised officers are immune from personal liability for any act or omission where they exercise or purport to exercise a power under the Act.

Tasmania

Tasmania has overlapping provisions concerning HIV and AIDS in the *HIV/AIDS Preventive Measures Act 1993* and the *Public Health Act 1997*. Under the *Public Health Act*, the Director of Public Health may make orders requiring a person to:

- Undergo a medical examination if the Director is aware of or suspects on reasonable grounds that the person has a notifiable disease;
- Be placed in isolation;
- Be placed under the supervision of a specified person;
- Submit to further medical examination, testing, treatment or counselling;
- Disclose the name and address of any person with whom they have had contact that may have resulted in the transmission of HIV;
- Refrain from doing specified work;
- Do or refrain from doing anything the Director determines.

The Director may order detention or quarantine of a person for up to 48 hours for the purposes of a medical examination; a magistrate may order detention for up to six months; and the Supreme Court may order detention for periods exceeding six months. At the time of writing, Tasmania did not have any publicly available guidelines on how a person who may be at risk of infecting others with HIV should be managed through the public health system.

Victoria

In October 2008, the Victorian Department of Human Services published the document, *Guidelines for the management of people living with HIV who put others at risk*. The guidelines, along with the *Health Act 1958* (Vic), represent the public health mechanisms for managing those at risk of infecting others. The guidelines are based upon a five-stage approach, and are largely similar to guidelines in other jurisdictions. The five stages are: initial counselling, education and support; counselling, education and support under advice from the HIV Advisory Panel; letter of warning from the CHO; restriction on the person's behaviour and movement (through orders made under s121 of the *Health Act*); and finally, detention and isolation (also through orders made under s121 of the *Health Act*).

A unique difference is the role that specialist staff in the CHO's office, called Partner Notification Officers (PNOs), play in the process. When the department is notified by a member of the public that they are concerned that a person with HIV appears to be putting others at risk of HIV, the PNO interviews that member of the public to gain further information about the person in question. Once complete, the guidelines stipulate that the PNO will contact the person against whom the allegations have been made and undertake an interview. Based on that interview, the PNO will make recommendations as to whether management should commence under the five-stage approach, and at what stage. If management does commence, the PNO is expected to be involved in case management through stages 1 and 2.

Western Australia

In June 2006, the WA Department of Health published *HIV Case Management: A program for individuals with HIV infections who knowingly expose others to the risk of infection*. The document sets out a four-stage program for managing individuals who are at risk of knowingly exposing others to HIV. At the first stage, an individual is provided with counselling, education and support from an HIV Case Management Program Team, or Department of Health Staff. If it is clear that no modification of behaviour has taken

place, the client is referred to an HIV Case Management Panel, which, following review of the case, can make a number of recommendations regarding management of the client. One of those recommendations is for the Executive Director of Public Health to issue a formal letter to the client warning them to discontinue any activity which places another person at risk of infection (stage three) or face the possibility of being isolated (stage four). The Executive Director derives the power to isolate an individual from s251 of the *Health Act 1911* (WA).

At the time of publication, the WA government was finalising a draft Public Health Bill to be tabled in parliament at some point in 2009. The consultation draft bill released by the previous WA government in 2008 included provisions which gave the CEO of WA Health the power to issue orders to individuals to undertake testing, along with the power to issue a public health order. A public health order would require an individual to do one or more of the following:

- refrain from specified conduct;
- undergo counselling by a specified person or one or more persons within a specified class of persons;
- refrain from visiting specified places or places within a specified class of places;
- submit to specified supervision;
- undergo a specified medical examination, or specified medical treatment, at a specified time and place;
- submit to being detained at a specified place for the purpose of undergoing a medical examination or medical treatment;
- submit to being detained or isolated, or detained and isolated, at a specified place while the order is in force.

Public health offences relating to transmission and exposure, and HIV disclosure

In addition to the range of powers outlined above, public health laws in most jurisdictions create specific offences relating to HIV transmission or exposure. The enactment of these offences suggests a person's actions merit punishment. In fact, these offences have been used infrequently. Moreover, they can be less 'severe' in terms of coercion and loss of liberty than public health orders.

Public health offences differ from offences found in criminal law in a number of ways. First, the severity of the punishment imposed as a result of violating an offence provision is generally considerably less in public health legislation than for criminal provisions. In most instances, a person found guilty of an offence under a public health law would be subject to a monetary fine; however, some jurisdictions also provide for small imprisonment terms. Second, the power to initiate prosecutions for public health offences lies with the Chief Health Officer or their equivalent, while prosecutions under criminal law are brought by police or public prosecutors. Third, although considered a punitive measure, a prosecution under a public health offence carries far less social weight and stigma than criminal prosecutions, and in almost all cases does not receive the media attention of an HIV transmission or exposure criminal trial.

In addition to public health offences relating to transmission and exposure, two Australian jurisdictions impose a legal duty on people with HIV to disclose their HIV status in certain circumstances. In New South Wales, a person who knows that 'he or she suffers from a sexually transmissible medical condition' (including HIV) commits an offence unless, before sexual intercourse takes place, he or she discloses the risk of contracting the sexually transmissible medical condition to the prospective sexual partner, and that person voluntarily agrees to accept the risk.¹⁵ In Tasmania, there are provisions in the *Public Health Act 1997* and the *HIV/AIDS Preventive Measures Act 1993* concerned with disclosure of one

HIV status. The *Public Health Act 1997* creates an offence of transmitting, or of knowingly or recklessly placing another person at risk of contracting, a 'notifiable disease'. 'Notifiable disease' includes HIV infection. It is a defence to a charge under the *Public Health Act 1997* to show that the other person knew of and voluntarily accepted the risk of contracting the disease.¹⁶ Tasmania's *HIV/AIDS Preventive Measures Act 1993* also requires the disclosure of one's HIV-positive status in advance to any 'sexual contact' or to a person with whom needles are shared. It is a defence to a charge under the *HIV/AIDS Preventive Measures Act 1993* of knowingly or recklessly placing another person at risk of HIV infection that the other person knew of and voluntarily accepted the risk of becoming infected.¹⁷

These provisions are not unique, and there are legal requirements of disclosure by HIV-positive persons to prospective sexual partners in various jurisdictions around the world.¹⁸ There is little empirical evidence regarding the efficacy of such laws, but that which exists indicates there is no connection between the existence of such laws, and belief structures or sexual risk behaviours. Recent research in the United States compared attitudes, beliefs and behaviours among 490 people at elevated risk of HIV infection, approximately half of whom were homosexually active men and the other half intravenous drug users. About half of each group lived in Illinois, which has HIV-specific legislation explicitly requiring prior disclosure by HIV-positive people to sexual partners. The other half of each group lived in New York, which has no such law. The study found no connection between the state-specific laws on the one hand, and belief structures or sexual risk behavior in the two populations on the other.¹⁹

Australian Capital Territory

Regulation 21 of the ACT *Public Health Regulations 2000* requires that a person who knows or suspects that they have HIV, or knows or suspects that they are a contact of such a person, must take reasonable and appropriate precautions against transmitting the condition. Failure to comply with this requirement can result in prosecution and a fine. 'Reasonable precautions' include precautions taken on the advice of a doctor or an authorised officer. A 'contact' in relation to a disease or condition means a person who:

- has been or may have been a source of infection to a person suffering from the disease or condition; or
- has been or may have been exposed to infection by a person with the disease or condition.

New South Wales

As stated above, s13(1) of the *Public Health Act 1991* provides that a person who knows that he or she suffers from a sexually transmissible medical condition (including HIV) is guilty of an offence if he or she has sexual intercourse with another person unless, before the intercourse takes place, the other person:

- has been informed of the risk of contracting a sexually transmissible medical condition from the person with whom intercourse is proposed, and
- has voluntarily agreed to accept the risk.

Section 13(2) of the Act also makes it an offence for an owner or occupier of a building or place to knowingly permit another person to have sexual intercourse at the building or place for the purposes of prostitution, and in doing so to commit an offence under s13(1).

Section 12 of the Act requires a medical practitioner who believes on reasonable grounds that a person receiving treatment from the medical practitioner suffers from a sexually transmissible medical condition (including HIV) must, as soon as practicable, provide the person with such information concerning the condition as is required by NSW regulations.

Queensland

Section 143 of the *Public Health Act 2005* makes it an offence to recklessly put someone else at risk of contracting HIV, or of recklessly transmitting HIV. A person convicted of an offence under s143 may be subject to a fine or to imprisonment for up to 18 months. An offence is not committed under s143 if, when the other person was put at risk of contracting HIV, the other person knew the first person was infected with HIV and voluntarily accepted the risk of infection.

South Australia

Section 37 of the *Public and Environmental Health Act 1987* provides that a person with a controlled notifiable disease, which includes HIV and AIDS (see Schedule 2 of the Act), shall take all reasonable measures to prevent transmission of the disease to others. A person found to have breached s37 may be subject to a fine.

Tasmania

Section 20 of the *HIV/AIDS Preventive Measures Act 1993* requires that a person who is, and is aware of being infected with HIV or is carrying and is aware of carrying the HIV antibodies to:

- Take all reasonable measures and precautions to prevent the transmission of HIV to others;
- Inform in advance any sexual contact or person with whom needles are shared of that fact; and
- Ensure they do not knowingly or recklessly place another person at risk of becoming infected with HIV, unless that other person knew that fact and voluntarily accepted the risk of being infected.

A person who is found guilty of having knowingly or recklessly placed another person at risk of becoming infected with HIV can be punished by a fine or imprisonment for up to two years.

A similar provision is found in the *Public Health Act 1997*. Section 51 of the Act states that a person who is aware of having a notifiable disease must take all reasonable measures and precautions to prevent transmission of the disease, and must not knowingly or recklessly place another person at risk of transmitting the disease. It is a defence to a charge under s51 for a person to prove that the other person knew of, and voluntarily accepted the risk, of getting the disease. A person found guilty of an offence under s51 is liable to a fine or imprisonment for up to 12 months.

The *HIV/AIDS Preventive Measures Act* creates a further offence of 'publicly promoting participation in sexual activity of a kind which is likely to cause damage to health through the sexual transmission of HIV' (see s22). The penalty for breaching this section is a fine or imprisonment for up to three months.

Victoria

The statement of principles in s119 of the Act includes the principles that:

- A person who suspects that he or she has an infectious disease must ascertain whether he or she is infected; and
- A person with an infectious disease must take necessary measures to ensure that others are not unknowingly placed at risk of becoming infected.

Section 120 of the Victorian *Health Act 1958* provides that a person must not knowingly infect another person with an infectious disease (which includes HIV). It is a defence if the other person knew of and voluntarily accepted the risk of being infected with that infectious disease. On conviction for an offence under s120 a person is liable to a fine.

Western Australia

There is no Western Australian law or regulation that specifically addresses the issue of intentional or reckless exposure to or transmission of HIV. Provisions in the *Health Act 1911* dealing with infectious diseases are clearly directed at control of diseases that may be transmitted through casual contact or inadequate public sanitation. For example, under s264 a person with an infectious disease who 'willfully exposes himself in any public house, or public place, or public vehicle without proper precautions for spreading the infection', commits an offence.

Conclusion

The Australian response to HIV is recognised throughout the world as one of the most effective to date. Underpinning that response has been the principle that the spread of HIV is more effectively checked through people's voluntary engagement with health information and support services, rather than through coercive measures historically associated with the control of communicable diseases, such as compulsory testing and isolation. Criminal prosecutions for transmitting HIV or exposing others to the risk of infection have been widely publicised. The confluence of serious and possible fatal infection with the primary means of disease transmission (sex) has often resulted in sensationalist media coverage, promoting inaccurate perceptions both of individual behaviour and of the key factors driving the Australian epidemic.

Have these prosecutions and their attendant publicity compromised Australia's public health response to HIV? There is no hard evidence, such as that which might be produced by randomised controlled trials, to answer that question. We do know that Australia's primary reliance on strategies of 'voluntary engagement' of people at risk has been effective to date. We also know that empirical research on other coercive laws, such as those imposing a legal duty to disclose one's HIV-positive status to prospective sexual partners, have found no relationship between such laws and either beliefs around HIV transmission or the prevalence of risk behaviour on the part of people with HIV.

In some Australian jurisdictions, notably Victoria and South Australia, criminal prosecutions for HIV exposure or transmission triggered a loss of confidence in the competence of public health officials to effectively manage HIV, and triggered review of and renewed focus on public health systems for managing those placing others at risk of HIV infection. While these reviews have strengthened the public health system for managing HIV risk and transmission, it should be noted that the changes are properly characterised as refinements to systems that already provided generally sound frameworks for risk management. Important elements of these and other jurisdictions' public health systems include access to public health experts, including general practitioners, experts in psychology and psychiatry, sexual health and public health nurses, and allied specialists. Public health systems provide access to professionals trained to deal with the complex range of co-morbidities which may exert a significant influence on individual behaviour, including mental health, intellectual disability, and problematic alcohol and drug use.

Whether the net impact of criminal prosecutions on public health has been beneficial or detrimental is not possible to determine. What we do know is that the amount of publicity given to criminal prosecutions has far outweighed the significance of these cases as factors driving the Australian HIV epidemic. We also know that this publicity carries with it a serious risk of fuelling HIV-related stigma and discrimination (with consequent detriment to public health), through the creation and perpetuation of misleading stereotypes of HIV transmission largely resulting from irresponsible or malicious people with HIV infecting others. While cases of this type have occurred, they are clearly unrepresentative of HIV infections in Australia. The great majority of Australian people have adopted and live by a set of values that include taking responsibility for one's own health, taking measures to avoid becoming infected with HIV, and if infected to avoid passing that infection to others.

The recent commitment of all Australian jurisdictions to introduce nationally consistent public health frameworks for managing people with HIV who risk infecting others has further strengthened the architecture of our response to HIV. Australian public health frameworks do not deny a role for the criminal justice system in exceptional cases, and do recognise the necessity for referral of cases of HIV risk or transmission to police where there is evidence of intent to cause serious harm. This is consistent with criminal laws which prohibit the intentional or reckless infliction of serious harm more broadly. While there may be a role for the criminal justice system in some cases, there is nothing in the history of Australia's HIV epidemic or response to indicate that we should depart from the principle enunciated in numerous policy documents on management of those placing others at risk of HIV infection, including the 2002 ANCAHRD paper on *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission*, which stated in the context of HIV that 'punishment under public health or criminal law should be reserved for the most serious cases of culpable behaviour as a last resort'.

Australia's public health laws, policies and procedures, provide the best approach to achieving behaviour change in the very small proportion of HIV-positive people who require intensive interventions to bring about the required behaviour change. All the evidence indicates we should maintain our faith in that system.

Endnotes

- 1** Rosen G. 'History of Public Health' *The History of Public Health and the Modern State* Porter D (ed) Rodophi, 1994 <http://books.google.com.au/books?id=1Z60hIDIWvUC>
- 2** Adopting this public health model has resulted in Australia experiencing a comparatively low infection rate. After 27 years, the epidemic in Australia remains largely among the first population group of contact (gay men), and infection rates among Australian sex workers and IDUs are some of the lowest in the world.
- 3** ANCAHRD (2002), *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission* p 2
- 4** For a useful summary of Australian laws and policies relating to HIV management, see the Australasian Society of HIV Medicine's (ASHM) pending *Guide to Australian HIV Laws and Policies for Healthcare Practitioners* (due for publication late 2009)
- 5** Griew R, Russell L, Buchannan D (2007) *Review of policies for the management of people with HIV who risk infecting others*, p 21
- 6** *Ibid*, p 21
- 7** *Ibid*, p 21
- 8** *Ibid*, p 21
- 9** Endorsed by Australian Health Ministers' Conference April 18, 2008
- 10** Australian Health Ministers' Conference (2008) *National Guidelines for the Management of People with HIV who Place Others At Risk* p 3
- 11** *Ibid*, p 3
- 12** NSW Health (2009) *HIV - Management of People with HIV Infection Who Risk Infecting Others*, p 1
- 13** Queensland Health (2008), *Protocol for the Management of People with HIV who Place Others at Risk*, p 4
- 14** Queensland Health, 2009, *Protocol for the Management of People with HIV who Place Others at Risk*, p 18
- 15** See *Public Health Act 1991* (NSW) s13
- 16** See *Public Health Act 1997* (Tas) s51
- 17** See *HIV/AIDS Preventive Measures Act 1993* (Tas) s20
- 18** Griew R. *Review of Policies for the Management of People with HIV who Risk Infecting Others* Report to Blood Borne Viruses and STI Sub Committee, Australian Population and Health Development Principal Committee, 2007
- 19** Burris S, Beletsky L, Bureson J, Case P, Lazzarini Z, 'Do criminal laws influence HIV risk behaviour? An empirical trial,' *Arizona State Law Journal* (2007) <http://ssrn.com/abstract=977274> cited in Griew R op. cit., p 12

Criminal transmission of HIV in Australia

Melissa Woodroffe

'HIV is a virus, not a crime.'

Edwin Cameron, Justice of Supreme Court, South Africa

Legislation in the form of both criminal laws and/or public health laws is being introduced in an increasing number of countries worldwide as a means of reducing the spread of HIV and to deal with its social consequences.

Australia has a strong and successful history of HIV prevention and management policies when compared to other developed countries. Notably, the estimated prevalence of HIV in adults in Australia is around one-sixth of that in the United States, and one-third of that in Canada and France.

Australia's successful response to HIV/AIDS has been achieved primarily through effective health education and interaction with communities most affected by HIV/AIDS. Such interaction was driven by the guiding principles of the 'enabling environment': an environment where people living with HIV are encouraged and supported to participate in policy, social and legal decisions related to HIV prevention strategies, and to access voluntary testing and treatment. That work requires an ongoing evaluation of the impact of government policies on people living with HIV, including evaluation of the effects of criminal sanctions on the management of the transmission of HIV.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has set out guiding principles for developing policy and legislation to prevent the spread of HIV¹: principles that apply to the use of coercive powers under criminal and public health laws. Those principles are based on the rationale that prevention of HIV must be the primary objective of any legislation, and any infringements on human rights must be justified and used only as a last resort. Likewise, the first objective of the current (fifth) National HIV/AIDS Strategy is 'to reduce the number of new HIV/AIDS infections nationally, through health promotion, harm minimisation, education and improved awareness of transmission and trends in infections'.²

Criminal prosecutions for HIV transmission were unheard of in the 1980s, and rare in the 1990s. Those undertaken occurred in Victoria where convictions for reckless endangerment went unrealised or were overturned (but resulted in considerable media and public resentment), basically as a result of the low risk of transmission associated with individual sexual encounters. Recently, there has been an increase in the number of cases being prosecuted, with around 20 cases in a number of states this decade. This increase in prosecutions mirrors a similar trend internationally.

This paper argues that it is not coincidental that the increase in prosecutions relating to HIV transmission offences has occurred at a time when HIV has transformed from the terminal diagnosis it once was. Some analysts are also suggesting that there has been a changed perception of the 'threat' of HIV in some sexually active and 'at risk' demographic groups, as well as a noticeable drift in Australian HIV policy focus that began during the Howard years.³ Conversely, transmission offences have attracted opprobrium and prosecution more often, even as improvements in HIV treatments have reduced the health consequences of HIV infection.

Criminal laws are designed to produce order in society through the punishment of offenders, provision of justice for victims and deterrence to others from committing similar acts. Public health laws on the other hand, seek to effect change in risk-taking behaviour among those who expose others to the risk of HIV transmission. This includes support and counselling and, if these fail, through more punitive measures such as court orders or (as a last resort, but a resort which has been applied⁴) detention.

The criminal law objectives of incapacitation, rehabilitation, retribution and deterrence are fundamentally ill-suited to achieving the policy goal of reducing HIV infections. Consider the following. An HIV-positive person who is imprisoned will still be HIV-positive when released. Furthermore, there is less ready access to condoms in a prison environment, leading to increased likelihood of unsafe sex practices and an environment where HIV transmission may be increased among the prison population. The rehabilitative aspect of prison is questionable, since 'human behaviours . . . are complex and difficult to change through blunt tools such as criminal punishments'.⁵ Counselling and education are more likely to have a long-term rehabilitative effect. The concept of retribution is not designed to alter future conduct, but to impose retrospective punishment. The blame rests on one sexual partner, rather than reinforcing the public health message that both partners are responsible for each other and for their own sexual health. Finally, in terms of deterrence, no studies to date have shown that HIV transmission has been prevented by the application of criminal law sanctions.⁶ There is a serious risk that harsh punitive justice will reinforce the HIV/AIDS related stigma, spread misinformation about HIV/AIDS and create a disincentive to HIV testing, as people fear a threat of incurring criminal liability.

Consequently, this paper argues that criminal laws should be applied only to intentional criminal transmission of HIV and not to exposure to the virus where no transmission occurs. Furthermore, criminal laws should be general and not include specific HIV transmission offences as the enactment of HIV-specific offences only serves to further stigmatise HIV and treat HIV-positive people as potential criminals. This approach has been endorsed by UNAIDS, which expresses concerns regarding the use of HIV specific offences.⁷

Criminal and/or public health legislation should not include specific offences against the intentional and deliberate transmission of HIV, but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.

While existing general criminal offences are preferable to HIV-specific offences, their use has the effect of leaving it unclear as to what charges could and should be used in HIV transmission cases. Will we see HIV transmission inappropriately included within offences such as murder, manslaughter and sexual assault instead of the more logical grievous bodily harm sections? That uncertainty is addressed below.

Criminal laws in Australia

In Australia, criminal legislation relating to HIV transmission/exposure is the responsibility of states and territories. The laws vary significantly between different jurisdictions and therefore different laws apply according to where an alleged transmission act took place. A summary of the different criminal laws is included in Appendix 1 at the end of this chapter. Criminal and public health laws applying to HIV transmission and/or exposure are inconsistent across the country in their definition of offences, defences and responses/penalties. Table 1 outlines some differences in Australia's eight jurisdictions with respect to whether criminal laws include transmission or exposure offences, and indicates which states retain HIV-specific offences. The table also outlines the responsibilities of HIV-positive people with respect to disclosure of HIV status and/or safe sex requirements as defined under public health laws.⁸

TABLE 1 **Criminal and public health laws with reference to HIV transmission and/or exposure**

Jurisdiction	Criminal Law	Public Health Law
NSW	Crimes Act 1900 Transmission or attempted transmission No exposure offences No HIV-specific offences	Public Health Act 1991 Disclosure required before sexual intercourse
VIC	Crimes Act 1958 Exposure and transmission offences HIV-specific offences (serious bodily disease)	Health Act 1958 Safe sex required Disclosure not specifically required but a defence to any infection transmitted
QLD	Criminal Code 1899 Transmission offences No exposure offences No HIV-specific offences	Public Health Act 2005 Safe sex required Disclosure not specifically required but a defence to transmission Additional offence of exposure to infection as well as actual infection
WA	Criminal Code Transmission offences No exposure offences No HIV-specific offences	Health Act 1911 No specific sections regarding responsibilities of HIV-positive individuals with respect to sexual intercourse or disclosure
SA	Criminal Law Consolidation Act 1935 Transmission and exposure offences No exposure offences No HIV-specific offences	Public and Environmental Health Act 1987 Safe sex required No specific disclosure requirement
TAS	Criminal Code Act 1924 Transmission offences No exposure offences No HIV-specific offences	HIV/AIDS Preventative Measures Act 1993 Safe sex required Disclosure to sexual partners and needle-sharing partners required
NT	Northern Territory Criminal Code Act Transmission and exposure offences No HIV-specific offences	No laws specific to HIV disclosure or transmission
ACT	Crimes Act 1900 Transmission offences No exposure offences No HIV-specific offences	Public Health Act 1997 No specific sections regarding responsibilities of HIV-positive individuals with respect to sexual intercourse or disclosure

Victoria is the only state with a specific HIV offence. New South Wales repealed its specific HIV transmission offence (s36 *Crimes Act 1900*) in 2007 and subsumed it within the more general grievous bodily harm section. Victoria⁹, South Australia¹⁰ and the Northern Territory¹¹ extend culpability beyond actual harm and criminalise exposure to HIV, where no actual transmission takes place. The HIV sector has strenuously criticised the criminalisation of non-disclosure and acts of exposure (only) to HIV, arguing criminal law should be reserved for only the rare and worst cases of deliberate and intentional transmission.

To date, a variety of charges have been brought against persons in different Australian states: grievous bodily harm; causing another person to be infected with a grievous bodily disease; transmitting a serious disease with intent; endangering a person by exposing to a risk of serious bodily disease; reckless

conduct endangering life, and recklessly causing serious injury (not to mention the ACT charge of 'knowingly transmitting' despite no evidence that any person had been exposed to the HIV virus¹²). However, those charges do not necessarily represent the full range of charges that might be laid. Prosecutions in overseas jurisdictions indicate that it is theoretically possible that charges could be brought in Australia for murder; attempted murder; manslaughter by criminal negligence, or unlawful and dangerous act; using a poison to endanger life; common law nuisance; negligently causing grievous bodily harm by criminal negligence; or sexual assault.¹³ More work needs to be done in this area to assess the applicability of those laws, and efforts made to ensure HIV transmission 'criminality' is not extended further.

Assault and statutory offences

The following section gives an overview of the *possible* offences, under which an individual could be charged in relation to HIV transmission. Due to the relatively low number of cases having been prosecuted to date, much of this is hypothetical and it may be that some offences are never used; however, it is important to highlight the (worryingly) broad coverage of the criminal law in many states.

Grievous bodily harm

All states and territories have grievous bodily harm offences (albeit worded slightly differently) including intentional and reckless elements.

Intent

Where HIV is transmitted through sexual contact, it may be difficult to prove actual intention to cause injury as the very nature of sexual relations is that they are conducted in private. This means that intention can often be proven only through witness testimony in the absence of any direct evidence. Proof of intent may largely rely on the credibility of witness testimony in a scenario where one witness's credibility is assessed against another's. In *R v Reid*¹⁴, the fact that Reid had publicly taunted the complainant with the fact that he had been diagnosed as HIV-positive as a result of sexual contact with Reid, was held to be evidence of intention.

Recklessness

The tests for recklessness used to establish the offence of murder, is foresight of probability of death.¹⁵ The prosecution must prove beyond a reasonable doubt that the accused person foresaw that death of the victim would be the *probable* result of the accused person's acts. Probability is a higher test than mere possibility. Where it is possible (but not likely) that HIV infection will occur as a result of the act, the offence of murder will not be established. For offences other than murder, for example grievous bodily harm, advertence to the *possibility* of injury would be sufficient.¹⁶ It is possible that evidence of the use of a condom and safe sex practices could be used to negate the requisite *mens rea* (mental element) of the offence.

The degree of knowledge possessed by the accused about their HIV status will be relevant to the test of recklessness. Recklessness will be made out where it is proven that a person knew they were HIV-positive but decided to engage in high-risk unprotected sexual intercourse and in doing so, 'run the risk'.

A person cannot be held liable for a transmission offence if it can be proven that they were unaware, at the time of the act that caused another person to become infected with HIV, that they were HIV-positive.

Negligence

A person could hypothetically be charged with the inadvertent transmission of HIV under section 54 of the NSW *Crimes Act*, or section 174E of the *Northern Territory Criminal Code Act*. These provisions might be used where the standard of 'recklessness' cannot be met. Given that most inadvertent transmission of HIV does not result in death shortly afterwards, it is possible that transmission could result in a charge of negligently causing grievous bodily harm. The question is whether a reasonable person in the position of the accused would have realised that the accused was exposing the victim to an appreciable risk of serious injury. A charge relating to negligence is worrying since it risks subjecting

mere inadvertence to liability for a serious offence and, as Bronitt argues, extending the use of the criminal law too far.¹⁷

One type of negligent act might be where HIV was transmitted by a person who was unaware they were HIV-positive but had previously engaged in risky behaviours that should have alerted them to the risk they might be HIV-positive. In 2008, a Swiss court ruled that a person who was unaware that he was HIV-positive, but was aware that a previous partner was HIV-positive, was guilty of negligent transmission of HIV for having unprotected sex with a later partner.¹⁸

Endangerment

Criminal legislation in Victoria, South Australia and the Northern Territory contain offences of reckless endangerment of life and/or health. This means that an HIV-positive person who exposes another person to the risk of contracting HIV, even if there is no actual transmission, can be charged with an offence. In South Australia, Parenzee was convicted of three counts of endangering life under s29(1) of the *Criminal Law Consolidation Act 1935* (SA). Similarly, Kuoth was convicted of reckless conduct endangering life under s22 of the *Crimes Act 1958* in Victoria.

Sexual assault and consent

The applicability of sexual assault laws to HIV transmission relates to whether there is an innate distinction between consenting to sexual intercourse, and consenting to sexual intercourse with an HIV-positive person. The Canadian Supreme Court held that an HIV-positive person has a duty to disclose their HIV status before engaging in any activity that poses a 'significant risk' of transmission of the virus, for example, unprotected sexual intercourse.¹⁹ Non-disclosure, or lying about HIV-positive status, is considered fraud that vitiates consent to sexual intercourse, and so the sexual intercourse becomes a sexual assault.

Could similar charges be laid in Australia? With the exception of Victoria, states and territories have definitions of consent in the criminal legislation that state consent is not valid if given as a result of misrepresentation or fraud as to the nature of the sexual intercourse. For example, in NSW, the *Crimes Amendment (Consent – Sexual Assault Offences) Act 2007* provides a new statutory definition of consent, and sets out the circumstances in which consent may be negated (at s61HA (5)(c)): 'A person who consents to sexual intercourse with another person . . . under any other mistaken belief about the nature of the act induced by fraudulent means . . . does not consent to the sexual intercourse'. The accused must also know that the other person only consented to sexual intercourse because they were under a mistaken belief as to the person's HIV status.

It is therefore conceivable that where a person consents to sexual intercourse and the other person knew that they were HIV-positive but did not disclose this fact, such non-disclosure could be held to vitiate the consent given, resulting in a potential charge of sexual assault.

Manslaughter by criminal negligence

Manslaughter charges could be laid if HIV were inadvertently transmitted, causing death. It has been held that in order for inadvertence to be held criminally culpable, there must be 'such a great falling short of the standard of care which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment'.²⁰ In the case of HIV, this would require proof of a high risk that infection would occur as a result of the accused's act or omission. If such a case were to arise in Australia, proof of careful condom usage, safe sex practices and low viral load could negate the level of risk required.

Manslaughter by unlawful and dangerous act

This offence requires there to be an unlawful and dangerous act that causes the death of another.²¹ This may be a possible charge if HIV transmission is caused by the commission of another criminal act such as sexual assault or intravenous drug injection, resulting in the person's death from the HIV infection.

Murder

There is no precedent in Australia of a person being charged with murder in relation to the transmission of HIV. Although unlikely given the increasing life-span of HIV-positive people where best conditions of care occur, it is still theoretically possible for a murder charge to be laid for a transmission offence if death occurred soon after transmission. In April 2009, a Canadian man was charged and convicted of two counts of murder for having had unprotected sexual intercourse with a number of women, two of whom contracted HIV and died within two years of diagnosis.²² While such rapid progression of HIV is rare, it can occur. (The case is likely to go to appeal so its precedence value is currently uncertain.)

An Australian prosecution for murder would need to establish causation (that the infection with HIV was the 'operating and substantial cause of death'²³), and also that the accused had the required *mens rea* (mental element) for murder: the accused must have an intention to kill or reckless indifference to life. Many cases of HIV transmission have not been understood as involving an intention to cause death but instead, recklessness to the risks of infection. The difficulty of proving the high level of mental culpability required to establish murder is likely to prevent murder charges being laid for HIV transmission cases.

Differences in laws across states

The criminal laws used, and those that could be used, to prosecute HIV transmission/exposure vary widely across Australian jurisdictions, as do public health laws. One of the most striking differences is that Victoria, South Australia and the Northern Territory criminalise HIV exposure (where there is no transmission) while other states do not.

The patchwork of laws is, however, more complicated than some states criminalising things that others do not. In numerous instances, laws in a single jurisdiction address a particular practice as illegal or as defence. That identification and targeting of different aspects of behaviour, differentiated and multiplied across eight jurisdictions, makes for substantial variation of laws. For example, in NSW, public health law requires an HIV-positive individual to disclose their status to partners before they have sex, and it is no defence if condoms or other safe sex practices are used. In Tasmania, disclosure is required before sex but also before sharing a needle (i.e., injecting equipment). In Victoria, a person is required to use a condom, but it is a defence if the person becomes infected after unprotected sex if they voluntarily consented to the risk of being infected.

The variation of laws impacts one of the important aspects of the law: people's awareness of their legal obligations. This is particularly important if the intention of laws includes the goal of modifying behaviour. In the case of HIV prevention, laws should encourage safer sex practices in order to prevent the spread of the virus in the population. A discussion of how criminal laws are inherently poorly placed to achieve this goal follows later in this paper. Here, however, we suggest the more general problem that if people are not aware of the law, they cannot adapt their behaviour accordingly and may breach laws inadvertently. This is a particular problem when there is such a wide variation in laws between states and territories, given people are not stationary beings. For example, an HIV-positive person living in Victoria may receive clear and comprehensive counselling about their legal responsibilities in relation to transmission and exposure risks of HIV and their obligations in relation to safe sex and relationships, but if that person moves to another state, or travels interstate for a holiday, they may unknowingly break laws that are completely different from those they know and understand without even realising laws differ across state borders.

The Australian National HIV/AIDS Strategy emphasises the need for national consistency in the management of people who put others at risk of HIV infection. The strategy clearly supports counselling and community management in the first instance, rather than recourse to the criminal law. It also urges states and territories to develop a common approach in this area, something that has yet to be achieved.

The National Public Health Partnership has developed a legislative tool on this topic²⁴ designed to inform and aid the development of new, and the review of existing, legislation. While it is mainly focused on public health law, there is recognition in the document that there is inevitable interaction with other legislation, including criminal law.

The impacts of criminal prosecutions

'AIDS makes us angry. But in law we must be rational.'

The Hon. Michael Kirby, Former Justice of the High Court of Australia 1996-2009²⁵

Criminal law is used to demonstrate society's disapproval of particular conduct, and to punish offenders either by monetary fine or by imprisonment. Criminal law should be used where there is a legitimate public interest at stake and not for private vengeance. At first glance it may appear straightforward that the public must be protected from being infected with HIV. Society has a right to such protection, and those who abuse that right should be punished. However, on closer inspection, taking that argument at face value can result in consequences that are clearly detrimental to public health, and result in outcomes that are not in the public interest. Furthermore, the application of the criminal law to HIV transmission, results in serious intrusions by the state (police and criminal justice system) into people's private (including sexual) lives.

The enactment of criminal laws thus causes some controversy. The most effective response to the HIV epidemic in the majority of instances is not punishment or prohibition, but strategies to affect human behaviour in a way that will reduce the spread of HIV. Fear, discrimination and stigmatisation of HIV-positive people are part of the general public's response to HIV. Criminal laws that result in media uproar over the very few cases prosecuted, serve only to reinforce such negative responses.

The Fifth National HIV/AIDS Strategy highlights the importance of high levels of testing in groups at risk of HIV and remains central to the management of the epidemic in Australia.²⁶ An undesirable result of criminalising HIV transmission is its potential to deter people from being tested for HIV. A reduction in testing may lead to increased risk of HIV transmission, due to people being unaware of their HIV status, not accessing appropriate treatment (so not minimising their viral load and infectiousness) and engaging in risk practices that may transmit the virus to others.

The most common mode of transmission of HIV is via sexual intercourse, a reality for which the blunt tool of criminal law is particularly ill-suited.

Prohibiting alcohol and other drugs, consensual sex, or prostitution has never succeeded in preventing these behaviours . . . the harm that follows from stigmatising them and driving them underground has been greater than any harm (or supposed harm) of the activities.²⁷

Sexual health should ultimately be the responsibility of every individual, irrespective of HIV status, with everyone encouraged and empowered to take responsibility for their own health, both in adopting safer sexual practices and in accessing sexual health testing, treatment and support services. The criminalisation of HIV transmission and exposure is in conflict with the principle of shared responsibility for health and sexual health. Putting a higher level of responsibility on the HIV-positive person to disclose their HIV status and practise safe sex suggests that HIV-negative people, or those who are unaware of their status, don't have the same responsibility for practising safer sex. This provides a false and dangerous sense of security.

'Criminalisation places blame on one person instead of responsibility on two.'

Edwin Cameron, Justice of Supreme Court, South Africa

Australian HIV transmission prosecutions currently occur without formalised guidelines on the kind of cases that should be pursued. The office of the Director of Public Prosecutions makes the decision whether to prosecute an individual under the criminal law. This decision is based on the likelihood of a successful prosecution, and the public interest in pursuing such a prosecution. For example, the prosecution guidelines in NSW state that in making the decision to prosecute, 'the general public interest is the paramount criterion'.²⁸ In a case of HIV transmission, where there is some evidence of deliberate intention to infect another, a prosecution would almost certainly be brought in the interest of protecting the public from infection. However, it is surely difficult to argue that imprisonment delivers greater behavioural change than public health interventions including intensive support and counselling, and consequently that criminal prosecution delivers a better 'public interest' result than a public health intervention.

In the United Kingdom, prosecution guidelines specific to different offences have been implemented to guide prosecutors in their decisions whether or not to prosecute.²⁹ For offences relating to the intentional or reckless transmission of sexually transmitted diseases, the guidelines outline the factual, scientific and medical evidence on which to base a prosecution. Such guidelines recognise the tension between public health and criminal justice considerations; for example, making it clear that only in the rarest of cases could a person who has actively sought to avoid onward transmission of HIV be successfully prosecuted (in line with sexual health promotion practice, encouraging the use of safe sex practices to prevent transmission of infection).

Also of some concern is the capacity of solicitors, barristers and judges to apply current expert argument and understanding to individual cases. Consider the following cases, which are not generally included as cases involving HIV transmission via sexual relations, but which are of some relevance:

- In January 2008, an HIV-positive man was arrested for public drunkenness in Brisbane. During his arrest the man bit a police officer although the bite did not break the skin. The man pleaded guilty to serious assault and his lawyer argued for a suspended sentence citing the fact that the bite did not break the skin in mitigation. The man received a twelve-month jail sentence. Even though he was not charged with an HIV-related offence, the judge observed in sentencing that the risk of HIV had been devastating to the police officer and his family. The judge did not note the absence of HIV transmission risk and consequently, via sloppy but routine reporting, harmful HIV transmission mythology was perpetuated.³⁰
- In 1989 (*R v Barry*³¹) a 17-year-old, HIV-positive Aboriginal man was charged with wilful exposure of HIV as a result of rubbing his faeces into the face of a police officer. He was sentenced to twelve months in prison and later committed suicide in his cell. Prosecutorial discretion should have been exercised due to the lack of HIV transmission risk (and because no transmission occurred), but, instead, the law was inappropriately applied, with dire consequences.

HIV transmission prosecutions have resulted in sensationalised media coverage, with the potential to jeopardise and undermine successful public health measures by negatively affecting public perception of HIV/AIDS and HIV-positive people. Moreover, such reporting may have significant detrimental and disproportionate impacts on certain populations such as gay men, Aboriginal people and people identified as migrants. In turn this may increase stigmatisation and feelings of isolation in already marginalised groups, and further hinder their access to health services, appropriate counselling and education.

Criminal prosecutions have a wide range of effects on HIV-positive individuals and their families. Extensive police investigations are required to prove transmission, often involving intrusion into the intimate details of people's sexual activities and private lives. This intrusion can result in violations of privacy, and stigmatisation of witnesses, the complainant and the accused due to their names being included in media reports. Even where name suppression is ordered for complainants and their families, this is often inadequate in an open court where the name of the accused is not suppressed. Recently, a man was charged with infecting his wife with HIV, and although her name and the names of her children (one of whom was HIV-positive and died) were suppressed, the name of her partner (the accused) was not, and so it would not be difficult in a small community to identify all members of the family.

HIV-positive people remanded in custody or serving prison sentences face particular challenges, especially those who are taking medication. Only certain jails have full facilities to provide the medical care required by HIV-positive inmates. Even when provided, it can be difficult, or impossible, for HIV-positive inmates to maintain their dietary and medication regimes. Another significant problem is the extreme difficulty faced by HIV-positive prisoners in keeping their HIV status confidential in the prison setting. Factors such as the requirement for specialised and often frequent medical consultations, visible signs of HIV infection such as lipodystrophy and special dietary requirements, and the housing of HIV-positive prisoners alone in cells serve to mark out HIV-positive prisoners. Rumours quickly circulate, and identification of HIV prisoners is not difficult in the prison environment. This results in discrimination, stigmatisation and often abuse of HIV-positive inmates, both from other inmates and from prison staff.

In the UN Political Declaration on HIV (2006)³², governments agreed that the way to address HIV, while simultaneously protecting human rights, was to make prevention of HIV the main focus of any national strategies regarding HIV transmission, and ‘to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV . . . with full and active participation of people living with HIV’. Criminal sanctions conflict with this stated goal. What alternatives should we be considering to the criminal law? The spread of HIV is, like the spread of any other disease, a public health matter and so public health initiatives should be enhanced and supported. Public health policies should be used to support HIV-positive individuals, providing them with education, care, and information on how to protect their sexual partners. There is no rational policy impetus for the increase in criminal prosecutions for HIV transmission.

APPENDIX 1

Summary of criminal offences in each state and territory

For each of the following offences, the prosecution is required to prove all the elements of the offence beyond a reasonable doubt. Note that the sections included below cover all *possible* offences under which HIV transmission could be charged, and charges have not necessarily been laid under each one, and may not be laid.

Jurisdiction	Section of Act	Penalty	Charges laid
NSW Crimes Act 1900	s33 Inflicting grievous bodily harm with intent	25 years imprisonment	No
	s35 Recklessly inflicting grievous bodily harm in company Recklessly inflicting grievous bodily harm	14 years imprisonment 10 years imprisonment	No No
	Old s35 Malicious infliction of grievous bodily harm	7 years imprisonment	Yes
	s39 Intention to injure by poisoning	10 years imprisonment	No
	s54 Causing grievous bodily harm by unlawful or negligent act or omission	2 years imprisonment	No
	s61I Having sexual intercourse with a person without consent is sexual assault	14 years imprisonment	No
	s344A Attempting to commit any offence under the Act	Same penalty as actual offence	No
VIC Crimes Act 1958	S16 Intentionally causing serious injury to another person	20 years imprisonment	Yes
	s17 Causing serious injury recklessly	15 years imprisonment	No
	s18 Causing injury recklessly Causing injury intentionally (10 years penalty).	5 years imprisonment 10 years imprisonment	No No
	s19 Offence to administer certain substances	5 years imprisonment	No

Jurisdiction	Section of Act	Penalty	Charges laid
VIC	s19A Intentionally causing a very serious disease (which is defined to mean HIV); penalty 25 years maximum	25 years imprisonment	Yes
	s22 Reckless conduct placing another person in danger of death	10 years imprisonment	Yes
	s23 Reckless conduct that places or may place another person at risk of serious injury	5 years imprisonment	Yes
	s24 Negligently causing serious injury	10 years imprisonment	No
	s31 Assault	5 years imprisonment	No
	s321M Attempts to commit the crime	Same penalty as actual offence	No
WA Criminal Code Act 1913	s266 Every person who has in his charge or under his control a dangerous thing, must use reasonable care and precautions to avoid endangering the life, safety or health of any person	Depends on consequence of actions	No
	s294(8) Intentionally doing any act likely to result in a person having a serious disease	20 years imprisonment	No
	s297 Unlawfully causing grievous bodily harm to another person If done in circumstances of aggravation	10 years imprisonment 14 years imprisonment	Yes
	s304 Acts or omissions causing bodily harm or danger	5 years imprisonment or 20 years imprisonment if done with intent	No
	s317 Assaults occasioning bodily harm	5 years imprisonment or 7 years in circumstances of aggravation	No
	s325 Sexually penetrating another person without their consent is unlawful	14 years imprisonment	No
	s552 Attempts to commit offence	Same penalty as actual offence	No

Jurisdiction	Section of Act	Penalty	Charges laid
QLD Criminal Code 1899	s317(b) Any person who, with intent to cause grievous bodily harm or transmit a serious disease, and who does grievous bodily harm or transmits a serious disease to any person	Life imprisonment	Yes
	s322 Administering poison with intent to harm	14 years if the noxious substance endangers the life or causes grievous bodily harm; 7 years imprisonment otherwise	No
	s328 Negligent acts causing harm	2 years imprisonment	No
	s335 Common assault	3 years imprisonment	No
	s339 Assaults occasioning bodily harm	7 years imprisonment or 10 years if aggravated	No
	s32 Unlawfully causing grievous bodily harm to another	14 years imprisonment	No
	s322 Administering poison with intent to harm	7 years imprisonment or 14 years if the poison or noxious thing endangers the life or causes grievous bodily harm	No
	s349 Having carnal knowledge of another person without their consent is rape.	Life imprisonment	No
s4 Attempts to commit offence	Same penalty as actual offence	No	
SA Criminal Law Consolidation Act 1937	s23(1) Causing serious harm with intent	15 years imprisonment or 20 years in circumstances of aggravation	No
	s23(3) Causing serious harm recklessly	14 years imprisonment or 19 years in circumstances of aggravation	No
	s24(1) Causing harm with intent	10 years imprisonment or 13 years in circumstances of aggravation	No
	s24(2) Causing harm recklessly	5 years imprisonment or 7 years in circumstances of aggravation	No

Jurisdiction	Section of Act	Penalty	Charges laid
SA	s29(1) Doing an act or omission knowing that the act or omission is going to endanger the life of another, and intending to endanger the life of another or being reckless as to whether the life of another is endangered.	15 years imprisonment or 18 years if the offence was aggravated	Yes
	s29(2) Doing an act or omission knowing that the act or act or omission is likely to cause serious harm to another and intending to cause such harm, or being reckless as to whether such harm is caused.	10 years imprisonment or 12 years if the offence was aggravated	No
	s270A Attempts to commit offence	Same penalty as actual offence	No
TAS Criminal Code Act 1924	s150 Persons in charge of dangerous things	21 years imprisonment at discretion of judge for all offences	No
	s170 Intentionally maiming, disfiguring or disabling or causing grievous bodily harm to any person, by any means whatever	21 years imprisonment at discretion of judge for all offences	No
	s172 Causing grievous bodily harm to any person by any means whatever	21 years imprisonment, at discretion of judge for all offences	No
	s175 Unlawfully administering poison with intent to harm	21 years imprisonment, at discretion of judge for all offences	No
	s176 Administering a noxious thing	21 years imprisonment, at discretion of judge for all offences	No
	s18 Having sexual intercourse with another person without their consent	21 years imprisonment, at discretion of judge for all offences	No
	s299 Attempts to commit the crime	Same penalty as actual offence	No
NT Criminal Code	s174C Recklessly endangering life	10 years imprisonment, 14 years for an aggravated offence	No
	s174D Recklessly endangering serious harm	7 years imprisonment, 10 years for an aggravated offence	No

Jurisdiction	Section of Act	Penalty	Charges laid
NT	s174E Negligently causing serious harm	10 years imprisonment	No
	s177 Intending to cause serious harm and causing harm by any means	Life imprisonment	No
	s181 Unlawfully causing serious harm to another	14 years imprisonment	No
	s186 Causing bodily harm	5 years or 2 years imprisonment if found guilty summarily	No
	s187/188 Common assault	1 year imprisonment	No
	s192 Sexual intercourse without consent	Life imprisonment	No
	s43BF Attempts to commit offence	Same penalty as actual offence	No
ACT Crimes Act 1900	s19 Intentionally causing grievous bodily harm	15 years imprisonment or 20 years in aggravated circumstances	No
	s20 Recklessly causing grievous bodily harm	10 years imprisonment or 13 years in aggravated circumstances	No
	s25 Causing grievous bodily harm by any unlawful or negligent act or omission	2 years imprisonment	No
	s27(3(b)) Intentionally and unlawfully administers or causes to be taken any injurious substance likely to endanger life or cause grievous bodily harm	10 years imprisonment	No
	s54 Sexual intercourse without consent and being reckless as to whether consent was given.	12 years imprisonment or 14 years if offence committed in company of another person	No
	s298 Attempts to commit crime	Same penalty as actual offence	No

Endnotes

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- 8 Public Health laws are further discussed in more detail in chapter 3.
- 9 *Crimes Act 1958* (Vic) s23: conduct endangering persons. 'A person who, without lawful excuse, recklessly engages in conduct that places or may place another person in danger of serious injury is guilty of an indictable offence'. Penalty maximum 5 years imprisonment.
- 10 *Criminal Law Consolidation Act 1935* s29: Acts endangering life or creating risk of serious harm.
- 11 *Criminal Code* (NT) s174B(1): 'conduct that may give rise to a danger of death or serious harm includes exposing a person to the risk of catching a disease that may give rise to a danger of death or serious harm'.
- 12 See details of the case against Scott in chapter 9
- 13 See, for example, chapter 2, and also GNP+ Global Criminalisation Scan
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- 16 *R v Coleman* (1990) 47 ACrimR 306, *Stokes v Difford* (1990) 51 ACrimR 25
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HIV transmission and the jurisdiction of criminal law

Peter D Rush

For some time now, the criminalisation of HIV transmission has occupied the attention of courts, legislators, the legal profession more generally, as well as policy advocates. Prosecutions for HIV transmission – and sometimes for exposing another to the risk of HIV – have taken place and been conducted in many, if not all, of the Australian states and territories. The most recent tally indicates something in the order of 20 prosecutions.¹ Three periods can be discerned in this process of criminalisation: in the early 1990s, the charges and prosecutions did not proceed to trial; in the mid-1990s, the trials resulted in not guilty verdicts; and then at the end of the decade, guilty verdicts and sentences were handed down. We are now in a fourth period: from 2005 onward, there have been an increasing number of prosecutions, guilty pleas and court hearings at both trial and appellate levels of the criminal courts. These continue to make media headlines, and sometimes legal headlines.

A number of themes inform legal commentary on the criminalisation of HIV transmission. One question that has loomed large is whether the institutions of criminal law or those of public health are the most appropriate venue for responding to the social problem of HIV transmission. The most commonly articulated position has been one which prefers a public health response, with criminal law relegated at best to a secondary role. Given this use of criminal law, a second question that has gained some traction in the legal commentary and policy debates concerns the most appropriate legal technology: if criminal law is used, then should criminalisation proceed by way of the general offences of criminal law or should it be a matter of creating offences specific to HIV? In Australia, a few HIV-specific offences do exist. Most prosecutions have, however, been under the general provisions of criminal law. A third strand in the legal commentary turns its attention to the details of the application of criminal law to the social problem of HIV transmission. Hence, a considerable degree of commentary has attempted to elaborate problems with the legitimacy of particular interpretations of judicial rulings and legislative will.

This chapter is situated in the vicinity of the last two strands of commentary. It proceeds by retracing the judicial and legislative elaborations of the law in this area of criminal law. The initial impetus for doing so is the experience of being struck by the way that the performance of criminal law displays considerable difficulty holding onto HIV transmission as a question of law. Yet this is not simply a personal predicament, although it is one to which I want to respond. It is also, I suggest, the predicament that structures the juridical experience of HIV transmission as a crime.

When we analyse and represent HIV transmission as a problem of the governance of crime, how can criminal law be rendered lawful in the criminalisation of HIV transmission? One common response to this question of jurisdiction, or legal speech, is to frame the authority and power of criminal law in terms of a normative narrative of moral principles and policies of responsibility. In the context of the criminalisation of HIV transmission, this issues in a debate about whether the response is best engaged as a social problem of public health or as a legal problem of criminal justice. Although I don't want to get into the details of this debate, I have no doubt that community regimes of public health are more apt. This is so because the communities of people living with HIV/AIDS – as well as the organisations which advocate for and represent this community – have a greater chance of ownership of the plural issues that come up, and hence having their lived experience represented in the response to and conduct of governance. Yet as Matthew Weait has forcefully argued and demonstrated, public health regimes are not the panacea that

they are often represented to be in the debates on criminalisation.² This is in part because public law, with its liberal tradition of individual responsibility, has few if any resources (of argument) to model the sexual relations of people living with HIV/AIDS in terms of shared responsibility.³ Nevertheless, as already mentioned, the dominant approach is to use a public health regime and leave criminal sanctions as an option of 'last resort'. Criminalisation remains (like a 'mop-up' strategy for the exceptional or extreme cases) to address the failures of public health regimes in effectively promoting education, counselling and prevention in recalcitrant individual cases. Yet, in this context, it is far from clear what criminalisation might mean as a question of law. Hence, my starting point in this chapter: *if and when the social problem of HIV transmission is brought before the order of criminal law, the performance of criminal law displays considerable difficulty holding onto HIV and its transmission as a question of law*. In part, this predicament is because in making sense of HIV and its transmission, the discourse of criminal law repeatedly finds itself using a rhetoric that depends for its meaning and legitimacy on other forms of knowledge: whether medical, epidemiological, sociological, or even the general cultural repertoire of images about drugs, bandits, grim reapers, sexual practices, and so on. In part, it is because the jurisdiction of criminal law is itself riven by rival and incommensurable traditions of legal argument. It is these distinct yet plural traditions that order the social problem of HIV transmission as an issue of *the legal grammar* of crime. And short of a revolution, it is these traditions which institute the structure of experience which we have come to think of as 'the criminalisation of HIV transmission'.

The chapter thus begins by briefly excavating the rival traditions which constitute the culture of argument in current criminal law. These traditions use different classifications of the conduct of law, and specifically its attribution of responsibility. *Who does what to whom when and in what manner* – in other words, questions of the legal grammar of crime – take on different meanings and values in each of these traditions. The effect is that the work of law is not held to the standards and idioms of risk, and when risk does appear it nevertheless remains a thoroughly juridical category. The second and third sections turn to another aspect of the legal grammar of crime – namely, the legislative and the common law classifications of responsibility for HIV transmission. Here, I explore the manifold ways in which HIV disappears in the grammar of the general provisions of criminal law, as well as in the logic of adjudication and judgment in the common law courts. Law misrecognises itself as monolithic, and HIV as injury and danger. The final section of the chapter draws out some of the implications of this legal predicament for how we can think about policy and advocacy around the criminalisation of HIV transmission. In particular, I want to suggest two main consequences. One, that the use of the general provisions of criminal law to criminalise HIV transmission is in need of some revision; even if I do not believe that HIV-specific offences are appropriate. Two, to the extent that an ethic of shared responsibility has been the cornerstone of HIV prevention programmes as well as policy advocacy, this ethic may have little purchase on a legal culture of argument which construes the virtue of the person living with HIV/AIDS in terms of the dangerous individual and the common good.

Rival traditions

The enterprise of criminal law orders social problems in terms of *legal* classifications and their *legal* categories. Legal classifications, however, emerge out of a number of different traditions. In an Australian context, two have dominated the form and idiom of the government of crime. One is the common law of crime and its narratives of adjudication organised around the institution and image of the court. Another is (modern) criminal law which is formed around a narrative of legislation and the role of the state. The criminalisation of HIV transmission is caught within the interstices of these traditions – and no more so than when such criminalisation speaks in the idiom of *risk*. In this section, I will thus schematically present these rival traditions of argument, their different modes of classifying the conduct of law (its attribution of responsibility), and the problematisation of risk that results.

The objects that criminal law constructs for its knowledge of social problems are different in each of these traditions. Where the common law of crime takes the *conduct and circumstances* of an event as the basis on which to construct criminal liability, modern criminal law constructs a regime of liability predicated on a representation of the event in terms of the *results* of the *behaviour* of individuals. This differentiation of the grounds of liability is one way into the predicament of law in understanding and responding to the criminalisation of HIV transmission. To the extent that our knowledge of HIV

transmission and exposure is ordered around the calculation and management of risks,⁴ then the criminalisation of HIV transmission does not sit comfortably with either of these two traditions (either the common law of crime or modern criminal law).

To be sure, the cases and legislative debates are replete with often hysterical (but also prosaic) invocations of the dire consequences of HIV transmission, as much as repeated representations of the circumstances and conduct of particular 'lifestyles'.⁵ But in these arguments the conduct or circumstances of HIV transmission function to index *risk*. This is incommensurable with the common law tradition of crime, in which the conduct and circumstances of HIV transmission would obtain their meaning as a sign of wrongdoing and an icon of a breach in an organic community of value, rather than as an index of risk to and for a heterogeneous population of typical groups and identities. A similar disparity exists for modern criminal law: this tradition takes up and understands the results or consequences of behaviour as its ground of liability. Yet for it, results obtain their meaning not as an index of risk but rather as a sign of the limits of the state. The results of behaviour are prohibited because consequences represent the limit of law's tolerance in caring for and promoting the health, wealth and security of its citizenry. Hence, the oft-invoked example of murder and the attempts in the legislation and the courts to hold HIV transmission in proximity with the crime of murder.⁶

Risk, however, is a relatively distinct category with its own history and trajectory. Some of its forms obtain their resonance from taking up the idioms of the 'society of risk'.⁷ Its form of knowledge is neither concrete and experiential (as in the imagistic tradition of the common law of crime), nor realist and empirical (as in the factual traditions of modern criminal law), but rather virtual and indeterminate. The reason of risk is calculative, its technologies are managerial, and its targets are the typical group identities that compose a population. It is neither conduct-oriented nor result-oriented but inhabits a virtual space suspended between the categories of experiential conduct and realist consequences.⁸

This is not to say that risk doesn't appear in the lexicon of contemporary criminal law. It does: its lawful names are 'recklessness' and 'dangerousness'. But with these names the order and meaning of contemporary criminal law is reformed, reshaped, reorganised around *juridical* categories of risk. As the judges have iterated in a plethora of rulings, the calculations and judgments of risk are not reducible to mathematical, statistical, epidemiological or social modes of evaluation. Rather, they are lawful questions and as such, on any given day, questions for the judge and/or jury. This is so in many crimino-legal contexts concerned with recklessness and danger, but it is especially prevalent in the context of the criminalisation of HIV transmission.

These three traditions of juridical reason give some texture to the predicament of constructing HIV transmission as a question of the legal order of crime. In summary, they are:

A common law of crime. This tradition fashions its question of liability for HIV transmission by focussing the attention of law on the *conduct (act and circumstances)* in which transmission or infection takes place. In this context, the acts of the accused and the situation in which the person living with HIV/AIDS acts, take on an increased significance as lawful questions of liability and responsibility. This goes some way to making sense of the way adjudication in common law courts spends an inordinate amount of time reconstructing and detailing the modes and manners of HIV transmission. It is at this level that common law constitutes norms of ethical comportment, which for criminal law is condensed in the demands of 'safe sex'.⁹

A modern criminal law. This tradition refashions the common law of crime by focussing the formal reason of law on the *results or consequences* of individual behaviour in order to differentiate between the licit and the illicit. This tradition gives some sense to the legally iterated remarks that link HIV transmission or exposure to 'death' or 'grievous bodily harm'. But it remains indifferent – for the purposes of legal liability – to the modes and manners of transmission.

Contemporary criminal law. While current criminal law is engaged through each of the preceding traditions, it also brings them into relation with the *virtual category of risk*. Legal judgments become fashioned in terms of the juridical calculation and management of recklessness and danger. This makes some sense of the fact that the medical and biomedical constructions of risk do not have the last word in the criminalisation of HIV transmission.

The point of drawing attention to these plural and distinctive traditions of law has been to emphasise two salient features of the order of current criminal law. One, criminal law orders social problems (and specifically the ‘social problem’ of HIV transmission) in legal terms which don’t simply reflect external social and political narratives, but rather obtain their force and power from the jurisdiction of criminal law. And two, that this ordering is riven by plural traditions of legal value such that in any single instance of the criminalisation of HIV transmission, the meaning of HIV transmission will take on its texture from how it is classified or placed in the juridical bestiary of criminal law.

In order to explore the nuances of these features, the remainder of this chapter turns to two vectors of legal classification where HIV transmission is brought before criminal law: the first concerns the *legislative* classification of HIV transmission, and the second concerns the classification of HIV transmission engaged by the adjudication of the *common law courts*.

Legislative classifications: HIV transmission in the key of harm, disease and danger

One vector for the legal representation of HIV transmission is through its legislation and its classificatory ordering of the problem of crime. The following provides a brief tabulation of the existing provisions. Its focus is on the general criminal legislation (the Crimes Acts or Criminal Codes) in the various Australian jurisdictions. This admittedly excludes from consideration two kinds of laws involved in the criminalisation of HIV: one, legislation creating quasi-criminal or regulatory offences such as those provisions found in public health legislation; and two, criminal legislation (often also of a regulatory kind) which targets particular activities such as the licensing and practice of sex work.¹⁰ As will become clear, my concern is with the ways in which general principles of criminal liability are taken up and function in the resort of the criminalisation process to general provisions of criminal law.

TABLE 1 **Criminal legislation relevant to HIV transmission**¹¹

Causing harm offences

Criminal legislation prohibits a range of offences concerned with causing harm – variously named as ‘harm’, ‘physical harm’, ‘bodily harm’, ‘injury’, ‘grievous bodily harm’ and ‘serious injury’. The legislation in most (but not all) cases defines the harm to include disease, as follows. In defining the harm, none of these prohibitions name HIV.

NEW SOUTH WALES

Crimes Act 1900 (NSW), prohibits causing ‘grievous bodily harm’ in ss33 (intentional) and 35 (reckless), and s4 defines grievous bodily harm to include ‘any grievous bodily disease’. For example, s35 was used as the prosecutorial instrument in *Kanengele-Yondjo v R* (2006) NSWCCA 354 (albeit a slightly earlier version of the section’s current language).

SOUTH AUSTRALIA

Criminal Law Consolidation Act 1935 (SA), ss23 and 24 prohibit acts causing harm and serious harm respectively. Section 21 defines ‘physical harm’ to include ‘infection with a disease’ and ‘serious harm’ to include ‘endangering life’ or ‘serious and protracted impairment of a physical or mental function’.

NORTHERN TERRITORY

Criminal Code Act 1983 (NT) prohibits causing harm or serious harm in ss186 and 181 respectively; and s1A defines harm to include ‘infection of a disease’.

WESTERN AUSTRALIA

Criminal Code Act Compilation Act 1913 (WA) contains prohibitions of bodily harm in ss294, 297, 304. Section 1(4) defines causing or doing 'bodily harm' to include 'causing a person to have a disease which interferes with health or comfort' and defines causing grievous bodily harm to include 'causing a person to have a serious disease'. For example, s297 was used as the prosecutorial instrument concerning the negligent transmission of HIV in the *Houghton* case.¹²

VICTORIA

Crimes Act 1958 (Vic) prohibits causing injury or serious injury in ss16-18 and threats to inflict serious injury in s21; the definition of 'injury' and 'serious injury' provided in s15 does *not* include causing a disease. The prosecutorial option has been to use the transmission of a serious disease provision and the endangerment provisions (listed below).

AUSTRALIAN CAPITAL TERRITORY

Crimes Act 1900 (ACT) ss19 and 20, 23-25 prohibits inflicting or causing grievous or actual bodily harm. The definition of 'grievous bodily harm' refers to 'permanent or serious disfiguring of the person', but, unlike other definitions in other states, does not name disease.

Crimes Act 1900 (ACT): the prohibition of stalking includes a definition in s35(6) which construes 'harm' to mean 'harm to mental health, or disease, whether permanent or temporary'.

COMMONWEALTH

Criminal Code 1995 (Cth) defines 'physical harm' to include 'infection with a disease' and defines 'serious harm' as harm that 'endangers' or 'that is or is likely to be significant and longstanding'. The offences to which this definition could be relevant concern – harm to public officials, serious drug offences, and drug offences harming children under 14.

Transmission of serious disease offences

While the causing harm offences have, in many instances, expanded their definitions to include infecting with a disease, these remain general legal provisions of assault. Nevertheless, there are a few *transmission of disease* offences in criminal legislation. Only the Victorian one is considered HIV-specific.

VICTORIA

Crimes Act 1958 (Vic) 19A prohibits 'intentionally causing a very serious disease' and s19A(2) defines 'very serious disease' to HIV as defined by the relevant Health Act. This section was first used in the infamous prosecution of Neal in 2008. In 2009, another prosecution of an unnamed male took place.

QUEENSLAND

Criminal Code Act 1899 (Qld), s317 (d) prohibits unlawfully transmitting a serious disease with the intention to transmit the disease. Unlike the Victorian legislation, what constitutes a serious disease for the purpose of the prohibition is *not* named. This provision was used, for example, in a number of legally unreported prosecutions in 2005 (guilty verdict, sentence 10.5 years) and 2007 (not guilty verdict).

Reckless endangerment offences

There are divisions within criminal legislation that take endangering the life of another as their subject matter (for example Part 3, division 6 of the *Crimes Act 1900* (NSW)). Here, however, I list a variety of specific endangerment offences in the general provisions of criminal legislation relating to offences against the person. These provisions are not HIV specific, yet they have been prominent in prosecutions for HIV transmission.

VICTORIA

Crimes Act 1958 (Vic), s22 (conduct endangering life concerned with risk of death) and s23 (conduct endangering persons concerned with risk of serious injury) contain prohibitions which have been used to prosecute HIV transmission cases. Maximum punishment is 10 years (s22) and 5 years (s23). This has been used in numerous prosecutions of HIV transmission since the mid-1990s (see later in this chapter).

SOUTH AUSTRALIA

Criminal Law Consolidation Act 1935 (SA), s29(1) prohibits acts endangering life or creating risk of serious harm. Maximum penalty for a basic offence is 15 years' imprisonment, for an aggravated offence 18 years' imprisonment. As in Victoria, these have been used to prosecute HIV transmission cases. See, for example, the judgment in *R v Parenzee* (2007) SASC 143.¹³

AUSTRALIAN CAPITAL TERRITORY

Crimes Act 1900 (ACT) s27 creates a prohibition of intentionally and unlawfully endangering life or causing grievous bodily harm (see s27(3)(b)). Maximum punishment is 15 years' imprisonment.

NORTHERN TERRITORY

Criminal Code Act 1983 (NT) contains offences of recklessly endangering life or serious harm in ss174C and 174D, and by virtue of s174B such offences include 'exposing a person to the risk of catching a disease that may give rise to a danger of death or serious harm'.

As this table indicates, there are at least three classifications which structure the form of the general provisions of criminal legislation that have been invoked in the context of cases of HIV transmission: one, presents the transmission of HIV as a question of **causing harm**; a second which grounds liability in terms of the transmission of a **serious disease**; and a third that invokes a legal tradition of **endangerment**.

In a sense, each of these legislative grammars conforms to the demand of the HIV community sector,¹⁴ as well as the human rights guidelines of the United Nations,¹⁵ that governments and states should avoid creating HIV-specific offences. Instead, if HIV transmission is to be criminalised, then it should be by way of the general provisions of criminal law. One often unacknowledged effect of this approach is that the meaning of HIV transmission obtains its authorisation from the existing grammars of criminal law. This is particularly the case with the causing harm offences and their grammar of injury.

The causing harm offences have a long history at common law but for present purposes it is sufficient to note a shift in the way they are put together. This will require attention to the form of knowledge they use, the senses in which the legislative provisions are general, and the objects that they constitute in speaking about criminal liability and HIV transmission.

At common law, the assault offences had been defined concretely and specifically by reference to the person, their actions, and the circumstances in which they acted (and sometimes the status of the victim¹⁶). This generated a plurality of discrete offences, such that the common law of assault was composed of a patchwork of overlapping and situationally discrete jurisdictions. In the late nineteenth century, these diverse jurisdictions of assault were consolidated, and the criminal law of assault emerged as a formal set of general offence definitions. The definitions were general in a number of senses. One, their definitions were constructed out of the settled general principles of criminal responsibility. The architecture of the general principles (and consequently the definitions of each offence) is structured around a division between on the one hand psychological criteria of responsibility and on the other hand behavioural criteria of liability.¹⁷ In this division, the primary standard for evaluating criminal liability is provided by the *mens rea*, the mental or interior element of the definition of the crime. Hence, the focus of prosecutions in this legislative regime of assault gravitates towards whether the accused intentionally, recklessly or negligently did acts which caused the prohibited consequences (such as transmission or exposure). However, there is a second sense in which the provisions of the criminal legislation are considered to be general: namely that, being defined abstractly, they would thus apply to an extensive range of different factual situations which were not specified in terms by the legislation.¹⁸

The definitions are general in the sense that they are generally applicable to a range of different factual situations. It is this sense that is primarily understood when policy advocacy exhorts governments to use the general provisions of the criminal law to criminalise HIV transmission. What is less examined or interrogated is the first sense of generality: namely, the fact that the general provisions are also general because they rely on the legal architecture of general principles of criminal responsibility in defining the crimes they prohibit. But it is this reliance on the general principles, and the shift in the form of knowledge of criminal law, that has a number of effects which still reverberate in the context of the

criminalisation of HIV transmission. One effect concerns the role of psychological liability in HIV transmission cases: namely, the mental state of the accused person becomes all important. These mental states have ranged across intention, recklessness and negligence.¹⁹ Intention, however, is a very high standard to prove. It is more onerous for the prosecution to establish proof of intent than recklessness or negligence. And apart from the intentional transmission of disease offences, the legislation makes it possible in the causing harm offences for prosecutors to rely on the less onerous standard of recklessness (in NSW),²⁰ and, in some instances, negligence (in WA). It is here that the criminal grammar of injury (causing harm) latches onto the management imperatives of public health: proof of the accused's knowledge that he is HIV-positive and of the risks associated with it (which is necessary to proof of recklessness at least) is often established by recourse to the counselling and notification regimes of the various state health departments.

A second effect derives from the fact that at the same time that standards of mental liability are privileged, the grammar of action in the law of assault is oriented towards the consequences of our behaviour rather than our conduct (acts and circumstances in which we act). In criminalising HIV transmission, Australian criminal legislation – like the English, and other common law jurisdictions – did not abandon this structure of classification but simply made explicit that harm (or its various analogues and aggravations) could include reference to disease. 'Causing harm' thus comes to include, by subsumption, 'infecting with a disease'. This is the case, for example, in New South Wales, South Australia, Western Australia, the Northern Territory, when amending legislation was introduced in the 1990s. But even then this depends on transforming the action and circumstances of disease into a logic of harm: for the purpose of liability 'disease' becomes the cause and 'infection' the prohibited consequence of the (unspecified) acts of the accused. How the accused acts and the circumstances in which she or he acts is a matter of indifference for criminal liability: whether you assault by hitting, kicking, spitting, penetrating, shooting is not to the point. Or in the context of disease, the manner of transmission is not determinative of criminal liability: the act of transmission could be stabbing with a needle, anal intercourse, vaginal penetration, etc; and the circumstance of transmission could be the fact that the sexual intercourse is 'unprotected', or that there are reduced or undetectable viral loads, or that the penis is uncircumcised, and so on. The general effect that I am emphasising here is that, although 'disease' appears as a term in the legislation, it is authorised and given meaning by the legal classification and history of assault offences rather than by any specific medical or health logic. And to the extent that HIV is understood as a disease (typically on analogy with other sexually transmitted diseases), HIV *disappears* in a general legal grammar of injury focussed on the harmful consequences of actions and the recklessness or negligence of the accused in relation to those consequences. In short, disease (for better or worse) is a legal category and in the grammar of injury (causing harm) it gets its meaning from the consequence of infection.²¹

'Disease' also appears as the specific referent of the second legislative classification. Again reliance is placed on the form of general legislative provisions. But, rather than simply amending the definition of existing (harm) offences to include disease, the approach in this second grammar has been to create discrete offences which specifically criminalise the intentional transmission of a disease – or more technically, a 'very serious disease' in Victoria and a 'serious disease' in Queensland.²² Consider the Victorian legislation. Section 19A of the *Crimes Act 1958 (Vic)* states:

19A (1) A person who, without lawful excuse, intentionally causes another person to be infected with a very serious disease is guilty of an indictable offence.

Penalty: Level 2 imprisonment (25 years maximum)

(2) In subsection (1) very serious disease means HIV within the meaning of the *Health Act 1958*

This is the section with which Neal was charged, prosecuted and convicted (amongst other offences) in Victoria. It is regarded as the only HIV-specific crime in Australia. And in a sense it is: it is not an offence of general *application*. It applies only to very serious diseases and until amended, the only very serious disease that is specified by the legislation is HIV. But it is also the case that the legislative provision is a general provision in as much as it takes up the general principles of criminal responsibility: and once again, the definition is structured by reference to a legal grammar of injury or consequential harm.

This becomes clear if we consider the placement of the offence in the legislation. It appears in the division of the *Crimes Act 1958 (Vic)* concerned with the so-called offences against the person, and specifically in that part of the legislation that legally creates and defines the assault offences and their logic of consequential injury (or harm). In this respect, the transmission of HIV (as a very serious disease) is simply represented as the means used by people to achieve a harmful end. HIV is instrumentalised: you intended to transmit, HIV was transmitted, and your acts were the cause of the transmission of the disease. This becomes even more explicit if we recall that the legislation presents the intentional HIV transmission offence as a variation on the pre-existing offence of ‘administering substances’ which are ‘capable of interfering substantially with the bodily functions’ of another.²³ Transmitting HIV is like spiking a drink, or using Rohypnol to effect date rape.²⁴ Or, as the comments of Jan Wade the then Attorney-General iterated *ad nauseam* during the Parliamentary Debates on the Crimes (HIV) Bill in 1993, the situation targeted by the legislative provision is one of needle bandits.²⁵ In short, the transmission of HIV as a serious disease obtains its legal meaning from a series of associations (conjunctions and distinctions) with factual situations and legal categories: substances, drugs, blood, semen, sexual assault, causing injury or harm, robbery (understand as theft by violent means), murder. To the extent that anything holds these disparate lexicons together in law, it is that they hold people responsible for the harmful consequences of their actions, and in doing so they situate people living with HIV/AIDS in an instrumental relation with those consequences by reference to the legal categories of intention, causation and disease. In this sense, HIV disappears into a means-end relation. And once again the *manners* of transmission disappear.

A third grammar of classification concerns itself with dangerous offences. These are also general provisions of the criminal law and, like the causing harm offences, are formed out of the attempt to replace concrete and situationally discrete legislation with statutes containing general offences of general application. As with the causing harm offences, psychological responsibility is measured not by the legal standard of intention but by the standard of recklessness. In terms of the grammar of action which structures the offences, the endangerment provisions are usually presented in terms of the consequences which have the acts of the accused as their antecedent cause.²⁶ But the legal problem that then arises is simply where the legal category of *danger* is to be placed within this grammar of mentality and action. I will return to this below, but here I want to briefly note that the contemporary ordering of criminal law has increasingly been reshaped since the 1970s around the standard of dangerousness. This has been particularly evident in the context of sentencing and punishment,²⁷ and to some extent in the reformation of policing practices, but it is less remarked in the context of the statutes and courts concerned with the trial and verdict stage of criminal justice. In terms of the trials, danger has emerged as an order-word in a number of ways: the increasing prominence of recklessness at the expense of intention, the inclusion of dangerousness as an element of an offence (as in the endangerment offences, or as in some of the causing harm offences), and the consequent restructuring of the entire field of offences against the person (from homicide and specifically manslaughter to common assault of the least serious kind) into offences addressing the dangers to individuals and the community. Given this, the use of the endangerment provisions in Victoria and elsewhere to prosecute HIV transmission and exposure is not that surprising, albeit that it is not without its considerable difficulties for the legal profession as much as the HIV community sector.

In summary, three points of emphasis about the manner in which criminal law reorders and shapes both itself and the meaning of HIV transmission:

1 HIV transmission is situated in a *plural field of legal signification* – disease, drugs, needles, substances, bandits as much as assault, rape, murder and endangerment. What the placement of HIV transmission in criminal legislation illustrates is that criminal law and the criminalisation process unceasingly tries to pin down the meaning of HIV: to fix its meaning. Yet it is continually being displaced by rival traditions in the ordering of criminal law, as much as by references to the social, the medical, the cultural and so on. In a very real sense, the criminalisation of HIV transmission is not about HIV at all – at least if criminalisation involves a question of the jurisdiction of criminal law. To the extent that it does involve a question of law, HIV disappears into a grammar of injury (harm) and a logic of danger. This disappearance is one effect of using general provisions of the criminal law to criminalise HIV transmission – even if only as a ‘last resort’. This, I think, raises a real question as to how to advocate for the proper representation of HIV within the criminal law (without necessarily committing ourselves to criminalisation).

2 A grammar of injury (or harm) has been the main way of authorising the criminalisation of HIV transmission in Australia, even when law is seemingly speaking a medical language of infection, exposure and disease. This results in a presentation of transmission as fundamentally a relation of means to end; on analogy with using guns to shoot, drugs to rape, needles to rob, bombs to endanger, sex to injure, and so on. The identities of people living with HIV are thus situated instrumentally in relation to HIV by way of the legal language of recklessness, causation and disease.

3 A grammar of danger has come to supplement the logic of injury in terms of a specifically legal form of risk. The criminalisation of HIV transmission is at the sharp end of this supplementation (and expansion) of criminal liability.

In the next section, I want to take up again this legal supplement of danger by turning to the second vector of legal classification – namely, adjudication in the common law courts.

Danger before common law courts

The common law tradition proceeds incrementally in response to contingent situations. Proceeding case-by-case according to their particular merits, the form of knowledge it generates is ordered around what can be thought of as *snapshots* – condensed images or short stories that bring with them already constituted subject-positions, transitive relationships, forms of unfreedom and fetishised objects.

Nine individuals have been prosecuted under the Victorian endangerment provisions. These account for almost half of all the Australian prosecutions for HIV transmission (infection or exposure), whether under the endangerment provisions or under some other criminal legislation.²⁸ In all of the Victorian prosecutions under the general endangerment provisions, the conduct prosecuted involved situations of sexual transmission, and specifically scenes of unprotected sexual intercourse by a person living with HIV/AIDS. These scenes have involved sex workers, prisoners, musicians, hotel managers, amongst others. Sex took place as part of their employment or in their personal lives. They have involved men having sex with men as well as men having sex with women. The sexual relations have been casual, sometimes conducted over the relatively short term, and sometimes the sexual partners have been husband and wife. The sexual conduct has involved single acts, but also several acts with different partners on separate occasions. The ages of the accused have varied, as have the ages of the complainants, although most have been in their 20s and 30s at the time of the prosecutions. The ethnic or cultural background of the accused as well as the complainants has been mainly white or Anglo-Australian, but the accused have also included men from Zambian, Sudanese and West Indian cultures. The accused have contracted HIV in a variety of ways: not only sexual relations, but also intravenous drug use, and contaminated blood transfusion. And at the time of the prosecution, the complainants have tested negative as well as HIV-positive, some have seroconverted or have been diagnosed with AIDS. The complaints against the accused have been initiated in a number of ways. Sometimes they are intelligible as part of a turf war between the police and the independent prosecution service. At other times, they have been initiated by way of prison authorities (a fellow prisoner complaining to a guard and then having the complaint passed onto detectives). And at yet other times through the concerns of workmates and in one instance the involvement of a member of an AIDS Council. In addition, police have identified several accused as a result of public health officials mistakenly handing over files to the police in response to a police warrant for the file of a different person being investigated. And finally, in most instances, there had been prior communication between officers of the Department of Health and the eventual accused notifying the latter of the diagnosis, the risks associated with sexual intercourse while HIV-positive, and various obligations concerning disclosure and unprotected sexual intercourse.

The charges in these cases were brought under sections 22 and 23 of the *Crimes Act 1958* (Vic).²⁹ The former (s22) prohibits ‘conduct endangering life’ or more specifically conduct which places or may place another in danger of *death*. If found guilty, punishment is imprisonment, and specifically, a maximum of 10 years. Section 23 varies s22 slightly to create a less serious offence. It prohibits ‘conduct endangering persons’, that is creating a danger of *serious injury* to a person. The punishment is again imprisonment, but the maximum is 5 years.³⁰ Apart from this differentiation between danger of death (s22) and danger of serious injury (s23), and a corresponding differentiation in the available sentence, the elements of the two offences are the same.

In terms of adjudication, evidence and judgment by the legal profession is presented as a matter of relating the grammar of the legislation to the evidence narrated in the court.³¹ This is conducted by way of a so-called ‘elements analysis’, in which the formal elements of the statutory definition are broken down into their constituent parts (and given a meaning authorised by the text of the legislation and preceding judgments interpreting that text in the light of the common law tradition and its modern variants). These elements are:³²

1 The accused *voluntarily engaged in conduct*.

In HIV transmission cases, the disputes have not concerned themselves with the voluntariness requirement. There have, however, been disputes about the *legal character of the conduct* of the accused – here, the acts and circumstances of sexual transmission. In one case, there was a brief dispute over whether the alleged act of anal penetration took place.³³ In another case, considerable time at committal and trial was given over to narrating whether or not the accused was wearing a condom since the conduct alleged, as it often is, an act or acts of ‘unprotected sexual intercourse’.³⁴ Despite the relative lack of legal dispute, the legal articulation of the prosecutions are redolent with narratives of the conduct of HIV transmission. In these narratives, the courts can be seen fashioning codes of sexual deportment for people living with HIV.

2 The conduct placed another in *danger of death* (or in s23, in danger of serious injury).

In HIV transmission cases, this has created the most difficulty for the courts: namely, the meaning of danger and how it relates to the risks of the actual conduct of the accused. The evidence narrated in court has been primarily (but not exclusively) biomedical and specifically epidemiological.³⁵ The legal definition of danger has, however, also been the subject of much argument. The current approach is to insist that the danger must be a real and not hypothetical danger; and to legally define dangerous conduct as that which carries with it an ‘appreciable risk’ (not merely a risk, nor merely a remote possibility) of death or serious injury.³⁶

3 The accused engaged in that conduct *recklessly*.

The legal disputes on this element have concerned both the definition of the category, and how to relate recklessness to the danger of death (and to a lesser extent, how to relate the conduct and knowledge of the accused to the meaning of recklessness). In relation to the first dispute, it is pretty much settled now that the accused must foresee the probability of the danger of death and nevertheless go ahead with the alleged conduct. As this indicates, the legal grammar of recklessness is concerned with the careless individual: it provides a snapshot of the knowingly careless individual. This places recklessness somewhere³⁷ between intention and negligence in the pantheon of criminal minds. In many instances in the HIV transmission cases, this would arguably mean that the person living with HIV/AIDS is under a duty to have sex using latex and to disclose their HIV-positive status to their sexual partner (and relatedly, to inform themselves of the risks of transmission, if only by reading the relevant Health Department letter).

4 The *reasonable man* in the position of the accused would have *realised* that she or he had placed another in danger of death (or serious injury in s23)

The ‘reasonable man’ standard is a staple of criminal law. In the HIV transmission context in Victoria,³⁸ it functions as a threshold standard: if the reasonable man would have realised the risks of transmission, then the legal inquiry and dispute can move onto the recklessness question. It also functions implicitly as a way of elaborating the meaning of danger (the second element above). This focuses the court’s attention on the regime of notification (counselling and prevention) in public health.

Much more could be said about each of these elements (and legal argument and judicial reasoning ranges across them with some degree of alacrity) but it is the legal structure of the offence that I will follow up here.

The offence structure pivots on the concept and category of dangerousness. It is the lynchpin that holds all the elements together. The acts of the accused must be legally related to it; the consequences of those acts must be related to it; and the psychological states of the accused must be related to it. Hence, although the legal adjudication proceeds by breaking down the offence into its component parts, it is also taken for granted by the legal profession that they must be unified if there is to be a crime. Dangerousness is that which *legally unifies* HIV transmission as a *crime*.

Nevertheless, what is especially evident in the adjudication of the HIV transmission cases is the way in which dangerousness pulls the legal profession and its judgment of conduct *in two directions at once*. In one direction, the courts address dangerousness as if it is an *intrinsic* quality of the *conduct*. The narrative is both moral and factual: unprotected sexual intercourse is an inherently risky activity when the accused is HIV-positive. Danger inheres in either the act itself or the circumstances which give character to the act *per se*: the fact that it is unprotected, or that it is anal penetration, or that the penis is not circumcised, or that it is sex, or that it is HIV, or how many times there was sexual intercourse between the partners, and so on. What becomes legible as the legal experience of HIV transmission is a legal narrative which arranges people living with HIV/AIDS as intrinsically dangerous: since after all a person is what he does and the context in which he does it!

In a second direction, the legal meaning of danger is determined by the end or result of the conduct rather than the conduct itself; it is attributed to the consequences of behaviour. The law requires proof of a danger of *death or serious injury* and it is this that makes dangerousness resonate in the bestiary of law. Hence, the repeated emphasis by prosecutors and defence lawyers, as much as the judiciary, on the necessarily fatal effects of HIV. In fact, the evidential narrative (including the biomedical evidence) in both *R v D* and *R v B* is arguably structured entirely around the image of death as that which makes anal and vaginal intercourse dangerous when the accused is HIV-positive.³⁹ But for brevity and recent illustration, Hampel J's remarks in *R v Mwale* will suffice.⁴⁰ In her ruling on a 'no case' submission by the defence, she summarises the epidemiological and biomedical evidence as being:

that HIV, once transmitted, caused a serious illness for which there was no cure, no prospect of spontaneous recovery and which would inevitably progress to AIDS and then to death.⁴¹

Having made the ruling, she returns to this theme in directing the jury to acquit the accused of the charges. She says to them:

It was also clear from what Professor Grulich said that, a person – once you've got HIV you've got HIV and although anti-retroviral drugs can significantly slow down the rate of progression in most people, there's no cure, you can't take drugs to take it away, it will always be in your system and it will inevitably progress through those stages and to AIDS . . . But once you've got it you've got it, that's the significant part of that part of his evidence and it doesn't go away.⁴²

As this indicates, even if infection is understood as the danger, then still the danger of the infection obtains its meaning from a narrative of fatality in which death is the intrinsic consequence of HIV transmission.⁴³

In sum, the meaning of danger is legally indeterminate: it is suspended between being a property of our conduct or a property of the consequences. And to the extent that the common law courts hold it together it is the *circumstances* which structure the legal experience of people living with HIV/AIDS. This, I suggest, is one reason that the circumstances in which people living with HIV and accused of a crime provide so much of the object of the adjudication's time and energy. But the anxiety is that this attention to the dangerous circumstances of sexual transmission (unprotected, uncircumcised, viral loads, and so on) relates a fundamentally juridical story: you are either a dangerous person or you are dying. In this, the common law judgment of conduct is somewhat parsimonious in its practices of mourning.

To end, then, I want to link the legal indeterminacy of danger to a striking feature of legal procedure in the endangerment cases. In many of the HIV transmission cases, the defence lawyers have presented the judge, after narration of the evidence, with a submission of 'no case to answer'. The submission has been that, although the biomedical evidence establishes the risks of unprotected sexual intercourse by

the particular HIV-positive person who is accused, this evidence is insufficient to establish or even settle the legal question of danger. If successful, this no case submission requires the judge to direct the jury to acquit the accused of the charges.

What is invoked in this procedural gambit is the relation between the judgment of conduct and the conduct of judgment – or in a more technical idiom, the proper relation between judge and jury in a criminal trial. Who is to decide? The role of the judge in a criminal trial is to address the form of law and make sure that its topics (such as danger) have been adhered to properly. The role of the jury is to decide: do we believe your facts or argument? The initial HIV transmission case under the endangerment provisions took this role of decision away from the jury and directed them to acquit. The judicial role becomes one of decision: the forms of law have not been adhered to, and you could not adhere to them, so I direct you the jury to acquit because there is no evidence by which you could reasonably find that the evidence of risk was sufficient to constitute the legal standard of danger.⁴⁴ Since then, the decision has been returned to the jury: in order that a judgment of HIV transmission can be made (in order that the common law can discriminate between endangerment and HIV transmission), the legal question of danger must be handed over to the jury. As Hampel J put it in *R v Mwale* last year:

In my view, ultimately the notion of appreciable risk, carrying with it value judgments about what is in the circumstances an appreciable risk, is quintessentially a jury question.⁴⁵

In short, not only is the concept of danger legally indeterminate, but the performance of judgment is indeterminate. The best chance, it would seem, of the HIV-positive person faced with the criminalisation of HIV transmission lies with the common law jury.⁴⁶ In terms of advocacy, this would mean that considerable educational work needs to be done with the various branches of the legal profession.

The predicament of criminalisation

The criminalisation of HIV transmission has difficulty holding onto criminalisation as a question of the jurisdiction of criminal law – understood as the power and authority to perform the judgment of crime and so differentiate the licit from the illicit. This predicament has been retraced on the space of legal classification – both in the criminal legislation, and in the courts of common law adjudication. Perhaps more difficult is to identify what follows from the predicament. By way of conclusion, a number of summary remarks:

1 I have suggested that HIV disappears in the grammar of the general provisions of criminal law. Law misrecognises itself as monolithic and HIV as injury and danger, but it is no less powerful and authoritative for all that it does misrecognise.

2 This might mean that the policy of advocating the use of the general provisions of criminal law is in need of some revision – or at least greater attention to the legal grammars that unsettle and concern so much advocacy in this area. That said, the use of HIV-specific offences promises very little as well, if the ways in which the common law courts give undue attention to the acts and circumstances of HIV transmission is anything to go by: to the extent that common law proceeds incrementally, the institutional impulse has been to supplement and expand the scope of criminalisation as law becomes aware of a different act and circumstance (the most recent being the impact of the science of ‘superinfection’ and viral loads on transmission risks⁴⁷).

3 No single practice or discourse – whether it is the plural traditions of the law of crime, or the no doubt plural traditions of medicine and social policy – has the final say. Although some of them seem to want to have the final say, the criminalisation of HIV transmission indicates that they are essentially contestable in a culture of argument. And this may be a good thing. I have simply focused on the conditions through which criminalisation of HIV transmission becomes the matter and material of legal argument.

4 To the extent that the common law courts suppose that liability for HIV transmission can map the virtue of the person living with HIV/AIDS in terms of the dangerous individual and the common good, then an ethic of 'shared responsibility' has little purchase in the legal culture of argument.

5 Policy advocacy could usefully direct its attention towards raising awareness amongst the legal profession (defence lawyers, as much as prosecution lawyers, the judiciary, but also the police) concerning the ethical cultures of meaning-making within the heterogeneous communities of people living with HIV/AIDS, as well as the disconnects and asymmetries between biomedical risk and the legal grammars of injury and danger.

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Endnotes

1 It is difficult to be exact about the tally. Among other reasons, there have been in some instances court prohibitions on publishing the names of the accused, as well as the difficulty of accessing more informal responses that would constitute part of the 'criminalisation of HIV transmission'. My best estimate of the formal prosecutions is 20, based on court reports in the media and also official judgments.

2 Weait M (2007) *Intimacy and Responsibility: the criminalization of HIV transmission* London: Routledge-Cavendish, pp 11-21

3 See Weait, *Intimacy and Responsibility* p 21 and chapter 6. See also Rob Lake, 'Don't ask, don't tell: disclosure and HIV' *HIV Australia* Vol 6 No 4 commenting on p 21 that 'Whether it's legal obligation, social marketing or other education strategies, the change in emphasis has moved us away from a community norm about shared responsibility in the face of HIV. Instead, strategies and practices that more explicitly place the responsibility for managing risk on the positive partner.'

4 The calculation and management of risk is taken up more directly in other chapters in this monograph. Chapter 7 examines the management of risk in relation to individual sexual encounters and chapter 8 examines the experience of risk in terms of practical ethics and media discourse.

5 In terms of the latter, I am thinking of the ways in which the various institutions of law display a fascination with detailing the various incidents – such as sex-on-premises, promiscuity, conversion parties and so on – which are presented as indicia of lifestyles defining particular group identities.

6 Murder represents the taken-for-granted and self-evident limit beyond which no individual can go and still remain part of the community. Jan Wade, then Victorian Attorney-General, for example lamented that the delayed action of HIV transmission prevents prosecution and liability for murder because death has not taken place quickly enough (Parliamentary Debates, Legislative Assembly, Second Reading of the Crimes (HIV) Bill *Hansard* vol 411 p 1259 (April 28, 1993) and p 1892 (May 12, 1993)). The suspicion is that this argument (and the more general association between HIV transmission and homicide) displays a veritable will-to-kill: 'if only HIV would kill quickly and so rid those people from our midst'.

7 The most prominent thinker associated with understanding the peculiarity of modernity in terms of its ordering around the experience of risk is Ulrich Beck. His most relevant texts in this context are: Ulrich Beck (1999) *Risk Society: towards a new modernity* (London: Sage); Ulrich Beck (1999) *World Risk Society* (Massachusetts: Polity Press); Ulrich Beck and Elisabeth Beck-Gernsheim (2002) *Individualisation: institutionalized individualism and its social and political consequences* (London: Sage)

8 Or put differently, between the artificial reason of common law and the scientific reason of modern law.

9 'Safe sex' in the crimino-legal context largely reduces to using condoms; the negative syntagm being 'unprotected sexual intercourse'. It is arguable that the norms of conduct associated with 'serosorting', 'strategic positioning' and so on, would become legal categories of conduct – albeit that they remain largely unaddressed by current criminal law.

10 For examples of public health legislation offences, consider: *Public Health Act 1991 (NSW)* s13 (prohibiting persons with a sexually transmissible medical condition from having sexual intercourse with another without first disclosing the risk of contraction of the condition and without the other voluntarily agreeing to accept the risk; and extending the prohibition to those who own or occupy places for 'prostitution' and knowingly permit sexual intercourse that breaches the prohibition); *Public and Environmental Health Act 1987 (SA)* (creating an offence of failing to take all reasonable steps to prevent the transmission of a 'controllable notifiable disease' to others); *Public Health Act 1997 (Tas)* s51 (creating an offence in situations where the person living with the 'notifiable disease' fails to take all reasonable steps to prevent transmission and where the person knowingly or recklessly

places another at risk of contracting the disease; also providing a defence where the other person knows of and voluntarily accepts the risk of contracting the disease). Sex work legislation and regulations have established licensing regimes which are often dependent on mandatory testing for STIs (including HIV) and sometimes criminalise failure to comply with licensing regulations and working with an STI such as HIV. See for example, *Prostitution Act 1992 (ACT)*, s25 (under which a male sex worker was charged in 2008) and the discussion in chapter 9.

11 For those wishing to follow up the citations to legislation and judgments in this chapter, the easiest access is via the online collection of legal materials at the Australian Legal Information Institute: accessible at www.austlii.edu.au. The citations I have used for the judgments and case reports are medium neutral, e.g., (2007) SASC 143 – and will indicate the specific judgment (where there might be more than one in the case). However, some judgments are unreported and as such are not generally available (either because they are not published, or because there are prohibitions on publishing the names of participants).

12 The *Houghton* case went through a number of judicial articulations: the ruling on the bail application is reported at (2002) WASCA 363; the judgment on appeal resulting in a quashed conviction and a retrial is reported at (2004) WASCA 20; the judgment in an appeal against sentence concerned with the relevance for the sentencer of the jury's decision as to the accused's honest and reasonable but mistaken belief (that the virus could not be transmitted if no bodily fluid was exchanged and that, by withdrawing before ejaculation, he could avoid an exchange of that kind) is reported at (2005) WASCA 216. The most extensive and latest judicial articulation is the appeal against sentence reported in *Houghton v State of Western Australia* (2006) WASCA 143.

13 See also the commentary on this judgment in Matthew Groves (2007) 'The Transmission of HIV and the Criminal Law' 31 *Criminal Law Journal* pp 137-141, 140-141, characterising it as a judgment on 'AIDS denialism'.

14 See Intergovernmental Committee on AIDS (Australia), Legal Working Party, *Final Report* recommending that 'special, as opposed to existing general criminal law sanctions, should be carefully considered by state governments because of the danger of stigmatising already alienated groups' (Canberra: Department of Health, Housing and Community Services, 1992, para 2.5.4)

15 See UNCHR (1998) *HIV/AIDS and Human Rights: International Guidelines* (United Nations: New York and Geneva). The Guidelines state in part that 'criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases.' (para 29a, p 14). However, see Weait (2007) *Intimacy and Responsibility* p 10-11, which discusses how there is a lack of commitment to the import and consequences of these guidelines in the more recent enunciations of the Council of Europe's Parliamentary Assembly.

16 For example, criminal legislation still includes a discrete crime of assaulting a police officer, where the only difference between the general assault offences and this offence is that the victim is a police officer.

17 The psychological criteria are referred to as the *mens rea* or mental element, and the behavioural criteria are referred to as the *actus reus* or physical and external element. The *mens rea* can be either intention, recklessness or negligence. Malice is the term of the common law, and it survives in New South Wales. This survival caused problems in the context of HIV transmission prosecutions, until amended by legislation to permit recklessness. The *actus reus* concerns itself with causing the consequences of actual bodily harm and grievous bodily harm (or in Victoria, the terminology is injury and serious injury).

18 See Rush P (1997) *Criminal Law* (Sydney: Butterworths) chapter 2, for the contours of this dual approach (general principles of criminal responsibility and definitions of general application) as well as the detailed structure and categories of the general principles.

19 A fourth category is less common now: 'knowingly'. It is a kind of intention now used in low level of regulatory offences, and so – in the HIV transmission context – crops up in disclosure offences under public health legislation.

20 In the context of the causing harm offences in NSW, the initial problem concerned the fact that the legislation required proof of 'malice'. With legislative amendment in response to debates about the criminalisation of HIV transmission, malice erased from the relevant text of the legislation. The effect is to put to one side the common law tradition. The modern law of crime is also displaced when recklessness, rather than intention, becomes the required standard of liability.

21 It is the analogy between 'causing harm' and 'infecting with a disease' that links the criminal law disputes to the administrative legal history of notification (in the late 19th-century context of the regulation of venereal disease generally and sex work in particular). This is the often unacknowledged context of the return to the judgments in *R v Clarence* (1889) LR 22 QBD 23 by judges and legal commentators. *Clarence* involved a prosecution of a husband who, knowing he had gonorrhoea, had sex with his wife and infected her with the disease. He was charged with assault causing grievous bodily harm and assault causing actual bodily harm. For commentary on the case and its take up by the judiciary in HIV transmission contexts, see Matthew Groves (2007) 'The Transmission of HIV and the Criminal Law' 31 *Criminal Law Journal* 137-141. The history that ties the debates to regimes of notification is, however, obscured somewhat by the tendency to treat the legal links between harm and disease as an issue of consent in sexual relations.

22 The Queensland legislation remains ambiguous on this front in as much as it simply transliterates 'do some grievous bodily harm' with 'transmit a serious disease'. It seems to want to have it both ways: situating itself as both a variation on a causing harm offence but creating an intentional transmission offence.

23 *Crimes Act 1958 (Vic)* s19

- 24** The use of drugs such as Rohypnol to effect rape is covered by s53 of the *Crimes Act 1958 (Vic)* and comparable provisions in other Australian jurisdictions. These provisions are concerned with *administering* a drug in order to sexually penetrate, and so provide a sexualised variant of the administering a substance offence of assault.
- 25** This is the legislative bill which introduced s19A into the general provisions of criminal law contained in the current *Crimes Act 1958 (Vic)*. As Jan Wade stated from the outset of the debates, ‘The purpose of the Bill is to respond to community concern about the use of hypodermic syringes filled with blood as weapons in cases of robbery and assault.’ (Parliamentary Debates, Legislative Assembly, Second Reading of the Crimes (HIV) Bill, *Hansard*, vol 411 p 1259 (April 28, 1993); and see the vitriolic response to Wade by Mr Cole, a Labor minister, p 1871-1879, and especially p 1872 (May 12, 1993)). In addition, in rejecting opposition to the bill because it is discriminatory, Wade stated that the bill ‘does not include consenting sexual activity’ (p 1892) at the same time that she argued that it may cover people who deliberately infect another during rape and those who deliberately spread HIV to others without warning them of the dangers (p 1893). Apart from the evident confusion in using a standard of consent to run together gay sex, rape and spreading a disease, it is ironic that the only prosecution under s19A did involve sexual transmission – and it was only conducted some 15 years after the section was introduced into law.
- 26** The most explicit statement of this structure was recently provided in *The Queen v Rajaa Abdul-Rasool* (2008) VSCA 13, para 30, per Redlich JJA: ‘The endangerment offences are concerned with the consequences of action – that is to say which follows as an effect or result of something antecedent.’
- 27** For the emergence and renaissance of dangerous in punishment practices, see John Pratt (1997) *Governing the dangerous: dangerousness, law, social change* (Sydney: Federation Press) and Mark Brown and John Pratt (eds) (2000) *Dangerous offenders: punishment and social order* (London: Routledge). In the latter collection, the essay most pertinent if not quite on point is Pat O’Malley’s essay situating risk in relation to three moments of liberal ideology in the 20th century.
- 28** That is, 9 out of a total of 10 individuals prosecuted in Victoria for HIV transmission offences (infection or exposure), or 9 out of a total of 20 individuals prosecuted throughout Australia. The endangerment provisions in South Australia have been used to prosecute 2 individuals.
- 29** Sometimes the prosecution has alleged the s22 offence, and in the alternative the s23 offence. Sometimes – as in *R v Mwale* (County Court, Judge Hampel, unreported, April 2008) – s23 was charged.
- 30** These specified punishments are the maximum available to the sentencing judge. For example, in the most recent case where the accused had pleaded guilty to a charge under s22 (maximum of 10 years), the judge described the accused’s conduct as ‘represent(ing) a shocking example of a serious offence’. The sentence imposed by the judge was 5 years imprisonment (with a minimum of 3 years). See the court report in ‘HIV husband spun web of lies’ *The Age* March 13, 2009
- 31** In Victoria, committal hearings are heard in the Magistrates Court. If the case goes to trial (and there are many reasons why it may not, and not only because the accused pleads guilty), the trial will be heard in the County Court. Appeals from the County Court have gone to the Supreme Court of Victoria (and these have been limited to questions of law). No appeals (whether from Victoria or elsewhere) have been taken to the High Court of Australia in the HIV transmission cases.
- 32** The following listing relies on but slightly varies the listing in *The Queen v Rajaa Abdul-Rasool* (2008) VSCA 13 para 19, the most recent authoritative restatement of the elements of the endangerment offences in Victoria. This is not a HIV transmission case; it concerns a woman dousing herself with petrol while in a school principal’s office and distraught about the whereabouts of her children. It is at an appellate level. A later case – *R v Mwale* (County Court, Judge Hampel, unreported April 2008) – is a HIV transmission case. It is a judgment at first instance which relies on *Abdul-Rasool*.
- 33** See *R v B*, Supreme Court of Victoria, Teague J, June/July 1995, Unreported, BC9507977. This was the first trial for HIV transmission under the endangerment provisions. The prosecution concerned two prisoners on remand in the City Watchhouse in Melbourne (the building has since been condemned, and replaced by the Melbourne Custody Centre). Although classified as ‘separates’, the two prisoners were placed in the same cell for one night by duty police. One prisoner complained to the duty sergeant the next morning after apparently hearing from ‘mainstream prisoners’ that the accused ‘had AIDS’. The accused was charged and tried, but the judge directed the jury to acquit, of one count alleging anal penetration. At committal and early in the trial, there was also some discussion over an act of oral sex but this was removed from the indictment (see *R v B*, Transcript of Proceedings, Supreme Court of Victoria, pp 5 and 8). Two earlier prosecutions for HIV transmission under the endangerment provisions did not get beyond committal: in a 1991 case, the charges against a sex worker were eventually dropped and public health legislation was used to keep her in protective custody. She eventually died of a drug overdose some three years later. See B. Calder (1991) ‘Setting an Ugly precedent’ *Outrage* (May 1991), pp 7-8, John Godwin et al. (1993) *Australian HIV/AIDS Legal Guide*, 2nd ed. (Sydney: Federation Press) p 55; and *The Age* December 3, 1994 pp 18, 28. In another 1991 case – *Queen v PD* (Prosecution Case File Y833; Committal Proceedings, Melbourne Magistrates Court, Barrow M) – the accused died of an AIDS-related illness before the trial date was set.
- 34** See *R v D*, Supreme Court of Victoria, Hampel J, May 1996, Unreported judgment BC9607711. This was the second trial under the endangerment provisions. The prosecution of D concerned four counts of unprotected vaginal intercourse; two of the counts related to sex with one woman, the other two counts with a different woman on separate occasions. As Hampel J stated in his charge to the jury, ‘each of the counts deals with one specific act of

intercourse. We don't look at this matter generally . . . It is inappropriate to take a global view of the general conduct.' (*R v D*, Supreme Court of Victoria, trial transcript p 310). The accused was found not guilty on all counts.

35 This takes place in all the cases. The most extensive and recent elaboration of the legal construction of biomedical and epidemiological constructions is illustrated by the judgment in the South Australian case of *R v Parenzee* (2007) SASC 143.

36 In the context of HIV transmission cases, the standard of 'appreciable risk' was set initially in the unreported judgment of *R v B* (Supreme Court of Victoria, Teague J, June/July 1995, Unreported BC9507977). This was obtained on analogy with the more serious offence of unlawful and dangerous act manslaughter. Subsequent cases have largely iterated the appreciable risk standard. Most recently, see *R v Mwale* (County Court, Judge Hampel, April 3, 2008, Transcript of Proceedings pp 529-534)

37 It is noteworthy that the standard of recklessness here is arguably less than the standard of recklessness used in other but similar offences against the person. This is because what must be foreseen in the endangerment offences is the probability of an appreciable risk (of death or serious injury), rather than simply the probability (of serious injury or death). This has caused some technical or logical problems for the judges and legal commentators, which stem from the analytical demand to relate, in a cascading series, the concept of recklessness to the concept of danger and then to the categories of death or serious injury.

38 In South Australia, the legislature and courts have not required the use of the reasonable man standard in endangerment prosecutions (whether concerned with HIV transmission and exposure or not). The question of risk is thus carried solely by the legal concepts of recklessness and danger. See *Criminal Law Consolidation Act 1935* (SA) s29 and judicial commentary on it. This classificatory difference has, however, not created any substantive difference between Victoria and South Australia.

39 *R v B*, Supreme Court of Victoria, Teague J, June/July 1995, Unreported BC9507977; *R v D*, Supreme Court of Victoria, Hampel J, May 1996, Unreported judgment BC9607711

40 *R v Mwale*, County Court, Judge Hampel, Unreported Judgment April 3, 2008. There are a number of striking features of this case. One, the accused was identified by police as a result of the health department mistakenly handing over his file (and many others) to the police in response to a police warrant for the file of Neal (who was later prosecuted for intentional transmission of a serious disease under s19A *Crimes Act 1958* (Vic)). Two, the female complainant in the prosecution was 'outed' as a sex worker albeit that the sexual conduct alleged in *Mwale* was not part of her sex work activity. In any event, and more generally, the occupational health and safety practices of the sex industry in Australia render her employment as a sex worker irrelevant in the context of prosecutions for sexual transmission. See chapter 9 in this monograph.

41 *R v Mwale*, Transcript of Proceedings p 536 lines 16-20

42 *R v Mwale*, Transcript of Proceedings p 548 line 28 to p 549 line 12

43 This association may go some way towards explaining how other STIs are differentiated from HIV in the context of the criminalisation of HIV transmission.

44 See *R v B*, Supreme Court of Victoria, Teague J, July 1995, Unreported BC9507977. See the direction or charge to the jury, Transcript of Proceedings pp 185-191

45 *R v Mwale*, Transcript of Proceedings (pp 533 ll 26-29) rejecting the no case submission on this ground. Judge Hampel did, however, accept the no case submission on the second ground: this argument concerned whether there was proof by the prosecution that the complainant, who was HIV-positive, was put at risk after the date that the accused was diagnosed as HIV-positive. Proof of the timing of the transmission or exposure raised issues of causation, as well as the effects of the new science of 'superinfection', and the relevance, if any, of the complainant's prior sexual relations with others. In a welcome note, the sexual history of the complainant – involving, amongst other things, a period of work as a sex worker prior to her diagnosis as HIV-positive – was forthrightly declared by Judge Hampel to be irrelevant to the legal question in dispute: namely, whether *the conduct of the accused* was capable of being categorised as placing her at risk of the transmission of HIV (Transcript of Proceedings p 541). That said, the judge was somewhat disturbed by the argument that, since the complainant happened to be HIV-positive, then the prosecution could not exclude the reasonable possibility that the accused may have infected the complainant *prior* to *his* diagnosis, and as such the charge could not be made out. She adds the coda – common in HIV transmission cases where no case submissions have been made – 'Of course, this [the resulting anomaly] is not a matter for me or for a court, but maybe it is something which parliament should consider.' (Transcript of Proceedings p 542).

46 This is despite the fact that several accused have pleaded guilty to charges for HIV transmission under the endangerment provisions. In one case, a Melbourne man – charged with two counts under s22, for having unprotected sexual intercourse and thus exposing (not infecting) the female complainant – pleaded guilty and was given a suspended sentence of two years' jail (he would only have to go to jail if he offended again). The accused was identified by police in much the same way as the accused in *Mwale*: public health officials mistakenly handing over files to police in response to the Neal police warrant (see **40**). The most recent guilty plea by an accused was this year, see the court report in 'HIV husband spun web of lies' *The Age* March 13, 2009. The sentence was 5 years jail.

47 'Superinfection' was particularly adumbrated in *R v Mwale*, County Court, Judge Hampel, unreported judgment April 3, 2008

Morality

Sexual grievances, HIV transmission and the law: the unintended effects of social movement mobilisation around sexuality and justice

Stephen Tomsen

In this chapter the author provides an account of the early policy responses to HIV/AIDS in Australia. One of the key aims was to 'contain' the epidemic to those sub-populations or groups which had already been affected, but this policy response was not about blame, it was a pragmatic response in the emerging epidemic. Furthermore, the most important aspect of this response included strategies of community-building and developing trust between government, medicine and the communities and groups affected, especially with the gay communities. Political, community and health sector support was also part of this pragmatic approach. The author notes that over the period of the epidemic in Australia legal processing of the issue of transmission is extraordinary and does not sit with the earlier, successful approaches. This shift may be a result of social movement activities around victimisation and criminal justice – including sexual attacks on women and hate crimes directed against gay men – that have given a new personal confidence in reporting a range of grievances to state authorities. The current trend toward criminalisation is divisive. A fresh dichotomy of guilty and innocent victims in media and public consciousness may spill over into legal discourse and rulings. This has the potential to seriously undermine a collective project of developing 'ethical sex' practices that can underscore and support safer sex as a cornerstone of HIV prevention.

Health, containment and collective trust

The domain of human sexuality comprises complex fields of desire, emotions, power, regulation and even social movement mobilisation. Heirs to the Sexual and Gay Liberation movements of the 1960s and 1970s faced a heavy challenge with the global spread of HIV from the 1980s onwards and the moral panics and debates that accompanied it. In some significant ways, local conditions shielded the advocates of sexual freedom and other people from the worst effects of the moral outrage and official complacency that often characterised the early epidemic in the United States.

The official response to the identification of the first Australian cases of AIDS in the early 1980s was characterised by two elements. First, local developments were notably shaped around the conception of this issue as a community health matter. This did not happen as a usual case of medicalisation, with the assertion of practitioner dominance over individual patients. Instead, it took the form of a quasi-medicalisation that resulted from political manoeuvring between distinct segments of the medical profession and a defensive gay-male community mobilisation (Altman 1994). Despite the ongoing advocacy of alternative treatments and therapies, and some brief and dubious questioning of the relationship between the manifestation of AIDS symptoms and HIV infection itself, this outcome did not deny the fundamental role of medicine and pharmacy in treating HIV progression and related diseases. But it did insist on a greater voice in policy-making and the evolution of prevention strategies in communities at high risk: sexually active gay and bisexual men, sex workers, injecting drug-users, and the medical recipients of blood transfusions in the pre-screening era (Sendziuk 2003).

Under the stewardship of key new community lobbyists and a sympathetic and accessible Federal Minister of Health, there emerged a strategic alliance between activists working in the HIV field and progressive elements in the medical profession that favoured consultation with patient groups (Ballard 1992). The resulting pragmatic solution meant that although HIV detection and treatment was still largely subject to professional regulation and the power of medicine, this was not done coercively: happening in a way quite distinct from the earlier historical regulation of 'venereal diseases' among passive and voiceless patients by a tight mix of medical supervision and legal measures (Milton 1998). Furthermore, this recasting of the threat of HIV as a community health matter served to restrain or mute the voluble moralistic views and debates about blame and morally appropriate (rather than efficacious) prevention measures that frequently paralysed developments in nations such as the United States.

The second major feature of the local health response was an equally pragmatic focus on the containment of HIV among those groups where infections had already occurred (Feachem 1995). Specifically, for health authorities this meant containment among the gay/bisexual male communities where the virus had been introduced through the deeper travel links between local and American urban gay subcultures arising in the 1970s. Australia had a more pronounced pool of gay male infections than other Western nations in this period (Sendziuk 2003). This led to some struggle to deny that AIDS was a 'gay disease' with all the stigma that arises from that conflation, and to insist instead that it was a disease that potentially posed a serious threat to the general community. By the 1990s, a heavy emphasis was placed on maintaining the limited reach of the virus and dealing with the life-taking and life-threatening costs of its existing circulation in Australian gay-male communities such as the subculture heavily concentrated around Darlinghurst, Kings Cross, Paddington and Surry Hills in inner Sydney.

There was abiding public fear about the spread to the community 'mainstream' or the 'suburbs' that could arise from bisexual sex, drug use, infected sex workers or an unsafe medical blood supply. Nevertheless, with the containment strategy in place, the worst hysteria about modes of transmission began to settle. In health terms, Australia reaped the results of its focus on containment and produced an important international example of education and HIV prevention campaigns (Sendziuk 2003). This also meant a type of bifurcated approach to thinking and attitudes about vectors of transmission. Dealing with the transmission of the virus among gay men was mostly the business of gay men. Agencies of the state and sympathetic medical professionals facilitated the education and prevention of community initiatives. Nevertheless, direct coercive interference with sexual activities and sites of sex did not occur in favour of determined consciousness-raising and education about prevention. This was pro-sex in tone rather than following some of the external cultural trends that had emphasised caution or the virtues of monogamy and abstinence. The collective practice of responsibility and mutual trust in 'safe sex' were stressed in education campaigns. In reality, astute gay men who engaged in sexual activities took protective measures and assumed the distinct possibility that most or all of their anonymous or casual sexual partners were HIV-positive.

HIV containment was premised on collective preventive sexual practices. Researchers found that 'gay community attachment' was a critical factor in positive results from education campaigns (Dowsett 1996). The goal of collective safe sex played on the radical mobilisation around sexual rights that began in the 1970s. For gay politics a celebration of a free sexuality was the core of a new social identity. As that identity became the very basis of fighting HIV, astute forces in the medical profession favoured consultation and power-sharing. Services were delivered through increasingly specialist public and private practices with staff who were generally sympathetic to the pursuit of sex as a critical factor in the self-esteem and daily lives of many HIV-positive individuals. The major concerns were the physical and mental care of infected people with a cultivation of doctor-patient confidence, encouragement of testing, strict monitoring and treatment of opportunistic and secondary infections in the sick, and dealing with grief and the stigma of physical decline and bodily changes. A professional and health sector imprimatur for safe sex was thus inscribed in these practices and intelligently preferred against unviable repressive solutions to the spread of HIV.

The result of this pattern of deliberate community-building around education and prevention, and the pragmatic approach of medical authorities was a collective entrustment of gay men relating to safe sex. The high gay profile on this issue actually meant a form of insulation from blunt authority in relation to sexual activity and HIV. A qualified but actual collective license for safe sex was affirmed. This was the

best available local response to AIDS as an apparently universally fatal illness before the refinement of treatment by anti-retroviral therapy in the early 1990s. It was also an open secret that in those dark days suicide support networks had emerged in inner-city gay circles, with discreet assistance from some medical figures and without police reaction. In and after the late 1990s this overall entrustment in relation to the practice of safe sex continued, even in the landscape of more professional treatment, including dozens of anti-viral drugs and more sophisticated monitoring of viral load and resistance. These changes may have eroded some of the patient autonomy and decision-making that was previously stressed in HIV service delivery. They have also meant a new knowledge base and levels of expertise that are serving to exclude most practitioners outside of a relatively small and ageing workforce in inner-city practices with high HIV-positive patient numbers.

Outside the gay urban communities of Australia, local concerns matched international warnings about the possible risk of infection to women in sexual relations with men. A small number of such cases of heterosexual transmission did emerge; however, the heavy concentration of the epidemic in gay men meant that the more difficult questions arising from the male/female power relations that went with them were less pressing. The melodramatic 'Grim Reaper' campaign of the early 1980s, with its images of destruction for all types of citizens, was intended to raise general community consciousness. Given the actual containment of the epidemic, the Grim Reaper approach soon seemed alarmist to most. A lower level of general risk from heterosexual sex translated into a much lower level of awareness of HIV than in gay, sex worker and fetish circles, and a wide complacency about safe sex practices. As a result, authorities seeking to control other sexually transmitted infections such as gonorrhoea, herpes and chlamydia, fought a hard battle to have condom use become standard among most sexually active heterosexuals. It appears that very tragic personal scenarios and grievances over transmission were dealt with by medicine, support and counselling, and little publicity.

The new scenario of legal intervention

Some level of fear and anxiety due to HIV infection has been a nearly inescapable force in recent decades, and even positive reactions to it have had intended and unintended effects. In recent years, observers with awareness of the long-term local shaping of the HIV epidemic as a health matter, have witnessed an unexpected run of legal complaints and cases that concern both homosexual and heterosexual transmission (Cameron 2008). As a consequence, gay men and HIV education and treatment sectors are witnessing courtroom discussion and even inflammatory press reporting about real, alleged or possible same-sex transmission scenarios. A cultural gulf about understanding matters of transmission and risk has emerged between the prevalent view of safe-sex-aware gay communities, and police, legal officialdom and 'respectable' public opinion as conveyed by the media. For those inside safe-sex culture, there is an everyday and even banal ring to these scenarios of casual, short- or long-term sexual relations and how they are first initiated.

In retrospect, expectations that a collective ethic of mutual care could always prevail in these encounters have been too idealistic. Nevertheless, a strong stress on self and other responsibility has prevailed for over two decades in millions of different same-sex encounters permeated by open or coded messages of risk. Decisions about sexual practices and condom use are frequently built on a physical choreography of directing actions rather than open verbal statements. This can be particularly so with bar-room pick-ups, visit to masseurs, attendance at a group party with open sexual activity, and the quick and furtive encounters of beat sex, saunas and sex-on-premises venues. This background knowledge of sexual activity now has to sit alongside troubling examples of the law dealing with revelations of covert or deliberate deceit about sexual risk. At worst, these seem to involve the apparent exploitation of intoxicated, drugged, young and naïve partners by sexually assertive men taking a licence for sexual activity to a new level of personal selfishness.

At the same time, the general community is witnessing legal cases that signal a disturbing new form of real heterosexual risk dissected in a public forum. This risk from sex between men and women has mostly arisen in equally ordinary circumstances of casual sex and committed relationships that may or may not have been accompanied by safe-sex practices. Yet a new spectre of fear from these may begin to undermine the problematic view that earlier historical warnings about general community risk were alarmist

and that heterosexual sex is itself fundamentally safe. The new demons of these fears in Australia have been black African men, the selfish internet dater, or the more ordinary, but equally disturbing, long-term partner who lies about HIV in the manner of married and partnered heterosexual men lying about any infidelity.

How can we explain this extraordinary recent legal processing of real or alleged transmission in homosexual and heterosexual cases that seem so familiar? This development is especially puzzling as it has occurred across a range of states and territories, and involves reporting and investigation by a mix of health professionals and police invoking either health regulations or criminal law. It seems that paradoxically, the deadly prognosis and very serious ailments of the early decades of the HIV epidemic may have meant little energy or time for pursuit of formal grievances about transmission.

It is important to note that the last three decades were a period of what may turn out to be a short-term waning in the punitive, criminal regulation of the highly stigmatised venereal diseases of the past with a range of legal consequences and severe warnings for the infected. An earlier generation of medical practitioners in the 1970s struggled to reshape the official response and redefine these diseases as a medical matter. However, the historical memory of the earlier punitive regulation partly resurfaced in the 1980s with the call by some doctors and political commentators for a vigorous legal-medical control of all infected individuals and the closure of gay venues and the cancellation of gay events to curtail HIV.

It could also be suggested that the new shift to legal responses to grievances about transmission may reflect a neo-liberal cultural shift in Australia and similar societies that more frequently involves blaming individuals for social wrongs rather than stressing collective responsibility and solutions to them.

There are other clues about this change. Critical legal scholars and sociologists in the 1960s and 1970s began path-breaking work on how the production of public causes, disputes and claims in society is not a simple reflection of the occurrence or level of actual injury incurred by individuals and groups. They illustrated how this was a complex and shifting process of 'legalisation' whereby a particular segment of a vast pool of proto-claims was transformed into public matters that were formally or legally acknowledged. This process reflected both culture and history, and the different availability of non-legal mechanisms for processing and treatment of claims, as well as levels of legal knowledge and resources among claimants. Importantly, levels of confidence and faith in such formal avenues were a significant factor in the dispute-processing mechanism. Middle-class and wealthy claimants favoured litigation and legal processes for many grievances.

Socio-legal research and criminology give some lucid contrasting accounts of the operation of these non-formal mechanisms. For example, ethnographic research revealed how in a working-class American neighbourhood disputes were often left unresolved, dealt with unofficially by third parties, or ended with direct conflict (Merry 1990). And criminologists have noted how physical redress as revenge attacks for actual or perceived wrongs from other parties is often the most obvious form of claim-seeking for underclass and disempowered groups. A small but significant proportion of all homicides are deviant forms of dispute resolution among regular criminals and people unable to consider themselves as respectable claimants contacting lawyers, police and other authorities (Polk 1994). Expanded access to the law and legal services, and the evolution of more open public complaint mechanisms in liberal democracies can expand the number of citizens involved in formal complaint activity. Yet the persisting message from this scholarship is that it is the social position and credibility of claimants, even more than real levels of injury, that underlie the transformation of personal conflicts into legal matters.

Sexual complaints and social movement activism

With this in mind, it seems important to now consider what significant historical changes have happened in the homosexual and heterosexual realms of our society that might in some way incite official and legal-focused claims regarding HIV transmission. Mixed evidence about a local growth in new infections may signal that effective anti-retroviral treatments are resulting in a new understanding of risk around different sexual practices. And it is not necessary to celebrate practices like bare-backing to recognise that some gay and bisexual men have always perceived and experienced their open sexual desires and activity as an important personal realm, removed from the regulation and apparent didacticism of HIV education

campaigns (Bartos 1996). Some observers have even argued the contentious view that such perceptions merged with a degree of long-term 'fatigue' about safe-sex messages (Videnieks 2003).

In relation to complaints about transmission, it is uncertain how many of the recent matters were truly victim-initiated rather than the consequence of zealous police activity. Nevertheless, it can be argued that some part of the social drive behind these claims is itself an unintended secondary effect of positive social movement activity to which HIV activists and educators have been closely tied.

Four decades ago, sexual liberation movements began to widely legitimate enjoyment of casual sex (Weeks 2003). This ground shifted quickly for most feminists who had serious reservations about the limits imposed on sexual pleasure in a patriarchal society (Segal 1994). But activism gave a new sexual confidence to many women and gay men in Western nations. In the same period, those contesting the prosecution of what were termed 'victimless crimes' challenged the reach of policing and criminal law into a range of behaviours that were viewed as moral issues, including such sexual activity as homosexuality and public soliciting. Decriminalisation of sodomy provisions became a key aim for many gay movement organisations (Willett 2000).

A quickly emerging pattern of positive uses of law to pursue rights and protections soon intersected sexual liberation thinking. Firstly, feminists dealing with violence and sexual assaults advocated better police and criminal justice responsiveness towards victims. They encouraged further reporting of attacks as matters to which authorities would be compelled to respond. For many commentators, not enough real change has resulted from such demands; however it is notable that a resulting major increase in the number of reported cases of domestic violence occurred in Australian jurisdictions in the 1970s and 1980s. It is also evident that the degree of victim reluctance to report matters of sexual assault and the absolute force of moral distinctions between pure and promiscuous victims declined over recent decades. For many women of a new generation, this change began to normalise decisions to make formal or legal complaints about abusive sexual encounters with men.

Secondly, gay men and lesbians also mirrored this social movement politics in a way that suggested another positive use of law to attain sexual justice by their campaigns in relation to homophobic assaults and hate crimes (Mason and Tomsen 1997, Jenness and Grattet 2001, Moran et al. 2004). Locally, this issue grew in profile throughout the 1990s. The advent of some new state agencies represented a vital shift. The NSW Anti-Discrimination Board conducted early surveys of targeted assault and harassment, and documented the wide-scale police refusal to assist victims. This research was afterwards validated in a series of important gay and lesbian community studies of violence that were conducted around the nation. To some extent, a significant historical change occurred in the heart of the police and legal apparatus. Especially in locations of inner-urban lobbying strength, there was a complex and unfinished, but still remarkable, change in the relations that exist between police services and gay men and lesbians built on consultation, mediation, publicity, and a community and official insistence on the reporting of a range of attacks.

Thirdly, decades of HIV activism have done much to reduce the stigma (still ongoing) that is attached to a positive status. Of course, most people are still cautious about the circumstances of divulging that they are infected with HIV. Yet for thousands of infected Australians, it has become more possible and frequent in dealings with health, education, employment, travel, customs and legal agencies. Paradoxically, it seems that with this muted stigma some women and gay men have a diminished wariness of dealings with authorities in sexual and HIV-related matters and are perhaps more ready to report a case of transmission to them in abusive or deceitful circumstances, as the source of an official grievance with a legal or criminal remedy.

This apparent new confidence about reporting victimisation is a positive measure of the successful working of feminist, gay and lesbian, and HIV advocacy in the public sexual arena and politicising of sexual matters as extra-personal. The mixed and unintended social, cultural and political effects of such advocacy are now visible. It seems regrettable that individualised grievances over sexual relations and courtroom arguments can now produce divisive public depictions and lurid details about gay men's sex. Similarly, the racialised representations of male danger to heterosexual women in key local trials are unwelcome. The potential for depictions of the dubious character of some gay or straight men in these

cases is evident enough. So too are the circumstances of uncertainty or serious doubt about different recollections of personal sexual encounters and practices in relationships, pick-ups and sex parties that are the ideal subjects for tabloid media reportage. The sexual realm is a ready locus for divisive expression of public emotions and moral panics (Irvine 2007). In such circumstances, it is harder to support those who appear to selfishly risk the health of other people.

The new confidence about dealing with authorities in relation to sexual matters could yet be eroded by volatile media and public interpretations of blame that mirror back on to complainants. More bluntly, a fresh dichotomy of guilty and innocent HIV-positive people is being implied in some heightened depictions. The community costs of this shift seem serious in further ways. Reduced trust in sexual matters and a reliance on peripheral claims in law to establish behavioural boundaries runs against the goals of preventive education about safe sex. The collective project of ethical sex (Carmody 2009) that included inculcating shared considerations around infection may be overridden with legal cycles of complaint and conflicting arguments and scientific division about medical advice given to patients, the timing and meaning of sero-conversion, viral loads and phenotypes, statistical risks of practices, the natural history of infections and each patient's prognosis.

Any serious policing of risk activity at beats, sex clubs and bathhouses would potentially clog the legal system with allegations, investigations and trials. What form would a preventive police raid now take with a report of an alleged gay 'conversion' party? In the notorious Sydney *Club 80* raid in the 1980s, officers rushed into a sex on premises venue and haphazardly arrested dozens of gay men and charged them in relation to a range of behaviours that were mostly assumed or concocted. Is there a new possibility that such sites, brothels and straight clubs with their own erotic shows and fetish nights could also become subjected to such surveillance? The actual form of many sexual encounters does not easily fit into the legal reconfiguration of issues of responsibility, risk, individual guilt, intention, and causality. The latter categories and terms and clear-cut scenarios of blame are well removed from the real complexity of sexual activity for many people with positive status and an ongoing experience of that activity and the subjective reassurance of desirability as a vital factor of personal identity.

The discursive framework for viewing sexual encounters resulting in transmission as abusive and culpable has always been in the legal backdrop. In 1990, a gay Sydney man named Tonks was killed by two youths in what appeared to activists and the gay community to be a homophobic hate crime. One of these youths, Andrews, had a casual sexual encounter with Tonks, arranged by ringing a phone number that was left in a public toilet. He had been infected with an undisclosed 'venereal disease' that shaped his immediate desire for revenge. Andrews returned to the victim's flat with a friend named Kane. An alleged confrontation about risky and selfish sexual behaviour and an allegedly dismissive attitude from Tonks, set off fatal violence. Tonks was bashed, bound with masking tape and suffocated. After the crime, Andrews presented at Albion Street clinic in inner Sydney with acute fears about being infected with HIV.

The killing was solved after years of investigation, and both Andrews and Kane were tried for murder. With a jury recommendation for leniency, Andrews received a six-year sentence (four non-parole) for manslaughter. He was later acquitted.¹ It seems likely that the scenario of an older, promiscuous and more experienced gay man taking advantage of the naivety of a troubled teenager, infecting him with an STD and placing him at possible risk of HIV infection, shaped much of the judicial and juror sympathy for the accused. Kane originally received a heavier sentence of ten and a half years (seven and a half non parole) for murder.² In the eyes of the court, the different culpability of these two youths may have related to the different risk of STD/HIV transmission from the deceased as much as to the levels of violence used by both while carrying out the killing.

The possible insensitivity of the deceased victim in this case could also signal to a contemporary audience that the collective ethical project was always a fragile one. Andrews later acknowledged his own gay identity, but with ongoing confusion and guilt from this episode, he committed suicide shortly after his release from prison. These trial details are also a sobering reminder of the difficulties around coming out and discovering the emotional indifference of casual sexual partners, as experienced by many gay youth. More broadly, it is worth considering if in a later period of time, the limited confidence of this youth being medically tested for HIV would also spill over into the resolve to make a police report rather than settle a grievance by violent extra-legal means.

Conclusion

It would be foolhardy to trivialise or openly dismiss the status of new legal claims regarding HIV transmission. This is especially so in relation to matters arising from encounters where significant power differences prevail. Some degree of criminal justice response to transmission may be necessary. But even if the situation of the new complainants was generated in part by progressive social movement agitation from the past, this expanded criminal law intervention is not the collective answer to the struggles people face around issues of sex, health and violence. Ironically, the rise of formal complaints about transmission also reflects a period where patient survival with new treatment is far more likely. In an earlier phase of the epidemic, those infected with HIV directed their personal energy and all support to the life-and-death issues of survival. Furthermore, it is now surprising to consider the activist backdrop behind the reconfiguring of transmission matters as legal grievances and how this reflects the empowerment of a new generation of sexually active women and gay men. The individualistic frame of transmission complaints threatens the centrality of community health containment and the collective agency of safe sex. It already appears to exacerbate stigma in a divisive way. Today's complainant could be tomorrow's accused.

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Endnotes

1 *R v. Andrews* (2002) NSWSC 489 Justice Greg James

2 *R v. Kane* (2000) NSWSC 1061 Justice Barr

Sexual practices, serostatus disclosure and relationships: life and law among gay men

John B F de Wit, Jeanne Ellard, Dean Murphy, Iryna Zablotska and Susan Kippax

Over the past three decades, affected communities and governments have responded to the HIV/AIDS epidemic in a range of ways. These responses have included the provision of timely and sustained treatment, care and support for people living with HIV, and the development of a number of effective prevention strategies. Many of these strategies were initiated by the communities most affected by HIV. Partnership between communities and government, underpinned by a strong behavioural and social science evidence-base, has been a hallmark of the successful response to HIV in countries such as Australia and New Zealand as well as the Netherlands and Switzerland. As part of the Australian response to HIV, the National Centre in HIV Social Research (NCHSR) has undertaken research with affected communities and used a range of data collection methods, theory and analytical approaches to develop a strong understanding of the social, cultural and behavioural aspects of HIV/AIDS. In this chapter we consider HIV prevention and the role of criminalisation in Australia in relation to gay men and other men who have sex with men (MSM) (the communities most affected by HIV in Australia) by drawing on a number of NCHSR studies including prospective cohort studies, cross-sectional survey studies, and qualitative research studies – to discuss HIV prevention and the role of criminalisation in the Australian context.

In Australia, the initial response to HIV was gay-community driven. Subsequently, official responses to the HIV epidemic were driven by public health needs, rather than by moralistic agendas. These responses were pragmatic and focused on harm-reduction for injecting drug use and promoting condoms for sexual intercourse. Targeted prevention for MSM, sex workers and injecting drug users, was coupled over time with efforts to avoid stigmatisation of the most affected populations. Of significance for the argument of this paper, the early national HIV/AIDS strategies ‘. . . also tackled important challenges such as the creation of a supportive, non-discriminatory legal, social and economic environment’ (Commonwealth of Australia, 2005), and involved advocating for the removal of federal and state laws that criminalised homosexuality, sex work or injecting drug use. In this and related ways the law has been an important focus of Australia’s response to HIV. These traditions of advocating for legal reform contrast strongly with the increasing tendency to bring cases of HIV transmission before the courts through either public health or criminal law.

Community-based HIV prevention underscores the importance of education, motivation, empowerment and support of people living with, and affected by, HIV and emphasises the shared responsibility for prevention of all partners involved in sexual and drug-related interactions. While this successful public health approach continues to dominate, some overseas countries and Australian jurisdictions have also put in place legal responses to the HIV epidemic. In contrast to a public health approach, the law approaches HIV transmission from the perspective of individual wrongdoing and sets up an adversarial relationship, in particular between former sexual partners. In a legal framework, public health notions of agency and shared responsibility are replaced by intent and endangerment. There is a concern amongst policymakers, AIDS organisations and affected communities that these recent legal moves could undermine the current prevention models by silencing open discussions about risky practices, stigmatising people living with HIV (PLWH) by depicting them as irresponsible, and shifting responsibility for prevention entirely to PLWH. Another effect may be a decreasing willingness to test for HIV among those most at risk.

In view of the potential risks of an increasing legal response to HIV transmission, including a shift away from prevention partnerships and notions of joint responsibility in favour of individual litigation and blaming, the present chapter will focus on the extent of social and other problems a legal approach aims to address. This chapter addresses gay and other MSM who continue to be disproportionately affected by HIV. The law may have little relevance for the lived experience of HIV transmission, sexual risk-taking and risk reduction in this community. We consider how a context of (potentially increasing and largely undebated) HIV criminalisation may negatively impact HIV prevention, specifically in relation to sexual agency, sexual interactions, and ultimately, sexual cultures.

Regulations and laws with relevance to gay sexual practices and cultures in Australia

In the Australian context, the explicit use of a legal framework in response to HIV transmission has to date been limited and infrequent, as it has in other developed nations. Although the HIV epidemic in this country predominantly affects MSM, a disproportionate number of cases coming before the courts have involved heterosexual transmission or exposure to HIV (see chapter 1 of this monograph). Also, there have been some cases involving sex workers, although a distinction should be made between the use of specific laws related to sex work and those related to HIV transmission.¹ The recent case in the Australian Capital Territory (ACT) for example was not related to actual HIV transmission. However, because the worker was HIV-positive, public perception and media interest conflated sex work, serostatus and HIV transmission. The ACT police used Section 25 of the *Prostitution Act*, which although titled 'Knowingly Infecting' was a charge solely relating to working as a sex worker while having HIV. In that context it is important to note that there is little risk practice among male sex workers with their clients. Safe-sex practices are deeply entrenched in the Australian sex industry and only a minority of current male sex workers reported any unprotected anal intercourse (UAI) with clients (Prestage et al. 2007).

In recent years a number of high-profile legal cases involving gay men in Australia have attracted substantial public and media attention. These cases have raised a range of concerns among affected communities, policymakers and prevention experts. In particular, while only a few prosecutions and convictions have occurred, there is a sense that legal responses are becoming more frequent and could foreshadow more draconian measures. These concerns are particularly salient in the context of a changing epidemic in Australia, where HIV notifications have increased in recent years and the underlying factors and changes in behaviours remain to be fully understood. Specifically, some of the highest-profile cases involving homosexual transmission have occurred in states (Queensland and Victoria) where recent increases in HIV notifications among gay and other MSM have been the most notable.

In Australia, a range of state and territory laws cover HIV transmission. These include public health laws as well as criminal laws (see Table 1). HIV transmission can and has been charged under generic, existing criminal offences, in particular 'harm or injury offences' and 'endangerment offences'. Some jurisdictions have 'disease transmission' statutes in criminal law that include HIV transmission. Of particular importance, in some states (notably New South Wales and Tasmania) there are public health laws that require disclosure of positive HIV status prior to intercourse, *regardless* of condom use. Further, in some states, such as Queensland, Victoria and Tasmania, an HIV-positive person charged with an offence related to HIV transmission, can use in his/her defence the fact that the other person knew of, and voluntarily accepted, the risk (for an extensive overview of criminal laws, see chapters 4 and 5).

TABLE 1 **Selected legal provisions to address HIV transmission in the Australian jurisdictions**

ACT	intentionally or recklessly inflict grievous bodily harm on another person
NSW	maliciously causes another person to contract a 'grievous bodily disease' (including HIV), or have sexual intercourse without informing the other party of the risk of contracting HIV
NT	cause grievous bodily harm to another person
QLD	transmit a serious disease (including HIV) to another person
SA	recklessly endangers another person's life
TAS	cause grievous bodily harm to a person by any means, or have sexual intercourse without advising the other of the HIV status in advance
VIC	intentionally causes another person to be infected with a 'very serious disease' (including HIV), or conduct endangering life
WA	commit an act that is likely to result in another person contracting a serious disease (including HIV)

From Cameron S (2008) 'Criminalisation of HIV transmission and exposure: risk, negotiation and consent' *HIV Australia* 6(3): 8

Legal frameworks that address HIV transmission in particular deal with situations in which transmission may have occurred intentionally, recklessly or negligently. However, the preponderance of HIV transmission and risk practices in the Australian context are not characterised by intent, recklessness or negligence. Moreover, the law endorses an explicit disclosure of a positive HIV status, at least by making it an aspect of defence. In prevention practice, in contrast, the understanding of HIV status disclosure is more ambivalent and is never seen as sufficient basis for sexual decisions. In particular, uncertainties surround the disclosure of an HIV-negative status as a person can be unaware of a recent seroconversion. Therefore, from a public perspective, any bearing public health or criminal law has on HIV prevention is at best limited and at worst counter-productive. The law calls for a clear establishing of causality and responsibility and this does not adequately recognise the myriad factors and interaction dynamics that affect the sexual practices that may result in HIV transmission in specific relational contexts.

Gay men's sexual practices, risk reduction and new HIV infections

So what are the current sexual practices of gay men and to what extent do these practices result in a potential for HIV transmission that could be addressed by the law? An important source of information regarding the sexual practices of gay men in Australia is provided by the *Gay Community Periodic Surveys* (GCPS; e.g., Imrie and Frankland, 2008), which provide snapshots over time in different jurisdictions. The GCPS show that, while anal intercourse is very common among gay men in Australia (reported by about 80% of men), unprotected anal intercourse (UAI) with either regular or casual partners is much less common and is engaged in by around 40-45% of all gay men participating in the surveys,² depending on the social context. In addition, much of the UAI in casual sex appears to be infrequent. Importantly, while UAI is the main mode of transmission of HIV among gay men, and is more frequently practised by HIV-positive than HIV-negative gay men, not all UAI poses a high risk, including when it is practised by HIV-positive men. In fact, as we will show, positive and negative gay men engage in a range of strategies other than the use of condoms, which may reduce the risk of HIV transmission. These strategies primarily revolve around the serostatus of the partners involved and may or may not involve actual disclosure of HIV status, may be explicitly negotiated in a relationship or implicitly understood in a certain context, and involve HIV-positive men, HIV-negative men, or both. Rather than suggesting that positive or negative gay men who engage in UAI are reckless or negligent, these risk-reduction strategies largely reflect an ongoing commitment to HIV prevention that is balanced against relationship intimacy and sexual pleasure.

On the face of it, 40-45% prevalence of UAI in the population of gay men in a six-month period would suggest ample possibility for the transmission of HIV, and might be understood as representing anything but a commitment to risk reduction. However, this proportion can be deconstructed to illuminate more complex sexual practices that tell a substantially more nuanced story. Firstly, most UAI happens in regular relationships, and the GCPS show that, while around 35% of all gay men engage in UAI with a regular partner, only around 20% report engaging in UAI with casual partners. Moreover, much of the UAI in steady relationships occurs between men with the same HIV status.

Notably, while up to 45% of HIV-positive men have UAI with their steady partner, some 50-55% of these men have UAI only with a steady partner who is also HIV-positive. Of the approximately 45-50% of HIV-positive men who (also) have UAI with an HIV-negative or status unknown steady partner, around 40-50% exclusively engage in receptive UAI and this is thought to pose less risk for the non-HIV-positive partner. Over the course of the years that the GCPS have been conducted, the number of HIV-positive men who have reported having engaged in insertive UAI to ejaculation with a non-concordant steady partner has remained limited to a small number of cases per survey, and these uncommon events presumably reflect partners' shared knowledge of their HIV serostatus and an understanding of the risks involved.

HIV-negative men are also more likely to report UAI with a steady partner than with casual partners, and most of this UAI is with partners who have the same serostatus. About 35-40% of HIV-negative men have UAI with their steady partners, and 80-85% of these men engage in UAI only with partners who are seroconcordant. About 60% of HIV-negative men who have UAI with their seroconcordant partners also have an agreement with their partner about sex with others to keep HIV out of their relationship, and only 10% of men in seroconcordant HIV-negative relationships practise UAI with others outside the relationship in the absence of any agreement. A very small minority of 1-2% of HIV-negative men have UAI with an HIV-positive steady partner. These men most frequently engage in insertive UAI with their steady partner and only half of them report receptive UAI to ejaculation with their HIV-positive steady partner. Only 10-15% of HIV-negative men have a partner whose HIV status was unknown, and only around 10% of respondents in the GCPS are not aware of their own HIV status.

As noted before, substantially fewer gay men engage in UAI with their casual partners (around 20% of all gay men, based on GCPS data). As with steady partners, HIV-positive men are more likely to report any UAI with casual partners than HIV-negative men (around 40-45% vs 15-20%). However, the *Positive Health* and *Health in Men* studies among HIV-positive and HIV-negative men, respectively, offer some information regarding the serostatus of men's casual partners that provides a more nuanced understanding of risk and risk reduction. These data in particular illustrate that, while around 40% of positive men and 25-30% of negative men engage in UAI with casual partners, only 5-10% of HIV-positive men engaged in UAI with a casual partner they knew to be serodiscordant (less than 5% of HIV-negative men reported the same). Moreover, not only is the number of positive and negative men engaging in serodiscordant UAIC small, the number of serodiscordant sexual events reported by each of these participants is usually limited to one or two events in the previous six months. Also, events do not happen on a regular basis, and the use of risk-reduction strategies may be negotiated (e.g., strategic positioning). In addition, qualitative research suggests that a number of HIV-negative men are engaging in UAIC on the basis of an explicit disclosure of HIV status with their partner, who equally attests to being HIV-negative.

Behavioural data indicate that UAIC and, in particular, serodiscordant UAIC, occurs more frequently in certain subgroups of gay men (often referred to as sexually adventurous men) who report a high number of partners, considerable drug use and more 'esoteric' sexual practices (Kippax et al. 1998; Hurley and Prestage 2009). While the number of these men is presumably small, they may account for a substantial proportion of the UAIC observed in both HIV-positive and negative men. Paradoxically, in contexts where transmission is potentially more likely to occur, such in networks of highly sexually active gay men, the relevance of any legal responses is limited for two main reasons. Firstly, the sexual practices of many men involved in adventurous sexual networks are often well informed, voluntary and consensual. Secondly, even in situations where that may not have been the case, the ability of prosecutors to secure a conviction for deliberate transmission of HIV is the most difficult. The reason for this is twofold: limitations of the technology used to show relatedness of viruses between two people; and the complexity of the sexual networks themselves.

HIV genotyping, and specifically phylogenetic analysis, has been used in such cases to show genetic similarity between HIV in samples taken from defendants and witnesses. However, as a leading Australian virologist interviewed in an ongoing research project on HIV genotyping said of a recent high-profile case in Victoria: ‘. . . the linkage of Neal³ with other people was consistent with transmission but did not prove it . . . you can’t show direct transmission using phylogenetics . . .’⁴ Further, expert witnesses in the Neal case provided opinion that the linkage of Neal with other people was not conclusive. Indeed, phylogenetic analysis is most useful in *disproving* transmission rather than the reverse.

Also, without additional evidence there is no way for phylogenetic analysis to prove the direction of transmission, or indeed if transmission occurred via an unknown third party. So, in dense sexual networks, where there is a substantial amount of sex and overlap of sexual partners, it is often possible to suggest that transmission could have come from someone other than the defendant. It is not unexpected – in fact it is highly likely – that two people in a sexual network would have similar viral strains. A strategy of the defence would be to prove that there were other sexual partners at around the time transmission took place. In the Neal case, the defendant was found guilty on nine charges of attempting to infect, but not guilty on the two charges of deliberately infecting another person with HIV.

Serostatus disclosure: practices, expectations and experiences

Disclosure of HIV status plays an important role in laws related to HIV transmission as well as in public health approaches to HIV prevention and in people’s everyday lives. However, these roles differ markedly, as indeed might their effects. Simply stated, whereas from a legal perspective serostatus disclosure by an HIV-positive person mitigates against prosecution or can be used as a defence because the partner has been informed of any risk, from a public health and everyday-life perspective serostatus disclosure serves the purpose of mitigating against transmission (rather than against responsibility only). Ironically, while the law may be understood to support prevention, legal approaches to disclosure may inadvertently contribute to HIV transmission in situations where an HIV-negative partner consents to UAI with an HIV-positive person. This potential may go largely unrecognised because of an assumption that no reasonable person would knowingly engage in such risk. In everyday life, however, gay men may calculate and lessen risk by strategies other than using condoms or rejecting sex with a positive partner; for example, by strategic positioning, withdrawal or reliance on an undetectable viral load (Prestage et al. forthcoming; Van de Ven et al. 2002, 2004, 2005). To complicate matters even further, recent findings from the *E-male Study* (Rawstorne et al. 2009) demonstrate that using a condom with casual sexual partners is more likely if there is *no* disclosure, suggesting that for many men disclosure signals the possibility of not using condoms.

Disclosure is a complex process: its purposes may be multiple, and its meanings change depending on the social and interpersonal contexts of sex. Decisions regarding disclosure of an HIV-positive status to a new sexual partner are likely to reflect a range of concerns around privacy, rejection, sexual desire, HIV transmission and sexual ethics. Further, these decisions are context dependent and disclosure might, for example, not be a priority in some casual sexual encounters, but may be very important when seeking to establish intimacy and trust with someone who is a potential new regular partner. It was common for the newly diagnosed men interviewed in the *Seroconversion Study* to describe struggles with disclosure in sexual contexts, trying to balance difficult legal and ethical issues with a desire for pleasure and privacy regarding their status. For example, one participant said:

Well I didn’t have sex at all for quite some months after I found out and then I had two one-off encounters with guys and I had a bit of debate about it with a few friends and one friend who is positive said he has a three-time rule. If he sees someone three times you tell them on the third date and I thought that is probably fair enough but two other friends who are in a long-term relationship say you should tell everyone, even if it is just an anonymous sex situation. I don’t think you need to because I don’t think most people having anonymous sex expect to be told. (Andy 2006)

As this suggests, newly diagnosed men in particular may be in the process of coming to terms with their new status and what it means to their lives to have HIV. For many of them, this takes time. They may experience anxieties around sex, including fears about being rejected by a potential sexual partner and about infecting sexual partners with HIV.

In jurisdictions such as NSW, HIV-positive people are legally required to disclose their HIV status prior to having sex. This may create a further pressure, as illustrated by the following quote:

He said, 'have you been tested?' and I said, 'well yes I have.' He said, 'well, I've never met anyone who is positive,' and I said, 'well, you will, and you won't know that you're meeting someone who is positive, you know people won't tell you.' And he said, 'are you?' and I said, 'no', so I lied . . . he was already freaking out . . . I just reassured him that everything we had done was safe . . . I think when I was sleeping I got a bit of an anxiety rush if you like, because in my mind, I don't want to lie to someone and I want it to be okay for me to say I'm positive and still have someone go, 'great, not a problem', but I know that I'm not necessarily there yet. (Tony 2005)

As this account attests, even when HIV-positive men engage in safe sex, sexual encounters can carry burdens related to disclosure that do nothing to further prevent HIV transmission, but rather cause significant distress and complicate the sexual and social relations of HIV-positive men.

Tony's experience also illustrates that current disclosure laws may inadvertently undermine prevention models that promote shared responsibility and obscure the agency of HIV-negative men in sexual negotiations. In particular, legal requirements may promote expectations that positive men will always disclose their serostatus. The absence of any explicit discussion of HIV status during a sexual encounter, initiated by either partner, may then lead both HIV-negative and HIV-positive men to make decisions about sexual practices based on differing assumptions rather than on explicit and certain knowledge of status. Notably, some men stop short of discussing serostatus openly and directly, and engage in what we call 'seroguessing' (Zablotska et al. 2009). On the other hand, HIV disclosure by itself does not necessarily always prevent HIV transmission. Data from the seroconversion study further suggest that disclosure among HIV-negative men can carry a significant risk for HIV infection because it is not always possible to claim an HIV-negative status with the same certainty as a HIV-positive status, as the following illustrates:

. . . he mentioned, oh you know, he is fine, he's, what's it called, negative, and I said 'and so am I', so you know, whatever. And we had unprotected sex for quite some time, but me fucking him. Then a week later he called me and said 'oh look, I don't want to alarm you, but I'm actually HIV-positive, and you should be tested'. The story was then that the guy in Sydney was mentioning that he had a light form of seroconversion and didn't realise at that point . . . he was very sincere about it and I actually . . . believe that he wasn't aware. (Adam 2004)

In this particular case both men believed that they were HIV-negative when they had sex, but both men were diagnosed with HIV shortly after their sexual encounters. Around 9-13% of HIV infections among MSM are undiagnosed, and recent mathematical modelling has estimated that these account for almost one-third of new infections in Australia (Wilson et al. 2008). Disclosure of HIV status would obviously not prevent HIV transmission in these cases (in fact it may potentially increase it as illustrated in the quote from Adam above) because these men are unaware of their own HIV-positive status.

Despite the uncertainty around their own HIV status, HIV-negative men hold high expectations regarding disclosure by HIV-positive men. In a national survey of MSM, conducted in 2000 by the NCHSR, some 80% of HIV-negative men agreed (or strongly agreed) that they expected an HIV-positive man to reveal his HIV status before having sex with them. Paradoxically, in this study a similar proportion of HIV-negative participants also said they always or sometimes avoid sex with people they think had HIV. Together, these responses do not suggest an environment conducive to HIV disclosure to sex partners. Some unpublished data from the *Positive Health* study indicated that as many as 27% of HIV-positive men reported being sexually rejected due to their HIV serostatus (Zablotska, personal communication).

Conclusion

In this chapter we explored the sexual practices of MSM in order to establish whether and to what extent a legal framework would meaningfully contribute to HIV prevention in the community most affected by HIV in Australia. Overall, the available data illustrate that while UAI is not uncommon, MSM generally attempt to manage their sexual practices in ways that balance the risk of HIV transmission with other social and sexual needs. This indicates a strong and continuing commitment to HIV prevention. There is no evidence to suggest a significant culture of reckless sexual behaviours and intentional transmission of HIV among MSM. Instead, risk-reduction strategies may sometimes be implemented imperfectly. A legal framework is unlikely to be relevant in many of the contexts or situations where HIV transmission is most likely to occur; for example, among men who participate in sexually adventurous networks, or for men who are unaware of their HIV-positive status. On the contrary, the law may actually be unhelpful because it can provide a false sense of security, particularly for HIV-negative men, overemphasises the responsibility of HIV-positive men, and (consequently) contributes to stigmatising of people living with HIV. Recent increases in new HIV infections may, in part, reflect the changed decision-making context, including new experiences and representations of HIV in response to effective treatments. This clearly presents a challenge, but not one to which the law has much to contribute. Just as we cannot treat our way out of the HIV epidemic, we will also not be able to prosecute our way out of it. Instead, sustainable HIV prevention requires a reinvigorated community response that thrives in an enabling rather than a prosecutorial environment and that is grounded in a social science-based understanding of human behaviour.

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Endnotes

1 Two 1991 cases in Victoria that were dismissed, and the 2008 prosecution of Scott in the ACT.

2 Here and thereafter all data from GCPS are presented as the proportion of all respondents who participate in the surveys, to illustrate the prevalence of sexual practices in the total population of gay community attached men.

3 Convicted in Victoria in 2008 on 15 charges, including nine of attempting to infect another person with HIV, although found not guilty on the two counts of deliberately infecting a person with HIV. See chapters 8 and 11 in this monograph.

4 The quote is from the Viral Families study conducted at the NCHSR (chief investigators: Dr Jeanne Ellard, Dr Kylie Valentine, Dean Murphy).

The Neal case: HIV infection, gay men, the media and the law

Michael Hurley and Samantha Croy

On May 22, 2006, ABC television reported that 'A grandfather of five from north Melbourne has appeared in court, charged with intentionally infecting people known to him with HIV.' The man was soon identified as Michael Neal. After a two-month trial in 2008, a jury found Neal guilty of 15 charges related to 11 people. Eight of the guilty verdicts involved attempting to infect a person with HIV, two were for rape, and another for administering a drug for purposes of penetration. Neal pleaded guilty to 11 other counts, including producing and possessing child pornography, indecent acts with a child under 16, and possessing and trafficking methamphetamine.¹ In January 2009, Neal was sentenced to 18 years' imprisonment.

The sentencing judge said that it was the first prosecution of its kind in Victoria, that Neal had little chance of rehabilitation, and that a 'clear message has to be sent to the community in relation to this type of offending' (Watts 2009). Neal had been under medical and psychiatric surveillance for some years. An advisory panel to the Department of Human Services believed Neal's behaviour justified use of the Health Act to remove Neal from the community. The police investigation into child pornography allegations began in February 2006, and in May, Neal was arrested on those allegations and 'claims that he had deliberately infected people with HIV' (Medew 2007a).

Our interest here is in how media accounts of the Neal case relate to the narration of HIV infection and gay male sexual interactions. We identify the extent of media coverage of the case in Australian mainstream print media. Our content analysis focuses on the Victorian media. Various kinds of discursive, linguistic and content analysis are used to examine selected articles. We position the articles in relation to social research and examine the ways Neal is 'figured' as an element in an ongoing system of media reporting of HIV infection and transmission in Victoria and elsewhere. We draw attention to some implications of this for how HIV infection amongst gay men is moralised. We do not address questions of accuracy in the reporting.

Neal's initial charging occurred in the context of six years of increases in HIV notifications in Victoria and the case reverberated politically at a state and national level. The media coverage of the Neal case links it with these wider matters and in doing so consistently relies on witness testimony in the trial and opinions sought from key community and other stakeholders. Social research is almost totally absent from the coverage. We note how, under the increasing pressure of politics and intensified moralisation, the tentativeness evident in some witness testimony on some aspects of gay male sexual cultures is transformed. It becomes evidence of a 'sinister sexual subculture' in a particular sequence of articles and in editorial narration.

HIV infection and transmission

The concepts of 'infection' and 'transmission' are often used interchangeably in relation to HIV. However, this blurs different contexts and usages. At a general level, infection involves how the virus moves *between* people. Over the past ten years, there has been increased public health emphasis and focus on the movement of the virus *from* HIV-positive people to previously non-infected people (i.e., transmission).

HIV-positive people are positioned at the centre of responsibility. This occurs in the context of increasingly individualised HIV prevention in which responsibility is moralised without regard for context. Unprotected sex is reduced to intentional risk-taking, irrespective of 'the circumstances of sex' (Race 2007).

Most HIV infection in Australia occurs during unprotected anal sex between gay men. The majority of HIV-negative gay men still practise safe sex most of the time (Crawford et al. 2006).² HIV-positive men also practise safe sex most of the time. About half of their unprotected anal intercourse (UAI) is with other HIV-positive men (Rawstorne et al. 2007). When we take that into account, the levels of UAI among HIV-positive men are similar to those among non HIV-positive men. These trends appear to apply, with some variations, in all states, including Victoria (Zablotska et al. 2008). Mostly UAI occurs in the context of some other form of risk reduction, such as strategic positioning or serosorting (Jin et al. 2009). Once these behaviours are understood contextually, there appears to be no scientific reason for treating HIV-positive gay men in general as the primary or sole bearers of responsibility, as distinct from doing health promotion that addresses HIV-negative and HIV-positive men separately and together.³ Murphy and Ellard's (2009) analysis of some of the Australian health promotion materials where this does occur indicates 'an attempt to open up a discussion about sexual ethics – what can and cannot be assumed in a sexual situation – and to instil cultural norms, i.e., to care for each other and not allow HIV-positive men to bear the full responsibility for preventing HIV transmission.

The media and HIV

There is an extensive international research literature on media coverage of HIV and AIDS. Bardhan (2001) reports a decline in coverage internationally, and a retreat to routinised, passive coverage. Persson and Newman (2008) identify the return of the 'innocent victim' and 'blaming' in media accounts of recent criminal cases involving heterosexual HIV transmission.

There is another literature on how the law frames HIV transmission and responsibility. In media and legal narratives, HIV is still figured largely in terms of it being a fatal infection, without regard to the availability of treatments or their effects. In the courtroom, infections becomes transmission: a person with an HIV diagnosis either recklessly or deliberately exposes his (so far all cases have involved males) sexual partners to the risk of HIV infection, and, by implication, death. The legal configuration of responsibility (Weait 2001; Worth et al. 2005) may or may not include notions of intention (see chapter 5 in this monograph). The person living with HIV is seen as both the active and the offending agent. No HIV-negative person involved has ever been charged with recklessness. They are mostly represented directly or indirectly as 'victims' of a perpetrator.

In the past, 'reactive legislative responses have accompanied media hysteria from high-profile exceptional cases', such as that of sex worker Sharlene Spiteri (Watchirs 2005). Spiteri was detained involuntarily, but not charged (Sendziuk 2003).

Media research indicates that news can frame and cue 'issue regimes' and structure public response. Shah et al. (2002:367) argue that:

choices about language, quotations and relevant information lead to emphasis on certain features of a news story, and, in turn, significantly structure citizens' responses to public events and issues by encouraging certain 'trains of thought'.

News stories tend to report social problems within 'comfortable frames' (Bennett and Edelman 1985).

Blame and fear of contagion was often linked to the stigmatisation of those infected in terms of their social identities: gay men, sex workers, intravenous drug users, heterosexual women, 'foreigners'. For Grover (1988) the term 'HIV carrier' is akin to the notion of 'patient zero'. The 'carrier' is reduced to their viral diagnosis and provides a simple resolution to 'the problem of blame, so central to the construction of AIDS as a moral issue' (p 22).

In an analysis of media reports in Australia from 1994 to 1996, Lupton (1999) reported that while three 'archetypes' dominated: the 'AIDS victim', the 'AIDS survivor' and the 'AIDS carrier', there had been a shift in moral discourse:

moral judgements related to people with HIV/AIDS presented in these news texts appear to be based less on how they acquired the virus than the manner in which they deport themselves once infected.

In the mid-1990s, new combinations of antiretroviral therapies became available in the West. The social effects of this on people living with HIV and on gay men's sexual behaviour were not clear for some time. Marcus O'Donnell, then editor of the *Sydney Star Observer*, remarked that 'what's going on is much more fluid than a neat genre story can encapsulate' (Kiley 1998). The clinical effects of these therapies were rapid and remarkable. By the early 2000s in Australia, the death rate from HIV/AIDS was about 90% less than in 1994. However, the 'AIDS carrier' remained positioned as a potential source of infection, particularly in criminal cases where s/he become archetypical, a threat not only to immediate others, but to everyone (Petty 2005).

Much of the subsequent discussion of the sexual implications of these matters has occurred in relation to gay male sex cultures and notions of 'barebacking', sero-sorting and disclosure. Barebacking involves HIV-positive men seeking other HIV-positive men as partners in unprotected anal sex. This relies on 'recognition' of each other. Amongst HIV-negative men, disclosure is associated with increased unprotected sex. Problems with 'recognition' occur when men of either HIV status fail to negotiate it adequately. Narratives of HIV risk amongst some gay men now take into account the effects of treatments on levels of viral load (Prestage et al. 2009) and the implications of treatments for infectiousness as well as longevity (Wilson et al. 2008; Hogg 2008).

Generally speaking, almost no HIV infection occurs in a criminal context. HIV infection occurs almost every day amongst gay men in Australia in consenting sexual interactions *between* HIV-positive and non-HIV-positive people.

Media coverage of these matters is often analysed as moral panic; however, moral panic 'makes sense in different ways to the different groups voicing their concerns at different times' (Lumby 1999: 103). Lawrence and Bennett (2001) argue that media reporting is part of how 'various publics construct understandings of news events and political issues' and that what matters includes 'symbolic constructions and collective sense-making of the political world'.

Media coverage of the Michael Neal case

The Neal story broke on ABC television on May 22, 2006. There were two more stories on the ABC on May 23. The first reports in *The Age* and the *Herald-Sun* appeared on June 3. Genres of reporting included news articles, feature articles, editorials and opinion pieces. Articles were written by legal and court reporters, health reporters and state political reporters.

A cleaned, limited-term search (Neal, HIV) using the Factiva media database produced 118 articles nationally on the Michael Neal case in major Australian newspapers. The search covered the period from the time the story broke in the press in May 2006 to Neal's sentencing in January 2009. Seventy-five of the 118 articles were published in the Victorian newspapers, *The Age* (48) and the *Herald-Sun* (27). *The Australian* published 21 articles and the *Adelaide Advertiser* published 9. Most of the Victorian articles substantially concerned matters associated with the Neal case, including its political implications.

The 118 items in the national major newspapers can be grouped in three ways. The first group contains 60 items (51% of total items) and is associated with the Neal story breaking in the media and subsequent legal processes. The second group of 50 items (42% of total) involves the political consequences of the Neal case in Victoria. The third group (7 items) includes articles on the national HIV response and on gay sex cultures. Some items involve only passing reference to the details of the Neal case.

Most of the articles in Groups Two and Three are published in April 2007, during and immediately after the committal which begins in March. Articles published in April 2007 constitute almost half (48%) of the entire coverage of the case in *The Age*.

Group One: The trial process

The items in this group come in four 'bursts':

- 1 When 'the Neal case' first came to media attention, May to October 2006 (14 items)
- 2 When committal hearings begin, March 2007 (29 items)
- 3 The trial, June-August 2008 (10 items)⁴
- 4 The verdict July 31-August 1 (3 items) and his sentencing, January 2009 (4 items).

Group Two: The political implications of the case in Victoria

The items in this group are associated with the political implications for the Victorian government, its management of the HIV response, public health procedures governing persons engaging in sexually risky behaviour, the Health Minister and the Chief Health Officer, April 2007 (50 items).

Group Three: HIV infection, its governance and gay sex cultures

This group includes articles on gay sex cultures, passing reference to Neal in news of another case in South Australia, polemics directed at 'the civil rights lobby' and privacy protection, and actions taken by the then national Minister for Health and Ageing. The latter involved 'national guidelines for dealing with risky HIV-positive patients' (Stafford and Medew 2007) and the use of genotyping 'to determine who or what factors are responsible for spreading the deadly virus' (Medew 2007b). There may be more newspapers articles on each of these matters that do not refer to the Michael Neal case.

The figuring of Michael Neal

When figures of speech are used about an individual, a link can emerge between how the individual is figured and wider social discourse. The linkage in the Neal case occurs via both how an HIV infection is understood and notions of intention. Some headlines and articles reporting Neal's sentencing in *The Age* and the *Herald-Sun* referred to him as the 'Grim Reaper' (Hagan 2009; Hatfield 2009). One sub-header reported the judge's description of him as 'a threat to the gay community'. Article headers in the *Herald-Sun* during the sentencing hearings referred to him as the 'sex fiend grandpa', and an 'HIV fiend' (Bice 2008a, b). In an early article, Neal is reported as suffering, both before and after his own seroconversion, from 'psycho-social problems, suicidal thoughts and depression' (Medew 2006b). *The Age* does not report on whether these were mentioned during Neal's sentencing.

The sentencing report in the *Herald-Sun* included a remark Neal made to his psychiatrist about his 'more cunning, and more evil' behaviour when he was not taking antidepressants, and the judge's comment that Neal's HIV, depression, asthma and back and eye problems 'would make jail more onerous'.

There are several reports throughout the trial that Neal requested Viagra to assist with condom use, but no mention of it appears in the reports of the sentencing. Previously a nurse had been quoted as saying: '(Neal) stated that he was having trouble maintaining erections with condoms and if we wanted him to continue having safe sex then the department should pay for Viagra' (Collins 2008a). The emphasis of the article is on moral character in the context of problematic behaviour rather than on the related practicalities of HIV prevention.

Early in the trial a psychiatrist was reported as saying Neal was 'the most evil man' he had encountered in 20 years. We note the use of 'evil' in a psychiatric evaluation for trial purposes.

Neal's belief that he was not infectious because of undetectable viral load is mentioned at least fourteen times across the articles. In *The Age* report on his sentencing, this is overridden in the judge's remarks on his failure to change his risky behaviour. The accounts of the various hearings preceding Neal's sentencing refer consistently to his responsibility for reckless behaviour, intention to infect and motivation: increasing the pool of potential HIV-positive partners. The judge said that 'the behaviour of Neal's victims did not lessen his criminality'.

The term 'grandfather' and the information that Neal lived in Coburg, a northern suburb of Melbourne (well away from known gay areas) occur throughout the reporting. The first two *Age* and *Herald-Sun* articles reporting his charging mention his five children, grandchild, ex-wife and current gay partner. Various articles refer to him as meeting partners in gay chatrooms, sex on premises venues, at beats and at his own private parties.

Any 'othering' occurring here is not made in reference to Neal being gay – that mark of othering is much earlier in the epidemic. It refers to his risky sexual behaviour and intentions. Being a grandfather and living in Coburg appear to make him out to be, at the most, somehow an atypical gay man. That atypicality emerges in the judge's sentencing remarks in two ways: first, the references to his 'deviant sexual practices' (in context, unsafe sex), 'aberrant sexual proclivities' and his motivation to infect to increase the pool of HIV-positive partners for unprotected sex; and, second, the need for the gay community in particular to be protected from him. In an analysis of sex workers and HIV, Scott (2003, p 285) pointed out that 'danger was constituted in proximity rather than difference'. Danger, in the figuring of Neal, appears to involve both elements, but they are discursified in relation to sex and safety rather than sexual identity.

References in the articles to being HIV-positive vary considerably. 'HIV carrier(s)' is used sparingly: directly in relation to Neal in headlines and to other HIV-positive people being investigated for risky behaviour.

'HIV-positive' and 'HIV positive' are used 38 times in various contexts, but mostly in relation to Neal. These include headlines ('HIV positive man'); medical contexts ('was diagnosed HIV positive'); and behavioural contexts ('denied he was HIV positive', 'wanted to make others HIV positive'). 'Pos pig' occurred twice in a verdict article when Neal's lawyer argued he had not really wanted to infect others and was simply engaging in a 'sick fantasy' when he spoke of his 'pos pigs' or made comments to sexual partners such as 'I've made 75 people pos'. (Collins 2008b)

The 'Grim Reaper' and 'HIV Man'

The term 'the Grim Reaper' was used eight times in the Victorian coverage. Six of the usages referred to Neal directly, all in two reports on the sentencing, and two usages referred to the 1988 television advertisements in which the Reaper featured as part of the Australian response to HIV. The term 'HIV-man' appeared seven times in headlines in both papers in reference to Neal.

The figure of the Grim Reaper personifies death. It recurs constantly in Australian media coverage of HIV. The reaper is a skeletal, sometimes hooded male figure carrying a scythe used to cut down the living. The apostrophes in the headlines function both to indicate the quoting of remarks by the judge, and to apostrophise Neal by personifying him as death's agent. A 'fiend' is a variety of devil and also refers to wicked and malicious persons, and people who pursue an activity zealously. The cultural connotations here are religious in origin.

Midway through the trial period in 2007, *The Age* published an article headed 'dance with death' (Kissane and Medew 2007). *The Age* had used the heading 'Dancing with Death' seven years before in an article about gay men and increases in HIV infection, with a cartoon evoking the *danse macabre* – the dance of death – and its reminders of the fragility of life (Dow 2000). In the dance of death, skeletal figures lead the dancers to their grave.

Headlines are, of necessity, terse and involve shorthand expressions. The term ‘HIV man’ was used across the period of the trial. Usages included: ‘Give HIV man 20 years’, ‘Prosecutor: grandfather still threat’, ‘HIV man guilty on sex counts’, ‘HIV man “ignored warnings”’, ‘Officials failed to alert police about HIV man’, ‘HIV man “had sex with hundreds”’, ‘HIV man’s new charges’.

On the surface, the use of the term ‘HIV man’ is innocuous; however, it too involves personification. Contrast it, for example, with the neutrality of ‘Melbourne man jailed for spreading HIV’ (Watts 2009). ‘HIV man’ reduces Neal first to his diagnosed HIV status and then to the virus itself. He becomes an avatar, HIV incarnate, and in the context of the headlines an uncontrollable marauder and an attitude. Aspects of this are reminiscent of how evolutionary paleontology creates taxonomies of emerging species of humans – ‘Cro-magnon man’. In the case of ‘HIV man’ the phylogenesis is viral and moral rather than related to brain size and cognitive potential. In this figuring Neal is almost too bad to be true: an evolutionary and ethical dead end. He exemplifies a total lack of ethical deportment. Neal is not made representative of all HIV-positive gay men. ‘HIV man’ acts instead as a limit case. He crosses the boundaries of secular intelligibility and becomes a ‘fiend’, yet is constituted in part at the intersection of unethical and criminal behaviour. The level of unease in the reporting is palpable.

In the figuration of Neal as the Reaper, and in the metaphor of the dance, HIV infection is equated with death, and associated with sexual pleasure. The meaning of the allegory is established by the criminality: people who behave like this will be abhorred and punished. This is HIV ground zero as constituted by reckless behaviour, the threat of infection and the twin spectres of death and the predatory HIV-positive (gay) male.

Sources in the articles

Mostly the press sources are court based (witnesses, judge, lawyers), people in positions of community and institutional authority or biomedical researchers. No social researchers are directly quoted, nor are participants in adventurous sex scenes (Kippax et al. 1998; Smith et al. 2004; Hurley and Prestage 2009) who were not witnesses in the trial.

The use of sources in the reporting of the Neal case was complicated by events associated with the charging of Neal. Police had raided medical clinics that provided services to people living with HIV and took confidential files. They also took files from the Department of Human Services. These included files mistakenly given to them on people other than Neal (‘three high-risk HIV carriers’) and confidential case notes mentioning ‘third parties who are not people who are engaged in any kind of criminal activity but who have given information in confidence.’ As a result, another man was charged with infecting a woman with HIV (Whinnet 2007) and police investigations were launched into the behaviour of two other men (Whinnet and Roberts 2007). Tensions evident between the police and the Department during the Neal investigation became the subject of a political row in a parliamentary committee almost a year after they occurred (Medew 2006a; Catalano and Rood 2007). In an environment constituted by raids, ongoing court hearings and increasing public political pressure, all spread over two years, with some exceptions, people were loath to speak.

This put a particular onus on key people in People Living with HIV/AIDS Victoria (PLWHA (Vic)) and Victorian AIDS Council/Gay Men’s Health Centre (VAC/GMH) who spoke on behalf of their constituencies (see chapter 11 for a more extensive discussion). Witnesses in the Neal trial were frequently quoted in the media reports in ways that made their testimony reverberate in relation to the wider political and sexual issues.

Gay sexual subcultures

In 1970s sociology, gay culture was thought of as a subculture, separate from but connected to the mainstream. In the field of HIV, sexual subcultures are seen as involving gay men who engage in specific behaviours in sexually adventurous contexts. Only some gay men are regularly involved in sexual adventurism. Any risk-taking involved usually involves risk reduction practices.

In what follows we trace the use of the term 'subculture' in *The Age*. 'Subculture' appears in six articles in a one-month period from March to April 2007, at the time of, and subsequent to, Neal's committal hearing. These coincide with the cluster of articles querying the management of the response to HIV in Victoria. The Chief Medical Officer was sacked in the week preceding the last three articles.

On March 31, 2007, the *Herald-Sun* wrote of the challenges faced by the police who had to investigate 'a seedy world' in 'the underbelly of Melbourne's gay community' (Roberts 2007 p 25). The same day, three articles appeared in *The Age* reporting the committal hearing (Medew 2007b,c; Medew, Stark and Catalano 2007).

The page-one news report linked Neal's behaviour to departmental management of his case: 'Health chief rejected seizure of HIV carrier' (Medew 2007b). The article listed a series of factors involving the department, including: 'Neal's committal hearing exposed claims of a subculture in the gay community of men wanting to contract HIV in order to create a larger pool of partners for unprotected sex, which has not been fully investigated by the department.'

The page-two article was headlined 'In pursuit of HIV: real or just fantasy?' It began, 'Gay leaders are sceptical about claims of a shocking subculture' and described 'an underground world wanting to contract HIV and spread it' based on terms used by witnesses in the courtroom: 'conversion parties', 'bug chasers', 'gift giving', 'breeding', 'seeding', 'pos boys'. The article distinguished between those who considered the terms 'just fantasy, used only during sexual role plays' and 'others' who 'believed it was a frightening reality, designed to create a larger pool of men who could have unprotected sex.' Three sources were added from key PLWHA, gay community and media organisations and the outgoing CEO of Vic Health (the state's health promotion body). Not one of these sources supported the notion of such a subculture. The gay journalist was quoted as saying that the publicity surrounding the case 'had led to fear and tension in the gay community'. No social research was referred to in this article.

Three weeks later, two articles discussed the evidence of witnesses during the committal (Kissane and Medew 2007; Medew and Kissane 2007). The page one article, 'Gays in HIV "bug chase"' is a news report that acts as a summary of the longer feature 'Dance with Death'. The summary constructs the news using testimony by two witnesses at the committal and invited comment from community sources who disagree on whether the subculture exists. The article began: 'A Melbourne man who fantasised about catching HIV before he contracted the virus has spoken out about a gay subculture in which infection is seen as desirable.' No evidence is presented that indicated the man himself linked his fantasies to a subculture, as distinct from describing his own behaviour and state of mind. The next sentence reports him as saying that his 'wish to have unprotected sex with an HIV-positive man he loved led him to become infected.' He then says 'maybe there were parts of me, dark corners, that wanted it . . . and then it [the possibility of infection] won't be an issue.'

We note the conditional form 'maybe' in 'maybe there were parts of me'. There is no reference in the article to sero-conversion research that would enable a comparison of this man's account with themes identified since the epidemic began. Missing also is any awareness that desires for unprotected sex generally were the motivation for the introduction of 'negotiated safety' as an HIV prevention strategy in the mid-1990s.

The statements of the man above are witness statements from a court case about his desires for intimacy in a regular relationship and how they manifested psychically. These are then referred to as 'taking part in behaviour that is known in the gay community as "bug chasing"'. The narrative link between the two appears to be the desire for unprotected sex which is then cut off from the desire for intimacy and moved to 'bug chasing'. Bug chasing becomes emblematic of the desire for unprotected sex. Research suggests, however, that it is the desire for pleasure that motivates gay men's participation in sexual adventurism, and that the risk to HIV-negative men in this context is infection. That is, infection is a risk rather than an intention. The risk itself occurs in contexts mostly characterised by risk reduction and practices of mutual care. That these relations break down circumstantially is one problem, and unhelpful cultural tropes are another associated problem.

The term 'bug chasing' is highly charged. Taken literally it refers to HIV-negative men seeking infection. It emerged on the internet and is possibly primarily both a cyber-based form of sexual performativity and an effect of gay men having to constantly negotiate safe sex in the presence of a virus, and the disruptive effects of this on pleasure. Much of its cyber use appears to be figurative. There is little behavioural evidence that it occurs, even amongst highly sexually active men, as distinct from various risk-reduction behaviours often described very loosely as 'barebacking'. While terms like 'bug chasing' and 'barebacking' have limited use analytically for the purposes of research or HIV prevention (Groves et al. 2006; Carballo-Diéguez et al. 2009), they do have to be taken into account. As Race (2007) points out in terms of prevention and risk reduction, it is 'a matter of forging a tactical relation to normative technologies', and while 'this can be enabled by supportive policy environments', it cannot depend on the quarantining of culture by locating the phenomenon 'over there'. The challenges for public health and prevention here are how to do this without it being defined only by attention to criminality and without fudging the issue of unacceptable behaviour.

The witness's seroconversion story is followed by an account of an HIV-positive man telling the hearing that bug chasing 'was a big thing out there'. He is later indirectly quoted as saying 'some negative men who attended group sex parties with positive men might want to 'join the club' so they could have unprotected sex more freely'. We note again the conditional form 'might'. He links his own seroconversion 'more with wanting intimacy with his partner "than a "tribal membership or a rite of passage"'. He distinguishes this from his remarks about 'out there', saying 'it was difficult to tell how many men who fantasised about the virus actually tried to get it'.

The article cites the CEO of another community organisation for people living with HIV as saying such accounts 'confirmed the need for leaders of Melbourne's gay community to stop dismissing claims of the subculture as an urban myth'. The article goes on to say that after the hearing 'many gay community leaders and spokespeople for HIV and AIDS lobby groups disputed claims of bug chasing and conversion parties'. An 'HIV worker who did not want to be named' is cited as referring to 'a party line offered to the outside world on the issue of reckless HIV behaviour'.

A 'worrying subculture' becomes 'extraordinarily reckless' then 'sinister'. The accompanying investigative article 'Dance with Death' began: 'Recent criminal charges over the alleged deliberate spreading of HIV have called public safety into question and exposed a worrying subculture within the gay community.' At this point 'a worrying subculture' has emerged based on descriptions of Neal's behaviour, the accounts given by two witnesses and disagreements by two informants, one of whom is unidentified. Neal's committal, it is said, 'has revealed an extraordinarily reckless subculture in parts of the gay community, and an apparently timid one among health authorities charged with keeping the public safe.' We note how 'public safety' has entered the narrative, and that it appears to refer as much to the safety of those gay men not participating in intentionally reckless behaviour, as it does to the safety of other communities.

The 'extraordinarily reckless subculture' is given descriptive detail in a sensationalised list which collates 'drug-fuelled orgies in private homes, sado-masochistic games', sex involving 'penis piercings that can tear the flesh, the picking up of teenage boys in toilet blocks and faceless group encounters in "dark rooms"'. Some items on this list are illegal, some legal. There is a later statement that '[W]hile no-one claims that this subculture is widespread, the fact remains: a small number of positive people who each have sex with hundreds can do a lot to spread the virus.' The remark is acrobatic in its attempt to balance fairness with identification of a problem. It ignores where non-HIV-positive men fit as active participants in this subculture, is sexually moralistic and identifies the behaviour of some HIV-positive men as the central element in responsibility for what is occurring. An 'HIV worker' is then quoted on degrees of recklessness that have to do with assumptions around sero-sorting and disclosure, and the 'extremely rare' phenomenon of 'deliberately lying and/or trying to infect others'. Some sources, if not the journalists, are hamstrung by a discourse of legalistic moralism that leaves no room for recognition of wrongdoing or even error without resort to blame and condemnation. To think otherwise is constructed as being complicit in peddling a 'party line'.

The second half of the 3102-word article deals with how recklessness is likely to be handled in the courts, expectations of disclosure, and 'the question of when a person's sexual behaviour crosses the murky boundary between being a public health issue and a criminal matter'. That is the nub. Some practices - extreme rather than representative - malicious rather than considerate of others - are made definitive of a subculture. They are prompted by a court case involving criminal behaviour, partly reliant on witness statements by participants, and investigated in a politically charged environment involving significantly run-down state and national HIV policy infrastructures.

The editorial was published on April 23, 2007 and referred to the two articles published the previous Saturday: those discussed immediately above. It set as its initial theme 'the disturbing number of HIV infections in Victoria' and identified 'a subculture in the gay world that encourages deliberate infection via unprotected sex with HIV-positive men' as the most sinister of the contributory causes to infection.

At this point, the sinister subculture outranks the substantial breakdown in the state's response to HIV which is momentarily reduced to a 'breakdown in bureaucratic communication'. Later, this 'bureaucratic breakdown' becomes a catastrophe for HIV prevention and the 'sinister subculture' becomes 'a murky underworld of indiscriminate encounters, fuelled by sexual enhancement drugs, where "gift givers" (HIV-positive men) and "bug chasers" (HIV-negative) conduct their activities.'

In these six articles, a tentative identification of a possible subculture becomes (over the period of one month) the most sinister contributor to infection. 'Sinister subculture' makes what was occurring amongst some gay men in Victoria intelligible, but in a very partial way. The search for an easy explanation makes it irrelevant that the irresponsibility sometimes involved in this subculture bears only a limited relation to its more general characteristic: an intention to manage risk while maximising pleasure. What begins as a curiosity-driven sideline prompted by a court case (what were these men doing?) becomes an alibi for moralism, but also acts to drive a necessary renewal of political will.

Conclusion

Criminal cases and the ways in which they are associated with sexually adventurous subcultures foreground the ongoing need for research and health promotion on the relation between values and the practical ethics of safe sex and risk reduction. However, unless discussions of values are informed by the contexts in which practical ethics are negotiated (Race 2003), we will reproduce a discourse of moralism and blame that is unlikely to affect sexual practice. How this can be done is constrained in the immediate context of criminal trials that have effects on the wider political environment. Identifying any longer-term effects of increased penalisation on sexual practices amongst gay men and their extent requires further research.

Even so, the linkages made in the media between the Neal case, HIV prevention and politics are having productive outcomes in the medium term. National procedures are now being installed for the public health governance of individuals believed to be putting others at risk. The Victorian HIV response is now better funded and HIV prevention and state policy advisory structures have been reinvigorated. Research is beginning into sexually adventurous men in Victoria that involves collaboration between the relevant community-based organisations, researchers and the cultures in which those men participate. In a less defensive, more productive environment it is possible to address the relations between care, risk and pleasure in ways that might lower rates of new infection.

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Endnotes

- 1 These remarks apply to contexts other than that of a criminal trial of an individual.
- 2 It should be noted that the trial was held in a closed court and that it is possible this limited the amount and kinds of reporting which occurred.
- 3 We rely in this chapter on the media accounts for the details of what occurred. Our focus is on how the events enter discourse, not the accuracy of the reporting. At different points in the trial, articles in *The Age* and the *Herald-Sun* report different numbers of charges and wording variations in different kinds of charges to which Neal pleaded guilty. Some of the variations can be explained by the police adding, dropping and changing charges at different points in the process.
- 4 We acknowledge the assistance of Dr G Prestage of NCHECR with this and the next paragraph, but the wording is ours.

Reality

Sex work: HIV criminalisation and control

Elena Jeffreys, on behalf of Scarlet Alliance, Australian Sex Workers Association

The terms 'sex work' and 'sex workers' referred to here encompass all forms of sex work for males, females and transgender people, including opportunistic sex work, internet sex work, transient sex work, brothel, private, escort, stripping with extras, BD/SM, street-based and migrant sex work.

Introduction

Sex workers in Australia work in a range of legal environments: criminalised, tolerated, legalised and decriminalised. Until the 1950s, Australian laws regulating sex workers – many of whom were imported from the UK – primarily related to disease control. Locked hospitals, mandatory health checks and jailing of sex workers with venereal diseases were commonplace (Sullivan 1997 p 20). Significant resources were expended and there is no doubt that this regulation dominated sex workers' lives. In the 1950s, emerging tolerance of sex outside marriage triggered a shift in thinking, and growing community debate (manifest in the landmark British Wolfenden Report) and discussions about liberalisation of sex work began in Australia (Sullivan p 102).

By the 1970s, this had transformed into legislative change, with the decriminalisation of sex work in New South Wales in 1979. Activists at this time were riding a new wave of women's rights and sexual freedom, and past obsessions with disease seemed far away. Such 'liberation' was short lived. In the 1980s, a new chapter opened, particularly for sex workers, injecting drug users and gay men: an about-face which returned to the concept of sex as medically dangerous, with a policy and legislative focus on disease control. Despite sex workers taking up condom use and having low rates of HIV, sex work regulation remains heavy-handed and somewhat dismissive of all evidence which points to the centrality and effectiveness of safe-sex practice by sex workers. Simultaneously, discussion about the reality of people living with HIV and working as sex workers has been avoided by key advocates in the HIV sector: a practice that has proved isolating for those individuals and counterproductive to the development of a best-practice response to their working norms. This paper addresses the practicalities of this approach and posits the criminalisation of sex workers living with HIV as central to HIV criminalisation debates.

Would the misplaced social and political pre-occupation with sex workers as vectors of disease have been shrugged off if HIV had never happened? Perhaps sex workers would still elicit sex-panic and hypochondria from our legal system, regardless of HIV. We will never know, but what we do know is that the arrival of HIV has changed the social position of sex work forever.

In the public consciousness sex work is inextricably linked to HIV, in all countries and in all social strata. Examples are found in developing countries such as Thailand and Cambodia, with the 100% Condom Use Policy enforced by police against sex workers as a public health measure, and in developed countries, such as the specific criminalisation of working as a sex worker when living with HIV in Australia and other jurisdictions. Despite sex workers having changed the entire culture of the sex industry in an effort to curb HIV transmission, we remain subject to mandatory HIV testing and are excluded from legalised workplaces if found to be HIV-positive. Sex work laws that increase the rights of some sex workers still go to extreme lengths to reduce the rights of sex workers living with HIV.

Effects of criminalisation on sex workers

HIV criminalisation affects all sex workers. HIV is not only a threat to sex workers' health but also to our ability to work without criminal sanctions. Sex worker livelihood, status in the sex worker community and future financial security is affected. Some sex worker communities are more affected than others, particularly those that already face social prejudice due to class, gender, sexuality and/or racial background. This prejudice is formalised in government policy, legislation and regulatory practices. Sex workers who bear the brunt of existing discriminatory sex work policies are more vulnerable to being criminalised for HIV status.

- Transgender sex workers have been the target of policing activity while also falling through health funding cracks. (Perkins 1994, Perkins and Bennet 1985)
- Sex workers of Asian appearance are targeted for anti-trafficking policing efforts in Australia, regardless of their visa status (Jeffreys 2008). The racial/ethnic background of these sex workers makes them more visible in a policy environment already anxious about HIV transmission in the sex industry.
- Men who have sex with men (MSM) are a target of HIV criminalisation and sex work laws. Anecdotal evidence suggests that it is not unusual for MSM in Australia to have had sex for money or to have paid for it at some time. These individuals are the same people who are making choices about sex in a personal (non sex work) context, with associated HIV transmission risks and prevention strategies. However, in relation to their association to sex work, MSM are particularly vulnerable to criminalisation, both as sex workers or clients and as a community affected by HIV.
- Female street-based sex workers in Australia are also vulnerable to HIV criminalisation. They work in public spaces and are perceived as promiscuous: viewed as flaunting both their sexuality and gender in public. The behaviour of female street-based sex workers is contrary to mainstream community expectations of female sexuality. They are also considered 'lower class' in comparison to other strata of female sex workers: a myth with no basis, but one that perpetuates prejudice and is used to justify harsh policing tactics. Discrimination on the basis of class may in part explain the institutional silence within the HIV sector on the criminalisation of street-based sex workers living with HIV. Notably, others occupying higher social positions (including policymakers) can seemingly justify harsh laws and policies against street-based sex workers. Extreme public policy to control the behaviour of female street-based sex workers living with HIV is actualised by a nervous health system attempting to maintain both public health *and* accepted systems of class, gender and sexuality.
- This nervousness was manifested in the high-profile incarceration of Sharlene Spiteri, a street-based sex worker in Sydney's Kings Cross in the 1980s, and the first person with HIV ever to be compulsorily detained for being positive (Donovan 1995 p 111 and Scott 2003 p 283). She was detained as an HIV/public health management measure under the since modified *Public Health (Proclaimed Diseases) Amendment Bill*. Her gender (female), sexuality (sex worker) and public workspace (William Street in Kings Cross) brought the locked hospital of sex worker history into contemporary discourses of HIV in New South Wales in the 1980s and 1990s and those ideas continue to influence policy and legislation.

To give some social context to the era of Sharlene Spiteri's incarceration, it is interesting to note that speakers *against* the Fred Nile bill to ban Mardi Gras in 1991 elicited images of street-based sex workers as the apparent *real* source of HIV infection in the community:

The whole concept of the Mardi Gras has become inextricably interwoven with the dissemination of the AIDS virus – a matter debated earlier today. I should like to quote from a statement in a scientific paper by Professor Leon Eisenberg, published in a recent issue of the *Australian and New Zealand Journal of Psychiatry*. Professor Eisenberg is Professor of Psychiatry and holds the chair at the Harvard Medical School in Boston. He wrote this paper on the AIDS problem in the community. He spoke of investigation by the American National Research Council into the spread of AIDS and the AIDS virus in America. Professor Eisenberg said that the NRC report noted in particular the growing problem among women who use drugs illicitly, women who trade sex for crack, minority women of child-bearing age and among adolescents, a sexually active population group among whom HIV infection already has been seeded. (Kirkby 1991, p 3316)

Street-based sex workers and drug users were used as a political foil to anti-gay sentiments stirred up by HIV panic, regardless of the irrelevance of US-based research in an Australian context. Mandatory testing of sex workers was a natural progression for legislators.

Criminalisation measures in Australian states and territories

Mandatory testing of sex workers for HIV and STIs is embodied within criminal law, regulations and policies in Australia. There is no other population group that is subject to comparable mandatory testing. states and territories where sex work is legalised (Victoria, Queensland, ACT and Northern Territory) have the most punitive and whorephobic approaches to testing, are completely out of step with public health best practice, and include the criminalisation of working with an STI, including HIV.

Queensland sex industry regulations require all licensed brothel workers to undergo regular mandatory testing and to have a doctor's certificate, in either a work name or pseudonym, to prove it (Queensland Health 2006). Doctors and nurses have been issued a range of rigid and complex guidelines to ensure that a certificate is not issued to an individual who has tested positive for HIV, chlamydia, gonorrhoea and/or syphilis, or who has visual symptoms of herpes, warts and/or scabies. Swabs, bloods, a visual examination and an internal examination are part of the mandatory testing process. The ensuing certificate is valid for three months and it (or a copy) must be held on record at the licensed brothel where the individual sex worker is employed. It is a criminal offence for a manager or receptionist to allow a sex worker to work without a valid health certificate.

By contrast, private sex workers, or sex workers working at premises that are not licensed, have no requirement for mandatory testing, can legally have sex while living with HIV or another sexually transmissible infection (STI), and are covered by laws applying to the general Queensland population rather than sex work-specific laws. Notably, available epidemiology does not reflect higher rates of STIs in the sector not covered by mandatory testing. Offering any unprotected sex without a condom, including oral sex, is illegal in Queensland. As a result of these laws street-based and private sex workers are more vulnerable than brothel workers. Members of the Queensland Police Service special purpose 'Prostitution Enforcement Taskforce' regularly go undercover, pose as clients, request unprotected sex, entrap sex workers, and prosecute. Street-based sex workers and others working outside the legalised brothel sector are the target of this police activity.

In Victoria, undergoing monthly testing and having a doctor's certificate is a prescribed defence for brothel owners in the case of a client becoming infected with an STI or HIV while visiting a licensed premise (a possibility which has not happened to date). As such, Victorian licensed premises comply with detailed regulations regarding mandatory testing of their staff (*Prostitution Control Act 2006, Health (Infectious Diseases) Act 2001*). This includes the legally mandated yet unnecessary, not to mention unethical, disclosure of a worker's private medical information to their employer, a practice about which the medical community has expressed concern. There are cases in Australia where doctors have been discovered providing false certificates to sex workers. For example, in 2007, a Victorian doctor was deregistered by the Victorian Medical Practitioners Board for writing medical certificates of fitness to work for sex workers without examining them (see Dr Cindy Yau Fung Lee Wong (2007) 1 MPBV 1).

Private sex workers cannot work while infected with an STI (*Prostitution Control Act (PCA) s20 Victoria*) and are still compelled to adhere to monthly testing in the same way as brothel workers, i.e., as a legal defence should transmission of an STI occur. Sex workers living with HIV are completely excluded from the licensed regime due to their HIV status, and are consequently pushed into the illegal sectors that attract higher criminal penalties for sex work generally and which offer no legal protection from exploitation or injury that may occur as a result of work. Sex workers living with HIV face double discrimination in Victoria: they are criminalised within the licensed brothel system and they are criminalised for working outside it.

The laws against working with an STI (including HIV) in the Australian Capital Territory (ACT) are contained in the *Prostitution Act*, and are unfortunately misnamed 'Knowingly infecting' (*Prostitution Act 1992 s25*), implying that working with an STI is equivalent to infecting a person (see below). The maximum penalty for working with HIV is six months jail, a sentence handed down to an HIV-positive male sex worker in 2008, marking the first time the law had been put into practice. The ACT also requires the registration of private workers and regulates brothels according to geographical zoning. Until this 2008 prosecution briefly referred to above (and explored in greater depth later in this chapter), these laws had not been enacted against a single sex worker. Living with HIV and doing sex work in the ACT made that person more vulnerable to the laws intended to regulate all sex workers.

Even in more progressive sex work legislation, the trend toward criminalisation of HIV is apparent. In 2007, the Western Australia Prostitution Amendment Bill sought to decriminalise sex industry businesses, while simultaneously introducing criminal penalties for sex workers with HIV. It seems the contemporary obsession with criminalising HIV has become a feature of new Australian sex industry laws. As with other issues relating to HIV and human rights, sex workers are on the receiving end and are considered vectors of disease. Consequently, when people with HIV are criminalised and maligned, so too are (HIV-positive and HIV-negative) sex workers. The vilification of sex workers living with HIV has a direct impact on those individuals and indirectly affects all sex workers. In the ACT, the high-profile criminal prosecution triggered a reduction in sexual health testing by sex workers through the Sex Workers Outreach Project (SWOP) of ACT mobile sexual testing service, from an average of 30 sex workers a fortnight to less than two (July 2008). The major reason given was because they feared the prosecution showed that the public health approach applied to a general member of the community with HIV or STIs (which generally involves education and support) would not be available to them as sex workers. It was clear that a drop in testing rates also occurred because sex workers 'did not want to be prosecuted for knowingly operating with a disease' and become part of a media circus such as the one that grew around the ACT case (Rudra 2008).

For many it might have appeared that privacy considerations do not apply to sex workers: the ACT Health Department had, after all, taken the inappropriate step of releasing personal information about a sex worker suspected of working with HIV. Fear of having personal materials released publicly adds to sex workers' insecurity about participating in regulated sexual health regimes.

2008 Needs Assessment of Sex Workers living with HIV

The *2008 Needs Assessment of Sex Workers living with HIV* (hereafter, the Needs Assessment), was conducted by Scarlet Alliance and the National Association of People Living with HIV/AIDS. Funded by the Elton John Fund through the AIDS Trust, it included a 12-month research project led by sex workers living with HIV, to better understand the needs of sex workers living with HIV and develop a contemporary policy platform. The Needs Assessment found that many positive sex workers were concerned about the vilification and misunderstanding of sex work that stem from criminalisation. There was widespread concern about criminalisation amongst the 14 respondents interviewed, typified by the response of one participant, 'just because you're a positive sex worker doesn't mean that you are deliberately spreading HIV' (Matthews 2008 p31).

Matthews, author of the Needs Assessment, summarised this concern within the sex worker community:

All participants believed there to be no good reason for criminalising commercial sex for people with HIV. Money does not contribute to increasing the risk of transmission. Safe sex and effective condom use can occur in both private and commercial sex settings. There is an awareness of criminal prosecutions of intentional transmission of HIV and all participants expected that if they were accused of this, the stigma associated with sex work and being HIV-positive would result in assumed guilt and that they would not be afforded due justice (Matthews 2008 p 30).

Of particular concern, the Needs Assessment found that a significant number of sex workers living with HIV were unaware of the specific HIV-related laws affecting their work. This has the possible consequence of putting such individuals at greater risk of prosecution because they are unaware not only of the restrictions resulting from those laws, but also of their rights. This lack of awareness, however, did not minimise their anticipation of the stigma and vilification they might experience should they be put before the courts, or their awareness of the rampant discrimination embodied within criminalisation. For example, as one respondent noted:

I got a feeling that if you went to court and they knew you were a [sex] worker and had HIV, I don't think, I don't know if they can prosecute you, I really don't know. I don't know, fuck, I can imagine it could get pretty ugly. (Matthews 2008 p 31)

Positive sex workers showed themselves to be clear that laws criminalising their work are based on discrimination e.g., 'I don't think you can ban a positive person from doing [commercial sex] because that is just discrimination'. (Matthews 2008 p 30)

The major recommendations from the Needs Assessment spoke directly to the core work of the HIV sector. As well as challenging criminalisation, sex workers living with HIV communicated a shortfall in the provision of condoms and information (the basics of responses to HIV in the 1980s) from key HIV organisations, namely AIDS Councils, sex worker organisations and People Living with HIV/AIDS organisations. Sex workers living with HIV are acutely aware that HIV services and funders prioritise other affected communities: gay men who are *not* sex workers, people living with HIV who are *not* sex workers, and sex workers who are *not* living with HIV. Other communities are receiving the desired basic support from their funded HIV organisations. Sex workers living with HIV are not. As noted by Matthews (2008 p 34):

Free condoms and lube are generally provided for high risk populations such as gay men and sex workers and need to be made readily available. It was generally felt that the use of safe sex equipment for sex workers with HIV had a greater benefit for others and for the community than for themselves and that it was in the best interest of the government to ensure adequate supplies were available.

Access to condoms and lube can be made difficult for HIV-positive sex workers through the need to disclose their HIV status and/or sex work involvement in accessing safe sex equipment. This disclosure is considered to be risky and would be preferable if access could be provided anonymously.

In spite of supplies not always being available, or sometimes difficult to access, using safe sex equipment and practices was [still] a high priority for all participants. (Matthews 2008 p 34)

Also evident from the Needs Assessment, was that sex workers living with HIV expressed frustration at the lack of government-funded health services available to them. They viewed lack of access to condoms and lubricant for sex workers living with HIV as a form of discrimination, stating that others had access to such services and demanding that they should too.

On the basis of this kind of feedback, it can be suggested that services funded by health departments are falling short of community expectations. How can the HIV sector advocate against criminalisation if unable to provide services expected by sex workers living with HIV? If some communities feel discriminated against and excluded by their own organisations, who are they to turn to when affected by HIV criminalisation? This calls into question the success of the community/government partnership, the maturity of the Australian response to HIV, and the inclusion of sex workers living with HIV in our community organisations.

One suggestion would be for HIV, PLWHA and sex worker organisations to take this message to their health departments in order to make sure that sex workers living with HIV receive condom and lube. They also need to create pathways for the inclusion of sex workers living with HIV within their organisations. This includes informing health departments that sex workers with HIV exist, and that they both need and are entitled to services and representation. Such advocacy to health departments has the potential to humanise sex workers living with HIV to the health bureaucracy: a step towards building allies within government who understand the detrimental public health outcomes of policies such as criminalisation.

Turning again to the responses of participants in the Needs Assessment, it would appear that sex workers living with HIV have a diverse range of opinions on this issue. For example,

- The HIV sector I think should get behind lobbying state and federal governments for a lot more rights for positive sex workers because at the moment they don't, they don't want to recognise it. They don't want to talk about it too much. It is a really sticky thing for them as well. They are really scared they are going to lose their funding and things like that. (Matthews 2008 p 39)
- I would like to see the profile of HIV-positive sex workers raised. It is something that is not discussed very much at all and I think if there was a bit more open dialogue about it and people did realise there were more people with HIV doing sex work it probably would become a lot more acceptable. The fact that it is not talked about people they instantly think because you're poz and doing sex work that you are a breeding ground and you will be infecting people. The more it's talked about, the more acceptable it is. (Matthews 2008 p 29)

An important step towards challenging the criminalisation of HIV is to share information about HIV and sex work laws openly and freely in gay and lesbian media, PLWHA and sex worker publications, and for advocates to comment in mainstream media on cases or laws that affect sex workers and people living with HIV. The provision of effective and accurate information would reduce the vulnerability of sex workers living with HIV in states and territories where they are criminalised.

The Needs Assessment identified the lack of available information about living with HIV and doing sex work for example, 'I just read up under the normal laws for sex. I don't know about the other laws' (Matthew 2008 p 24). Access to such fundamental information is surely a basic entitlement as well as a cornerstone of HIV prevention work. Lack of access to information for sex workers living with HIV has an impact on the criminalisation debate. Without clear information, sex worker communities are less able to consider the effectiveness of legislative and policy endeavours and advocate for the strengthening of those measures. AIDS Councils, People Living with HIV/AIDS organisations and sex worker organisations must become more active in informing HIV-positive sex workers of relevant laws.

Gay and lesbian media is another source of regular information for gay men, women and transgender people who are sex workers in Australia. Participants in the Needs Assessment expressed feelings of both alienation from and ownership over gay and lesbian media in Australia. They were angry about the lack of profile for their issues in gay and lesbian media and wanted more information to be available in that media and from community-based services. Comments included:

- I would like to see information . . . updates on what is happening with current [legal] cases or whenever a case comes up just as reassurance or information on what is happening as opposed to what you're just reading in the paper.
- There should be more awareness of what the laws are or more access to the information.
- Is there something illegal in the ACT?
- Where do people find that out? That's what I would say to that. How would people know that? They should at least advertise that . . .
- It should be a national campaign, cause if I'm travelling to ACT from Sydney for the weekend, and I want to hire a sex worker, and then I'm prosecuted, how the fuck was I supposed to know?!
- Maybe have the rules a little bit more known, that sort of thing. Somehow like in the gay papers or something like that 'cause there are sex workers advertising there and that sort of stuff.
- If I go to Melbourne for a dance party and I want to do some work while I'm there to pay for my holiday, how am I supposed to know? These sorts of things should be advertised and easily accessible for everyone to know.

Matthews commented further:

Participants reported that sources of information were difficult to find and unreliable. The Agency Review, conducted by Scarlet Alliance as part of this project, also indicated that incorrect and misleading information was being provided . . . This situation forces HIV-positive sex workers to rely on close friends and peers rather than professional organisations, even those organisations who claim to be supportive. (2008 p 23)

The recommendations from the Needs Assessment offer ways that information dispersal could happen more effectively for sex workers living with HIV without putting people at risk of disclosure. It recommends that information about criminalisation be incorporated into HIV publications, sex work publications, gay and lesbian media and sexual health material targeting sex workers, gay men and people living with HIV. This would result in legal information and information about available health and community support services being mainstreamed into a range of publications, and would facilitate improved knowledge about criminalisation generally among the affected communities. Increased knowledge will break down myths and misunderstanding. A model for incorporating such information is suggested below:

TABLE 1 **How to distribute information** (Matthews 2008 p26)

HIV and the law across Australia	Include information on sex work
Sex work and the law across Australia	Include working with HIV
Sexual health – legal rights and obligations across Australia	Include sex work, and living with HIV and working as a sex worker living with HIV

A deeper exploration of the 2008 prosecution in the ACT

Gay male sex workers living with HIV are subjected to homophobia and discrimination as a result of their gender, sexuality and HIV status. In the ACT, that discrimination manifested in a criminal prosecution of a gay male sex worker living with HIV. Lack of information fuelled a worst-case scenario when the high-profile case began in 2008. Never before had a sex worker been charged under these laws. Female sex workers had not been subject to surveillance for prosecution under this law or under any of the associated laws under which the individual was charged. Sex worker and HIV advocates faced particular challenges as a result of the inappropriate titling of the offence relating to HIV-positive sex work. The title, 'knowingly infecting', caused confusion as to the true nature of the offence and led to misguided anger and assumptions of irresponsibility. Most were unaware that the individual had, in fact, been prosecuted for simply *working* as a sex worker while living with HIV. This was not a case of transmission and there was no evidence of risky behaviour.

The ACT prosecution illustrates that gay men living with HIV and working as sex workers are particularly vulnerable to sex work related criminalisation in Australia. Laws that criminalise sex work particularly affect gay men living with HIV. Gender, sexuality and HIV status affected the way sex work laws were prosecuted and how those prosecutions were perceived. Even without evidence of risk behaviour, the ACT sex worker was subject to laws that had not previously been enacted against a single sex worker in the ACT. Community organisations and journalists saw the title of the laws and assumed that the sex worker had infected others with HIV.

One HIV community organisation unknowingly contributed to misinformation when they condemned deliberate infection in a media release relating to the case. Matthews (2008a) and others at Scarlet Alliance followed up on inaccurate media reporting with some success with correspondence as follows:

The sex worker in the ACT is being charged with

1 Failing to register as a sex worker in ACT. *Most of the sex workers in ACT do not register, and certainly do not wish to be identified;*

2 He's also been charged with 2 counts (one for each working name) of engaging in commercial sexual service while having an STD, in this case HIV. *This charge DOES NOT indicate that unsafe sex occurred, or that anyone was put at risk at any stage. This charge is unfortunately named 'knowingly infecting' even though it has nothing to do with infecting anyone, or putting anyone at risk of being infected.*

The actual wording is:

PROSTITUTION ACT 1992 – SECT 25
Knowingly infecting

A person shall not, at a brothel or elsewhere, provide or receive commercial sexual services if the person knows, or could reasonably be expected to know, that he or she is infected with a sexually transmitted disease.

Maximum penalty: 50 penalty units, imprisonment for 6 months or both. (Prostitution Act 1992, Section 25)

There has been no evidence put forward in this case about any risk behaviour. For the individual to do sex work while having HIV is lawful in NSW, but not in the ACT. If no money changed hands then the sex is totally legal in the ACT. He is only being [prosecuted] because he charged money!

These charges are a reflection of how badly designed the ACT laws around sex work are! They fail to take into account the realities that some people in our community have HIV, and having HIV still means you have a right to have sex. And with a right to have sex, also comes the right to do sex work. (Matthews 2008a)

Australian Associated Press and the *Sydney Morning Herald* updated their reporting of the case after prompting from Matthews about the actual charges. Unfortunately, that did not lessen the stigma of the original story, as a wave of panic spread through a number of gay male communities in cities where the individual had worked. All notions of privacy discarded, his photo and personal information were posted on e-lists and news websites.

The ACT prosecution of the same man for failing to register an escort service with the ACT Registrar of Brothels and Escort Agencies came as a surprise to many: in particular ACT-based private sex workers, many of whom are not compliant with registration. Until this case, no one had been charged for not registering in the ACT or working with an STI. It seems highly likely this case was pursued because the accused was HIV-positive. His failure to register was viewed by police as 'more criminal' than the same act by other ACT sex workers. His HIV status made him more vulnerable than other sex workers.

When lobbying the ACT Attorney-General, Mr Simon Corbell, Janelle Fawkes and Kane Matthews of Scarlet Alliance were heartened to hear that Corbell acknowledged the problems with the laws. Prior to the sentencing of the sex worker living with HIV, Corbell stated:

The question is, should there be a complete prohibition on people operating as commercial sex workers if they have HIV? Because we know that with appropriate safe-sex measures in place, the risk of transmission is negligible. (Rudra 2008)

Unfortunately, his words had no effect on the magistrate, who handed down the maximum jail sentence less than a week later. The frustrating and unfortunate irony of this situation was summed up in Fawkes' public response:

Last week, the ACT Attorney General, Simon Corbell, came out and stated that Section 25 should be reviewed and considering current risk in transmission that, in fact, an HIV-positive person being a sex worker does not hold a higher risk for the community, but this week, we have a Judge in the ACT making an example of a person who was only being a sex worker, [not engaging in risk behaviours,] whilst HIV-positive. That sends a clear and cutting message that simply having sex with an HIV-positive person is unsafe and that is simply not true. (Canberra Times 2008)

The key issue that became apparent during the ACT case is that the laws themselves are inappropriate and out of touch with current approaches to HIV. The ACT Human Rights Commissioner, Dr Helen Watchirs, also reflected on similar anti-discrimination cases that had been heard in relation to the ACT's *Discrimination Act*:

. . . applying the reasoning of *McHugh J* to the circumstances surrounding a sex worker who has HIV/AIDS, then the provision of safe sexual services is likely to be considered as 'essential' to the position of sex worker. This does not of itself automatically mean that s.49 of the *Discrimination Act* would apply so as to counter any complaint of unlawful discrimination pursuant to ss.10(1)(b) or (2)(c) of the *Discrimination Act* – again a balancing exercise would need to occur as to the degree of risk associated with the disability. The outcome of such a balancing exercise would depend significantly on the details of the specific complaint and the nature of the sexual service provided, eg oral sex is less dangerous than penetrative sex. If a HIV-positive sex worker provides commercial sexual services only for HIV-positive clients, then the known risks (such as increased viral loads) associated with the provision of that service with a condom as they relate to the disability of HIV status would be significantly different to the situation in *X v Commonwealth*. (Watchirs 2008)

Funding of sex worker organisations

Funding for sex worker peer education is more important than ever: strong independent sex worker organisations are a vital component of decriminalisation and for provision of services for sex workers living with HIV.

As identified by the Needs Assessment and the 2008 case in the ACT, both described in some detail above, discrimination forms the principal plank of human rights abuses contained within the criminalisation of HIV. This discrimination is not only against people who are sex workers living with HIV, but also people who are clients living with HIV, and the expression of sex work for all people living with HIV. The challenge ahead is to maintain the successes of peer education in the face of such discrimination, and counter these issues by decriminalising sex work and HIV. Laws relating to HIV are likely to affect all sex workers by increasing stigma and discrimination, and laws relating to sex work affect also those sex workers living with HIV.

Funding for sex worker organisations is an ongoing issue. While some within the HIV sector appear content for HIV funding performance to be measured by reductions in HIV transmission, this measure unfairly penalises sex workers, including sex workers living with HIV, as sex workers' success cannot be 'measured' against the incredibly low transmission baseline for HIV transmission in a sex work setting. Perhaps the 0% transmission rating breeds complacency among policymakers. At least one sex worker organisation in recent years lost a large percentage of funding due to the low rates of transmission within their community (Scarlet Alliance 2003). This short-sighted approach costs health departments more in the long term: higher investments are required to re-establish failed projects if sex worker organisations are left to languish with little funding or autonomy.

Sex worker organisations should be funded to maintain work on HIV transmission, including working with sex workers living with HIV, *because* of the low rates of transmission, not despite them. Measuring sex worker organisations by the standards of AIDS Councils, which are aiming for measurable decreases in HIV transmission rates, is inappropriate and illogical. Sex worker organisations are in a special league of achievements for an affected community and broader public health outcomes, but are in a precarious position if not treated differently in a policy and funding context. Sex workers are an affected community, include people living with HIV, and sex worker organisations are central to the Australian response to HIV.

Conclusion

The positive community within our sex worker community experiences the most acute forms of criminalisation relating to HIV, and this stands out as the most challenging issue for policy, community development, organisational competency and leadership in the HIV sector in Australia.

The voices of sex workers living with HIV must be actively sought and welcomed by the rest of the HIV community and integrated into discussions about criminalisation. The HIV sector needs new rhetoric that addresses criminalisation without creating new victims. Sex workers living with HIV don't identify as victims and don't want to be portrayed as such. One participant in the Needs Assessment commented:

I am either a sex worker or I am positive in my life, the two don't mingle. Hey guys, they don't mingle! They don't need to. I mean if all of us [sex] workers don't think that way then why do you guys do? We are a sex worker, it's like saying 'Hi I am a positive truck driver' or 'Hi I'm a positive doctor'. You're not! You're a doctor that does their job. You know, the whole thing, what we should be teaching people is you treat everybody as positive. When a doctor picks up a patient, a nurse, I have studied first aid, when you find a patient you treat them as infectious. Bang that's it. We don't think of a difference of being different to negative sex workers so you guys shouldn't. (Matthews 2008 p 37)

Sex worker organisations and sex workers have been successful in implementing routine condom use within the Australian sex industry. Through peer education and leadership by sex worker organisations, policies and approaches in Australia have led the world, resulting in the lowest rates of HIV among any sex worker community anywhere. Decades of research and anecdotal evidence point to the ongoing investment in sex worker peer education in Australia as a fundamental ingredient for this success. Sex workers agree.

As a subset of the broader HIV criminalisation issue, sex workers must continue to be included in the family of HIV communities that will advocate our way out of a no-win legal quagmire of criminalisation of activities that do no harm. The recent Needs Assessment brought to the attention of HIV organisations and government a number of shortfalls in service delivery relating to criminalisation. We now have to meet these challenges and move into the next phase of responding to HIV in Australia, including the roll-back of criminalisation of HIV and sex work and the ongoing provision of services and advocacy.

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The impact of criminalisation on community-based HIV prevention

Daniel Reeders

The recent spike in prosecutions for wrongful transmission is often described as the ‘criminalisation’ of HIV, even though most developed nations had criminalised HIV transmission in some way or another by the early 1990s. Earlier prosecutions in Australia almost invariably concerned heterosexual transmission, with the absence of homosexual cases making for a bit of a puzzle. This chapter locates the answer at the intersection between a larger cultural trend problematising unprotected anal intercourse (UAI) between gay men as reckless/intentional transmission and a move to normalise, professionalise and re-medicalise the government response to HIV in Australia and worldwide.

A secondary objective of this chapter is to articulate some of the implicit understandings that underpin community-based prevention (CBP) discourse and strategy. As a tradecraft learnt by apprenticeship and documented more in PowerPoint presentations than peer-reviewed journals, CBP suffers wholesale disqualification in the name of ‘evidence-based practice’. Rising HIV infection rates have led to the charge that prevention is failing and calls for ‘innovative’ new strategies in response (Guy and Hellard 2004). However, as UK prevention strategist Ford Hickson has pointed out, ‘Anyone who says HIV prevention is failing wants it to, usually so they can either take the reins or take the money’.

When news of the Neal case first erupted in Melbourne, People Living With HIV/AIDS Victoria convened an *HIV and The Law* dinner forum, where members expressed concern about a possible ‘shift’ from the existing public health response to one based more on criminal prosecution. Their concern evinced a degree of trust in the tender mercy of public health bureaucracy. As the Griew and Leach (2007) and Falconer and Scott (2007) reviews would reveal, the five-stage ‘behaviour change’ protocol for persons living with HIV (PLHIV) who might place others at risk of infection in parts exceeded the authority conferred upon the Department of Human Services (DHS) by the *Health Act* (Vic) 1958. In fact, its provision for incarceration without a court hearing led one commentator to compare the process to the denial of *habeas corpus* to detainees at Guantanamo Bay. Although the dust has now settled, serious questions remain to be asked about the ‘soft power’ exercised in the name of public health: not just its internal conditions of legitimacy, but its external cultural supports and justifications, and how it is ‘sold’ by its proponents.

Rather than criticise criminal prosecution and argue for public health management of HIV transmission as a social problem, this chapter will treat both as members of an option set of regulatory technologies, treating the issue more broadly as a problem of governmentality: the choice of strategies most finely tuned for the promotion of health in the population. Concern about the supposed shift towards criminalisation obscured the real choice between the expert model adopted by modern public health management and a revitalisation of CBP. By reinstating the latter in the option set, we can compare the relative effectiveness of the three approaches – criminal prosecution, modern public health, and CBP – and better understand the articulation of individualising discourses like law and public health with stigma and moral panic.

Comparing criminal law, public health and CBP as regulatory technologies

Foucault offers the concept of 'governmentality' as a way of understanding the shift from government as a committee-form surrogate for the sovereign, towards government of *the population*, which

has as its purpose not the act of government itself, but the welfare of the population [and] the improvement of its conditions . . . This is the birth of a new art, or at any rate of a range of absolutely new tactics and techniques. (Foucault 2000 (1977) pp 216-7)

'Population health' inaugurates this modern form of government, in which science is the bulwark against politics, replacing populist decision-making with rational, 'evidence based' practice. One of its key techniques is subjectification: the creation of compliant, self-managing individual bodies (such as the 'good gay citizen') through technologies of the self. Kippax:

Recently we have seen a turn to a 'modern' public health with its concern for and focus on the individual – the neo-liberal rational and autonomous subject – who is positioned as responsible for his or her own health. Within this model of public health the claim is that change is best achieved by providing an individual with the necessary expert information on which to base a rational response. (2007)

And, in the words of the Department of Human Services:

A strong economy can only be built on a healthy and active society. For human capital to be maximised, there needs to be a greater emphasis on promoting health, preventing ill-health, and a more efficient and evidence-based service system. (2006 p 1)

By comparison (as Peter Rush details in chapter 5) criminal law is an extremely old and spectacularly multivocal regulatory technology. Only a very naïve commentator could believe that government enacts a law saying 'Thou shalt not' and the populace reads the legislation over breakfast the following morning and henceforth complies accordingly. The relationship between criminal law and 'normativity' – actual impact upon behaviour – is wholly intermediated by tabloid and talkback journalism. These outlets have their own theory of normativity wherein longer sentences and vocal condemnation reinforce the social code: an assumed consensus with which legal outcomes are frequently found to conflict.

Perhaps in recognition of the dependence of legal normativity upon media culture, the courts have adopted an extremely cautious, almost minimalist theory of deterrence:

The community has an immediate interest in the administration of criminal justice to guarantee peace and order in society. The victims of crime, who are not ordinarily parties to prosecutions on indictment and whose interests have generally gone unacknowledged until recent times, must be able to see that justice is done if they are not to be driven to self-help to rectify their grievances. (*Jago v District Court* (NSW) per Brennan J, cited VLRC 2004 p 90)

On closer inspection, this reflects a concern about the possibility of what the law calls 'self-help' – vigilante justice and the vendetta – rather than primary prevention of crime. Deterrence is routinely invoked as a consideration during sentencing, but there is certainly no process of 'checking up' to see if deterrence actually occurs as described. As criminologist Alison Young puts it, 'Criminal law . . . pretends a purity of disciplinary constitution untouched by issues of policy or theory (or, at most, permits them a secondary place outside the rationality of the law)'. (Young 1996 p 3)

The Victorian Law Reform Commission's deliberations on sexual offences law reform (and the thirty years of debate that preceded them) make sobering reading for anyone wishing to claim the law is an effective source of deterrence of sexual offences:

Many submissions expressed concern about the low reporting rates for sexual offences and the difficulties that arise in successfully prosecuting people charged with these offences . . . Low reporting, prosecution and conviction rates are a legitimate community concern because they are likely to result in some offenders escaping identification and conviction. (VLRC 2004 p 81)

Communication, risk and responsibility

Sue Kippax (2007) notes the relationship between communication and responsabilisation in modern public health:

[T]he claim is that change is best achieved by providing an individual with the necessary expert information on which to base a rational response. (. . .) Risk-taking is positioned as a function of a misperception of risk or a lack of information on the part of the individual. (. . .) The individual is held responsible and blamed if s/he does not act rationally or appropriately.

By comparison, the law simply does not ‘do’ communication. Notably, in *Ostrowski v Palmer* ((2004) HCA 30) Gleeson CJ and Kirby J quote the UK decision in *Blackpool Corporation v Locker* (1948), where Scott LJ ‘called the rule that ignorance of the law is no excuse “the working hypothesis on which the rule of law rests in British democracy”’. Crimino-legal obligations can be created to bind individuals without any requirement that those individuals even know the law exists. This avoids the problem of ignorance of the law providing an escape from liability, but when the objective is actual behaviour change, the law, lacking any communicative process, is the wrong tool.

As Foucault points out, the rationality of government is the management of risks to population health, and public health messages about HIV transmission have consistently been framed using risk-management terminology. The criminal law has not been immune to this approach, with the addition of reckless endangerment offences to the *Crimes Act (Vic) 1958* to capture conduct which did not *but could have* caused injury. These charges are significantly easier to prove than ‘purpose-built’ offences such as intentionally causing a serious illness; whereas the very low transmission efficiency of HIV makes it difficult to prove the coincidence of intention and causation without resort to the doctrine of attempt, reckless endangerment offences are concerned with probabilities of injury, and posit a reasonable person in the position of the defendant to detect a ‘falling short’ in his/her actual conduct.

At this point there are two things to note:

- 1** both public health and crimes of reckless endangerment suppose a rational, autonomous, risk-avoiding individual decision-maker;
- 2** the crimes used to respond to HIV transmission are so contingent and multi-layered they cannot provide sensible behavioural guidance to a lay member of the public, destroying any possibility of ‘deterrence’ and increasing reliance on expert advice.

Later sections of this chapter will engage with these problems.

Understanding the concept of ‘option set’

One of the most intriguing aspects of the Neal case as it played out in Victoria concerns reports in *The Age* of a series of leaked documents, including pre-release copies of the Falconer-Scott and Griew-Leach reports, and a policy change including referral to police as a possible endpoint of the behaviour change process. The leaks represent a clear example of a departmental official acting as a ‘moral entrepreneur’ (Becker, 1963), deploying private knowledge and the media to powerfully constrain the ‘option set’ available to senior department officials and the Health Minister.

In an article 'Inaction on HIV cases fear-led', Julia Medew (2007) wrote:

Leaked documents revealed that Dr Hall and four other senior departmental figures, including Victoria's current Chief Health Officer, Dr John Carnie, were reluctant to refer the man's case to police because of 'traditional differences between public health and criminal investigations'.

Medew continued:

Police sources say that during Dr Hall's tenure, the department was reluctant to co-operate with police investigating HIV-positive people who may have committed criminal offences, but staff were now referring cases of concern to them for investigation.

After such reportage, the easiest way to minimise ongoing media coverage was to accede to the implicit demand to refer such cases to the police, and soon afterwards, DHS announced a change of policy to this effect:

HIV-positive people who ignore warnings not to have unprotected sex will be reported to police under new Department of Human Services guidelines. Victoria's Chief Health Officer, Dr John Carnie, said anyone who intentionally infected someone else, committed crimes such as rape, or showed they were unwilling to change their behaviour after being ordered to do so by the department would be reported to the police. (Medew 2008)

In effect, defending and preserving the status quo was removed from the option set of the state government.

In *The Strategy of Rhetoric* (1996) William H. Riker offers the term 'heresthetic' to describe 'the activities by which a person frames, primes, or otherwise sets the agenda and provides the context and interpretation for a subsequent decision' (Kedar and Schepsle 2001). The advantages of the heresthetic action undertaken by the DHS employee who leaked documents to a journalist are not immediately obvious. In the short term, they provoked a media firestorm to descend upon the Department, setting up an apparent conflict between public health and crimino-legal management of HIV transmission. However, adding criminal prosecution to the option set (an ineffective, unsystematic and yet highly punitive approach) made the public health approach look like a moderate and reasonable halfway point between hard-headed prosecutors (from Mars) and soft-hearted community prevention workers (from Venus).

The cultural environment of prevention work

Criminal prosecution is the endpoint and logical consequence of a new way of making individuals responsible for 'rational' sexual decision-making – but it is the logic that matters, more than the outcome. The analysis in the preceding section suggests criminalisation can be viewed as re-medicalisation, waged by other means. In *Learning to Trust* (2003), Paul Sendziuk documents vociferous opposition to emergence of CBP from stalwarts of the biomedical response, Prof David Penington and Dr Bruce Shepherd, the former declaiming that:

A high level of control of policy has been achieved by those suffering from the infection or likely to be infected, with inevitable distortion of the policies and their depiction to the community. The HIV epidemic is a public health issue and the principles of public health must take priority if the spread of the infection is to be contained. (Sendziuk, 2003 pp 102-3)

As Sendziuk argues, the success of CBP flowed from the trust government placed in gay men as a community to regulate HIV transmission through campaigns and discourse – in effect creating an 'exceptional space' of self-management. In Victoria, this can be seen very clearly by comparing the strict regulation of brothels with the non-regulation of gay sex on premises venues: brothel clients are assumed to need protection from commercial sex workers (when in fact it is clients who threaten sex workers' health and safety), while gay venues are not even required to provide condoms and lube.

In recent years, the community response has come under pressure from two separate directions:

- 1** local discussion of ‘continued’ and ‘rising’ infection rates ‘despite’ widespread knowledge of HIV prevention strategies – defined as ‘prevention failure’ and ‘condom fatigue’, and resulting in calls for ‘innovative’ strategies;
- 2** global circulation of media myths about ‘barebacking’ and ‘bug-chasing’, introducing questions of intentionality.

I describe barebacking and bug-chasing as ‘images in a jurisprudence of desire’ and argue that their circulation in popular culture via the mainstream media operates to introduce the question of *intentionality*. As Gregory Tomso (2004) put it, this takes place via the question of ‘What makes them do it?’ It supplied the missing prerequisite element in the structure of a crime – the *mens rea* or mental element – enabling contemplation of crimino-legal intervention into the previously exceptional space of gay male sexual cultures.

When *Rolling Stone* first reported on ‘gift-giving’ and ‘bug-chasing’ at ‘bareback parties’, the evidence was tissue thin: interviews with a single informant, Doug Hitzel, who offered a post-hoc rationalisation of his seroconversion, emphasising how much intentional control he retained over the whole process. But the story spread like wildfire, fuelled by commentators such as Steve Dow (2000), simultaneously castigating and introducing for their readers the possibility of barebacking.

Dow did not see fit to mention that barebacking was primarily practised between *already-positive* men, a fact which might have gone some way towards deterring HIV-negative uptake of a practice they had just publicly anointed as the next big thing in gay male sexual culture. Neither seemed to consider the prevention implications of telling every gay man in Melbourne that every *other* gay man has apparently abandoned condoms. Men who ‘sometimes’ have casual anal sex without condoms in Melbourne increased from 13% in 2002 to 19% in 2007 (drawn from data contained in the Melbourne Periodic Surveys). This is hardly the wholesale abandonment of safe sex, but it is important to note that repeated media messages about gay men’s ‘complacency’ and their supposed abandonment of safe sex is likely to have contributed to the decline observed.

The shift towards intentionality makes visible an older tradition from earlier in the epidemic, in which it was assumed that gay men *simply could not help (infecting) themselves*. They were either too weighed down by the experience of homophobia (DHS 2008 p 1) or too perverse and hedonistic to expect any better (Penington, quoted in Sendziuk 2003 p 107). As the publication of Callen and Sonnabend’s pamphlet *How to have sex in an epidemic* and the famous graphs of a steep decline in new infections after 1984 demonstrate, both of these accounts were utterly untrue (Watney, 1999). Nonetheless, they were adopted strategically to counter morality tales in which the wages of sin was AIDS. As a ‘no fault’ narrative, the ‘sanctioned deviance of the sick role’ (Parsons, 1991 (1951)) beat the hell out of the alternative portrayal of gay men as sex-crazed vectors of death.

As Dowsett and McInnes (1996), Rofes (1998) and Hurley (2003) have documented, the advent of effective treatment and the resulting dissolution of crisis mentality around HIV reduced the need for unified, monolithic, ‘under attack’ ways of doing community. As this shook the foundations of the community-based response, conservatives saw their chance to attack old shibboleths – like the ‘no fault’ narrative – and, in the absence of real resistance, to fashion the reaction against them into the next big narrative in gay socialisation – responsabilisation, normalisation and the fight for gay marriage.

Larry Kramer screamed that gay men have been ‘murdering each other with great facility’ (2004), while Michaelangelo Signorile (1998) released a prurient report on the seamy underbelly of gay sexual culture. Writing about the Aziga case, *Globe & Mail* journalist Margaret Wente (2009) wrote ‘The idea of giving anyone a pass because they’re victims makes many people deeply angry’ – anger as moral truth: ‘I’m mad as hell and I’m not gonna take it anymore!’ In Wente’s article, gay marriage activist Michael Leshner says ‘They [PLHIV] have the right to make moral choices,’ but in the same breath, denies them any choice in disclosure: ‘The true victimization is by people who say that gay men with HIV do not have an *absolute obligation to disclose*’ (my italics).

Since the availability of highly active antiretroviral treatment (HAART), this narrative has gained greater strength, driven by two main factors:

1 with the greater visibility of gay people and stories in the mainstream entertainment media, their social role has changed; no longer seen as objects of pity and disgust living on the margins, instead they are expected to 'pull their weight' – buying into property, monogamous couples, starting families, and living in the same normative domain as mainstream heterosexuals;

2 with the introduction of effective treatments and better management of side-effects, anxiety has grown around the idea that PLHIV 'conceal' their status.

These explain the mainstream media's 'discovery' of non-normative gay sexual practice and the paradox that, in an age when HIV-positive life expectancy has never been better and treatments are easily tolerable for many (not all) PLHIV, commentators have been reaching hard for analogies between HIV infection and death/murder, with the 'death sentence' trope appearing with a wearying inevitability. Naparstek writes, 'Barebacking is not just something transgressive, something to shock Nanna: it kills. And it should be condemned in terms appropriate to matters of life and death' (2008). And Wentz (2009) cites a doctor 'fed up with the efforts of the HIV/AIDS establishment to evade the issue of personal responsibility', comparing non-disclosure (defined as deception) to shooting someone dead.

In the media treatment quoted here it is not difficult to identify the elements of 'moral panic' (Cohen, 1973; Hall et al., 1978; Goode and Ben-Yehuda, 1994; Lumby, 2000; Hurley, this monograph). However, I am struck by the conceptual and structural similarities of moral panic and the social process of stigma – to the extent I would describe moral panic as the acute phase of a longer-term social process of stigma.

Responding to Link and Phelan's (2001) component definition of stigma, Parker and Aggleton (2003) sought to distinguish and emphasise the role/purpose of stigma in sustaining and reinforcing *social order*: in particular, relations of marginalisation and oppression. Parker and Aggleton note that psychological literature has been dominated by research into the attitudes of people who stigmatise and the experiences of stigmatised people, focusing heavily on the extent to which these are based on correct/incorrect beliefs about HIV – mirroring a similar debate about moral panic as media representation 'out of proportion' to supposed objective facts. Rather, they argue, stigma can be understood only in relation to broader notions of power and dominance, reproducing social inequality and exclusion. (2003 p 16)

The normalisation of gay (what some trendy social scientists are now calling post-Gay) has meant a recuperation of gay men from the social margins, via the demand upon them to renounce sexual transcendence and join in adherence to the mainstream social values: putative monogamy, risk aversion, and no more dirty weekends. Link and Phelan's (2001) components of stigma can be used to step out the objectives of moral panic about gay sex:

1 Labelling – unprotected sex becomes barebacking, bug-chasing, gift-giving (Tomso 2004);

2 Stereotyping – as the Sexual Outlaw or Vector-Predator (Young 1996);

3 Us-and-them thinking – Othering 'them' has been done to death, but as Lumby and Hurley have noted, moral panic 'creates' (by assuming) a community or shared public, including the author and consumer of media products ('we/us');

4 Status loss and discrimination – 'stereotype threat' or 'felt stigma' prompts mainstream gay men to write into the papers issuing hysterical defences of their normality, further demonising sexually adventurous men;

5 Social power – 'Elites as strategic players design the setting under which ordinary people make their decisions'. To use Lyengar and Kinder's language (1987), elites (via media) cannot tell people *what* to think about an issue, but they can tell them *how* to think about it.' (Kedar and Schepsle 2001)

Moral panic and stigma therefore have a significant role to play in the subjectification of gay men as compliant sexual citizens. Parker and Aggleton (2003 p 17) note Foucault:

highlighted how the social production of difference (what Goffman and the US sociological tradition more typically defined as deviance) is linked to established regimes of knowledge and power. The so called unnatural is necessary for the definition of the natural, the abnormal is necessary for the definition of normality, and so on.

The final thing we need to note is how stigma and moral panic about intentional UAI, and gay normalisation, have an impact upon HIV prevention work. They dramatise, intensify and raise the stakes, socially and emotionally, around the two principal drivers of new infections in Australia: adventurous sex with casual partners, and men having unprotected sex in relationships.

In Canada, Wentz (2009) castigates the faceless 'AIDS establishment' and unnamed 'AIDS activists', quoting a physician who:

believes the position of the activist establishment (sic) is flat-out irresponsible. 'They've put the stigmatization issue in front of the transmission issue', he says. 'For me, as a gay man and a physician, this is particularly dismaying.'

Wentz's article represents CBP organisations as complicit in guilty silence with positive vector-predators hiding behind victim discourse. In fact, as the next section of this chapter will document, we have good reasons for refusing to take sides.

Working towards a prevention economy

In a controversial article in the journal of *Social Science and Medicine*, Ronald Bayer (2008) asks a provocative question: 'Are there occasions when the mobilization of stigma may effectively reduce the prevalence of behaviors linked to disease and death?'. He points out that stigmatisation of cigarette smoking might actually benefit individual and public health, and calls for an ethics of 'good' stigma, invoked for public health purposes, which 'permits, even has as its goal, the reintegration of those who have been shamed' (2008 p 470). Margaret Wentz and her Australian colleagues, Karen Kissane and Julia Medew, certainly saw themselves shining the light of moral clarity into the murky undergrowth of gay male sexual practice. But they had the luxury of picking a single question to consider: whether it is 'right' that some positive men have unprotected sex without disclosure. Educators consider the *whole complex* of issues and how they interact: a 'prevention economy' calculating the unintended consequences and feedback loops resulting from regulatory intervention.

In fact, economic regulation affords a number of insights relevant to the problem at hand. Successive financial crises have shown how regulatory asymmetries and lacunae create opportunities to profit by arbitrage across differentials of risk. Whole markets can bubble and burst around tax exemptions, and when regulations change and markets collapse, the more powerful players even lobby governments for compensation: they seek to privatise the profit but nationalise the risk. With regard to regulation, individual economic actors are motivated to enhance their agency and minimise responsibility. It is this insight that can productively be transferred and applied to the problem of regulating HIV transmission: in calling for an absolute duty to disclose enforced by criminal prosecution, HIV-negative men seek to 'outsource' their prevention responsibility onto government and HIV-positive men.

Both modern public health and criminal legal discourse assume a rational autonomous individual subject. However, as Dan Ariely puts it, humans are in fact 'predictably irrational' (2007). Behavioural economics is premised on the concept of bounded rationality: the notion that individual cognition is 'very much bounded by the situation and by human computational powers' (Simon 1983 p 34). Rather than positing irrationality as a pathological exception, bounded rationality treats it as the norm. The take-home message is that human individuals are neither perfectly rational, nor especially autonomous. Community prevention tradecraft is based on this insight: rather than depending upon individuals to behave with perfect rationality, it seeks to deploy social and situational bounds to encourage pleasurable sexual practice that does not transmit HIV.

Catherine Dodds (2008) undertook a qualitative analysis of responses from the UK Gay Men's Sex Survey to an open question about support for imprisonment of PLHIV who transmit HIV. Responses which supported imprisonment and emphasised the exclusive responsibility of positive men to prevent infection (what I have described as 'outsourcing' the responsibility) predicted respondents never having tested for HIV and showing higher need for prevention education. Psychological research explains the mechanism through which this can occur: outsourcing responsibility is a *message discounting* strategy deployed as a *fear control* mechanism (Witte and Allen 2000):

'[W]hen people doubt whether the recommended response works (low perceived response efficacy) and/or whether they are able to do the recommended response (low perceived self-efficacy), they are motivated to control their fear (because they believe it's futile to control the danger) and focus on eliminating their fear through denial (e.g., 'I'm not at risk for getting skin cancer, it won't happen to me'), defensive avoidance ('This is just too scary, I'm simply not going to think about it') or reactance ('They're just trying to manipulate me, I'm going to ignore them).'

In my experience of running focus groups, undertaking online and face-to-face outreach, and debating these issues in chat sites and weblogs, I have repeatedly encountered a pattern of motivated reasoning where negative men will exaggerate the risk of condom breakage to justify their belief that positive men should always disclose (and rejecting them when they do). It seems no amount of information provision about condom skills, transmission efficiency, or post-exposure prophylaxis can influence this belief. It is defended by declaring an absolute right to protect themselves against HIV infection and by reference to media coverage of HIV-positive sexual predators. The castigation and responsabilisation of positive gay men (Race 2001) reinforces a positive feedback loop of ignorance and outsourcing in HIV-negative men.

Instead of educators 'taking sides' (which would be both unfair and ineffective) community prevention seeks to lower the emotional temperature and promote a more reasoned understanding of the contingencies of sexual negotiation. Towards this end, the 'mistaken assumptions' paradigm embodied in the AFAO/NAPWA Education Team's (ANET's) 'Think Again' campaign represents a 'no fault' theory of HIV infection, inviting audience members to think again about sexual negotiation. Consistent with Prochaska and DiClemente's Stages of Change model (1986), community prevention accepts that acquiring skills and confidence around condom use and disclosure does not happen overnight.

This is equally true for HIV-negative and HIV-positive men. And for the limited small minority of PLHIV who struggle to modify their behaviour, the public health systems' staged case management process ensures the provision of time, second chances, services and support to the small minority of PLHIV whose behaviour places others at risk of infection (see the overview in chapter 3). It is imperative that PLHIV organisations are able to tell their constituency that they can talk fully, openly and honestly about their sexual practice with doctors, counsellors, social workers, peer support and education workers. However, such assurances are compromised by a growing awareness that such conversations are documented in case records available under *subpoena* in the event a complaint or case referral is made for police investigation.

In the *Mwale* case, the HIV-positive accused was detained under a public health order until he admitted in counselling to having unprotected sex (without HIV transmission), which may have been a therapeutically necessary milestone, but it completely destroyed his ability to mount a defence against criminal charges. The outcome of that case (a criminal conviction but notably a suspended rather than a custodial sentence or a fine) added only publicity to powers the state already had under the *Health Act* (Vic) 1958 to detain and compel him to undergo treatment and counselling.

In the meantime, however, it may now be necessary for PLHIV organisations to counsel their members to seek legal advice before talking about unprotected sex with healthcare providers. The possibility of criminal prosecution introduces an element of coercion and requirement of compliance that are anathema to the Stages of Change (Prochaska and DiClemente 1986) model upon which the process is based. The new *Public Health & Well Being Act* (Vic) 2008 has replaced the existing requirement to disclose or use condoms (simple and practical) with a generalised obligation to 'reduce or eliminate the risk' of HIV transmission, potentially supporting the unilateral use of risk-reduction strategies instead of condoms and disclosure.

CBP has borrowed critically from advertising strategy, including the insight that behavioural guidance needs to support a 'single-minded proposition'. (Barry 2008 p 17) Messages fail when they are contingent, multi-layered, and require audience members to consult an external expert to make sense of the message. The new obligation fails in all these respects and is silent about disclosure, the single issue where positive and negative men's responsibilities for HIV prevention converge. In the Partnership approach to HIV prevention in Victoria, the governmental response is letting the team down.

Conclusion

As Australia's early response to HIV/AIDS shows, prevention is most effective when government responses support and underpin communities taking responsibility for the health and wellbeing of their members. Although ways of 'doing gay' have diversified, it remains possible to say that gay community, like Western civilisation according to Gandhi, would be a very good idea. It is an idea we should not easily give up, despite pressure from an industrial competitor based around an alternative mythology of the rational, autonomous individual. To this end, advocates of CBP must do better at articulating our tradecraft and challenging the terms of its disqualification from the official discourse of public health decision-making.

In responding to the impact of criminalisation on our work, it is necessary to think about the management of HIV transmission as a problem of governance. Rather than simply accepting the 'good cop, bad cop' strategic framing of public health and criminalisation, in this chapter I have sought to reinstate community-based prevention as a more effective alternative among the choices available to government.

It would pay to remember the advice Michael Hurley gave in an 'unpublished' discussion paper (c2003) he circulated through educator networks when HIV infection rates first began to rise: 'don't panic'. But since 'panic happens', in acute and chronic forms, our best defence is a stronger account of CBP in partnership with government – as Kippax (2007) calls it, a 'social public health'.

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The impact of the criminalisation issue on HIV-positive people

David Menadue

The events that have occurred around the HIV criminalisation issue in recent years, particularly in 2007, have had a significant effect on many HIV-positive people in Australia. In this paper I will argue that the media coverage of a number of hearings and trials of HIV-positive people for 'reckless endangerment' and other HIV transmission charges, along with some unfortunate political comments and pressures on state health departments to act in a more punitive way against people living with the virus, threatened to undermine the confidence of affected communities in the management of HIV in Australia.

It did so because the profile of several cases, occurring almost simultaneously in Melbourne, Brisbane and Adelaide, gave weight to arguments for compulsory disclosure of HIV status, mandatory reporting by medical professionals of unprotected sexual practices, and greater powers for public health authorities to refer HIV-positive people to the police, thus increasing the potential for criminal charges for alleged transmission to be laid.

The media coverage of the trials, including the salacious details revealed in one in particular, could be seen to have unfairly implicated the broader HIV-positive community, adding to the stigma that people with HIV/AIDS have experienced since the beginning of the epidemic, and the general fear and misconceptions which the broader community may have about them. The burgeoning publicity surrounding the issue on a global level, including the recent increased criminalisation of HIV in many countries, has contributed to the concerns of HIV-positive people in Australia about the local directions this issue could take.

The role of stigma

Very few HIV-positive people have escaped the stigma of living with HIV or the discrimination that comes with it. Those of us who have lived with it through the horrors of the 1980s will remember the extremes of prejudice and ignorance exhibited by a range of people, including family and friends, to people with HIV. Hospital workers refused to deliver food to patients with HIV. Doctors refused them service. Conservative politicians and religious leaders attempted to blame gay men and people with HIV/AIDS for the epidemic, arguing that their lifestyles put at risk the welfare of the nuclear family or 'normal people'. The media demonised gay men, particularly over the death of three babies in Queensland from infected blood donations, as an attempt to construct homosexual guilt for the AIDS epidemic. (Sendzuik 2003)

Even the government's education campaign using the image of the 'Grim Reaper', despite what it may have done to shake people out of complacency about HIV, stigmatised HIV-positive people because inevitably some people started to fear people with HIV rather than the virus itself. That Grim Reaper representation had an appalling effect on some of those living with HIV/AIDS who were ill at the time, leading them to give up hope and to believe that death was inevitable. (Sendzuik 2003)

Fast forward to 2009, and those working in the HIV sector know that people newly diagnosed with HIV still receive the news with considerable fear and emotion, despite a much-improved prognosis. There is the constant medicalisation of one's life which comes with being HIV-positive: the blood checks, the treatments, the burden of taking pills every day and dealing with their sometimes debilitating side-effects.

The biggest problem though, as I see things in my personal networks, is around sex: sexual negotiation and disclosure to partners. Most people experience several episodes of rejection if they are upfront with every sex partner about their status, and some find it difficult to get the confidence to disclose until they have been HIV-positive for some time. Any kind of sexual rejection can be crushing to the ego and to self-esteem, and for quite a few, disclosing every time takes considerable courage and bravery. A high burden of responsibility rests on the sexually active. The fear of criminal repercussions can only make disclosure that much more difficult.

International research

There have been no surveys of the effect of the HIV criminalisation issue on HIV-positive people in Australia. An international study of this issue was completed in 2006 by Dodds and Keogh, in which 125 people living with HIV were interviewed in three UK cities following several highly publicised trials for HIV transmissions. Ninety percent of the participants were critical of the criminalising of reckless transmission of HIV, with many referring to the negative impacts that criminal cases will have on HIV prevention and care. A strong theme of increased stigma also emerged, including the belief that prosecutions counteract the ability of people with HIV to be open about their status within their own and other communities, that it increases the difficulty of disclosure in sexual settings, and that it provides a disincentive for those at risk of exposure to reflect on their behaviour and come forward for testing.

However, a more recent report from Sigma Research found the views of HIV-negative gay men or those gay men who have never tested on this issue, to be quite different. In the report, *Sexually charged* by Dodds et al. (2009), 8252 gay male respondents to the UK Gay Men's Sex Survey 2006 gave their views about the criminal prosecution issue. Of the respondents, 57.4% thought that people with HIV who know they are HIV-positive should be imprisoned if they passed on the virus to sexual partners who did not know they had it. A higher percentage (63.5%) of people believed this in the group who had never tested for HIV, suggesting that those who had tested were more likely to have come in touch with people with HIV and to be aware of concepts such as shared responsibility for safe sex.

The authors noted that a majority of those interviewed expected people with HIV to disclose their status and they believed that it was the primary responsibility of the HIV-positive person to ensure the safety of their partners. When this didn't occur, there was a high propensity to attribute blame to the HIV-positive person, and:

as long as having HIV is associated with blame, those who acquire the virus will continue to be regarded as wrong-doers, both for behaving in ways that got them infected in the first place and also as holders of a terrible 'knowledge' which they can withhold from sexual partners. Such responses to HIV reinforce the underlying and long-standing association between infection and deviance, meaning that the person with HIV is feared and maligned.

Enlightened views were also expressed, particularly amongst the older, the university educated and those who lived in larger urban areas such as London. For example, some felt that the undeniable increase in HIV-related stigma that results from media coverage of prosecutions was likely to negatively impact efforts to reduce HIV incidence because criminalisation increases stigma in marginalised and vulnerable groups, may dissuade people with HIV from disclosing their status, and dissuade people of unknown HIV status from being tested. The report's authors argue:

Stigma functions against openness and fosters an environment where 'certain' people are regarded as 'deserving' of their infection, which in turn reduces people's capacity and motivation to seek out interventions that reduce their risk of being involved in HIV transmission. Thus, the argument here is that criminal prosecutions serve to reinforce that sense of 'otherness' which HIV-related stigma carries, contributing to a social environment that makes it even harder to achieve the aims of HIV prevention.

The findings in the *Sexually charged* report may well have a resonance for the Australian situation if HIV-negative gay men, or those who haven't been tested, were to be surveyed with the same questions. There are many similar epidemiological trends between the UK and Australia in terms of the place of gay men in the two epidemics. As the gay community is by far the largest affected population group in this country, their views are an important determinant of attitudes towards HIV-positive people and the stigma they may experience as a result of the criminalisation issue.

It is interesting to note, too, from the report, that 19.6% of the HIV-positive cohort (565 people) agreed with the view that an HIV-positive person should be imprisoned if they had not disclosed and then transmitted the virus to a sexual partner who didn't know they had it. Some of these undoubtedly include people who felt wronged by sexual partners who have given them HIV and believe others should be punished for doing the same.

Given the lack of Australian research on this issue, I can only rely on my own personal experiences and networks as an indicator of the level of concern and increased stigma that this issue has raised for HIV-positive people here. It is impossible to generalise about the experience of all HIV-positive people, and we cannot assume that the effect is felt equally in all states or by every individual. Certainly from my perspective as a long-term national office holder in the National Association of People living with HIV/AIDS (NAPWA) who has contacts with PLWHA groups in Victoria, Queensland and South Australia, I can report an increased anxiety and fear expressed to workers and Board members of those organisations after the various court cases and the consequent media coverage played out in those states. This anxiety was strongly correlated with a concern about an increased stigmatisation of HIV-positive people and fears about changes to laws and public health practices around HIV as a result of the concurrent court cases and government and media responses. These fears were also expressed by heterosexual people with HIV, including the president of the heterosexual support group Straight Arrows in Victoria, who stated his concerns in various forums about the implications of the current developments for all people with HIV. It is also important to note that NAPWA considered it necessary to hold a national forum in April 2007 to deal with the various member groups' concerns about these developments. Canavan and Rule took up the issue in late 2008 in an article entitled 'Forced to the margins . . . again' in *HIV Australia*.

The Neal Case in Victoria

The most notable evidence of the negative effect the Neal case has had on Victorian HIV-positive people was a forum conducted in July 2007 by People Living with HIV/AIDS Victoria (PLWHA Vic) on the legal issues associated with HIV transmission in response to the recent spate of criminal charges against HIV-positive people for 'reckless' and 'intentional' transmission of the virus. PLWHA Vic invited representatives from the Health Department and Victoria Police, as well as an HIV advocate trained in HIV legal issues, to address the event. The atmosphere in the room was palpable, with a level of anxiety the organisation had not seen since the early days of the epidemic. HIV-positive people in the room wondered about the possible implications of the recent Neal case (Neal had recently been committed to stand trial), the sensational details revealed in the media from the pre-trial hearings in April that year, and 'general rumblings' that the Health Department may be going to involve police more often in their management of people with HIV.

The Neal case had been in the press since his arrest on child pornography and HIV transmission charges in July 2006. Later in the year, the police executed a search warrant on the offices of the Department of Human Services (DHS) to obtain confidential documents the DHS had been keeping on Neal and other individuals regarding public health orders for 'reckless behaviour' in relation to HIV. The police acted after pressing criminal charges against Neal related to child pornography, but the implications of this action (to gain more evidence on him for their criminal case) were the beginning of a sensational story that has resonated with HIV-positive people and the HIV sector ever since.

Revelations from the documents Victoria Police found at the DHS offices that day were to find their way into the press. They were a factor in the sacking of Victoria's Chief Health Officer, Dr Robert Hall, by the Victorian Minister for Health, Bronwyn Pike, in April. They showed that Dr Hall had not acted on the advice of the Department's HIV Case Advisory Panel to detain Neal under the Public Health Act for alleged reckless behaviour in relation to HIV. While editorials condemned Hall for his alleged poor response in protecting the public, HIV-positive people wondered about the significance of the police raid in terms of protecting records held about them and others. When police followed up with visits to high HIV caseload GP practices, hospitals and the Melbourne Sexual Health Centre to request and/or subpoena medical records on Neal and a range of individuals who may have been his sexual partners (as potential witnesses), the alarm bells got louder.

The response of some medical practices to the police request for confidential medical records surprised many of their HIV patients. They handed over the files of the requested patients with little resistance and without first informing the patients themselves. Others declined to do so at first, but handed them over when presented with a search warrant or subpoena.

The Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) saw the potential public health implications and resolved to resist if they could, deciding to agree to hand over records only with the signed permission of patients. The VAC/GMHC Centre Clinic's doctors refused to make statements about patients' medical records or their treatment histories. They earned the respect of their patients and PLWHA groups for acknowledging the importance of the issue – which, to VAC/GMHC, was about maintaining the confidence of their patients in the privacy of conversations with their doctors and the confidentiality of their records. When Neal was charged, they were compelled to hand over their records of his treatment, and the police issued subpoenas to the Clinic's doctors to appear in court. Several Clinic patients decided to give the police access to their records. The police then decided not to pursue an earlier subpoena on VAC/GMHC to access the records of any patients thought to be linked to Neal.

People at the PLWHA Victoria forum expressed fears that were likely to have arisen from these police actions, including:

- If a positive patient was recorded as having an STI in their medical records, would this be construed by authorities as evidence of unprotected sex – and possibly illegal behaviour?
- Would an admission by a patient of unprotected sex with a person of unknown HIV status or difficulties with adhering to safe sex at all times, as recorded in a patient record, be enough to 'incriminate' an HIV-positive person?
- Can't I talk to my doctor or counsellor anymore without worrying about what they might have to tell the police?

Much as these concerns were probably misplaced, and the representatives from Victoria Police and the DHS provided reassuring answers that these things were unlikely to happen, the degree of anxiety about the direction things could take was clear.

At the same time as the result of the political pressure that had been placed on the Health Minister over the bungle around Neal's case, the Victorian Health Department was reviewing its *Guidelines for the management of people with HIV who put others at risk*. At the PLWHA Victoria forum a question was asked about when the Health Department would refer an HIV-positive person who had been managed under the *Health Act* and a public health order to the police for an investigation of possible criminal charges. It was not to be until 2008, when the Department released its updated Guidelines, that community advocates were somewhat appeased that such referral powers would be used rarely and under specific conditions.

Fortunately, this community concern was picked up by police investigators who decided to involve some of the HIV agencies, including PLWHA Victoria and VAC/GMHC, in briefings about the processes they were undertaking in investigating the Neal case. They understood (or had been subsequently informed about) the public health consequences if HIV-positive people were to stop trusting their medical professionals with any discussion of sex and STIs, or to fear that details about their sexual lives, however minor or trivial in the scheme of things, could one day be perused by detectives from Victoria Police.

The media response to Neal

No-one in the HIV sector could have anticipated the amount of media coverage which the Neal case was to generate, the profile the issue gained in the community in Melbourne (as well as nationally and internationally) and the salacious details about the accused and his sex life. There has been media coverage of HIV-positive transmission cases previously in the Australian press throughout the HIV epidemic, albeit relatively few in number. Persson and Newman from the National Centre for HIV Social Research recently completed an analysis of the media treatment of heterosexual men accused in HIV transmission/exposure cases, the findings of which are presented in their article 'Making Monsters' (2008). They examined issues of the *Sydney Morning Herald* between 2000 and 2005 and made useful observations about the media's representation of individuals involved in heterosexual relationships (not the least of which is that African heterosexual men with HIV got a particularly hard time):

In personalised stories featuring HIV-positive heterosexuals, men and women are given distinct subject positions. The women are invariably portrayed as innocent victims of men's betrayal. They are reported to have been infected by cheating or deceitful male partners, whom they had mistakenly trusted. Their stories are conveyed with empathy and respect, and the women's own voices are often included (e.g. Halliday 2005). In contrast, the HIV-positive men are typically presented in a negative way, as violent (Editorial 2004), vindictive (Pedersen 2004), despicable and selfish (Lamont 2003a), a threat to public safety (Butcher and Delaney 2003), and as predatory wreckers of women's lives (Wallace 2005). The men's experiences are left unexplored, consolidating their position as guilty culprits. Their actions and characters are construed solely through the voices of their victims, legal representatives and the police. Only one article in the whole media archive gives voice to an HIV-positive heterosexual man. He is quoted as saying: 'I want to kill people' (Pedersen 2004).

The Neal case was not the first of a gay man tried for HIV transmission, but it is certainly one of the most sensational cases to date, largely because of the lurid details presented about the sex life of the accused and his alleged intention to infect. Previous HIV transmission trials had not been able to prove the charge of 'intention to infect', but Victoria Police clearly believed they had a chance to prove this with Neal and to get a substantial prison sentence as a result.

It is probably easy to blame the media for sensationalising the details of the trial hearing, and some certainly did this. The use of emotional terms such as 'victim' and 'sexual predator' were a feature of reports on the case in the mainstream press. To be fair though, a lot of the accounts of the Neal case in Melbourne took the form of reporting of court proceedings: the journalist cannot be blamed if witnesses have proceeded to tell the world about someone being registered as a dog with the local Council, about the supposed drugging of a fifteen-year-old boy, about alleged 'conversion parties' where 'bug-chasers' come looking to be infected with the virus, and 'gift-givers' (HIV-positive people) came along to gladly infect others. This was easy and welcome fodder for the press that has always relished titillating tales of wild sex parties, with some extra fascination about the sexual lives of those exotic beasts called gay men.

The problems with the coverage of the Neal case developed with the opinion pieces that began to appear in the press. These drew generalisations and assumptions about what such behaviour said about gay men, and particularly HIV-positive gay men, in an environment of rising HIV infections. Julia Medew and Karen Kissane in their 'Dance with Death' article in *The Age* (April 24, 2007) developed their take on 'gift-giver'/'bug-chaser' stories:

The recent committal hearing of Michael John Neal, 48, who is charged with deliberately infecting two men and trying to infect 14 others, has revealed an extraordinarily reckless subculture in the gay community.

And later:

At Neal's committal, witnesses also spoke about fantasies about catching HIV. Gay men spoke about alleged 'conversion parties' where positive men ('gift-givers' or 'breeders') have sex with negative men who want to catch the illness ('bug-chasers') or ones who do not know that they are being exposed.

While no one claims the subculture is widespread the fact remains: a small number of positive people who have sex with hundreds can do a lot to spread the virus. Is it time to examine the psychological issues around HIV for some in the gay community . . .

To back up their claims about the existence of such a sub-culture, Medew and Kissane interviewed a young gay man called Andrew (not his real name) who talked about how he had become infected after sex with his HIV-positive partner:

Andrew also acknowledges that, at times, part of him longed to be infected, because he would feel closer to his partner, because he would feel freed of safe-sex constraints with other HIV-positive gays and he would never again feel the odd one out in a group encounter with HIV-positive men.

The journalists also interviewed an unidentified HIV worker who spoke of degrees of recklessness being exhibited by HIV-positive people in their attitudes to sex. This worker gave his views about three 'levels of recklessness' shown by HIV-positive people towards their sex partners including this:

The next level of recklessness is where a person who is HIV-positive goes into a sexual encounter with the attitude that it is the other person who should be assuming responsibility for raising the issue. Some have a view, the worker says, 'that the onus is on them to ask me, if they are negative and care about their status. If not, I'm not going to disclose it because it's not their business unless they make it their business.' That's probably the stance of at least 50% of HIV-positive people in Australia.

I cannot deny the reality of 'Andrew's' feelings about wanting to get infected or challenge the HIV worker's analysis that some HIV-positive people can be reckless in their sexual behaviour to others. It is, however, about a sense of proportion. My view from my personal networks and contacts with HIV-positive people over twenty or so years, is that the HIV worker's suggested figure of 50% of the HIV-positive population who will willingly put others at risk of infection if no question is asked of their status, is an alarming and extraordinary overestimation. The HIV worker cannot back this up with research¹, any more than Andrew's desire to be infected can be taken as a representative view of HIV-positive people and the reasons they become infected; for more on this, see chapter 8.

Willis et al. showed 'that an overwhelming majority of HIV-positive men avoid unprotected anal intercourse with partners of negative or unknown status, regardless of whether the partner is casual or regular' and that 'the very small amount of unprotected anal intercourse . . . is as likely to be with a positive partner as with one of negative or unknown serostatus' (Willis et al. 2009). Subsequent research has indicated how risk-reduction practices used by some gay men also reduce the likelihood of infection. (Jin et al. 2009, Van Griensven 2009)²

The difficulty for HIV-positive people reading media coverage which promoted the idea of 'gift-givers' and 'bug-spreaders' raised in the Neal case, was in the general impression of recklessness and irresponsibility that was being created. This kind of stigmatising comment fed into the image of the reckless HIV-positive person who doesn't care about the welfare of others. The scandalously reckless individual impressionistically comes to stand for the group.

During this time, *The Age* in Melbourne published only one letter from HIV researchers querying the nature of the representation of the bug. As with much media of this kind, no alternative HIV-positive perspective was presented, and no spokespeople from PLWHA Victoria were contacted for comment. The journalists did interview Mike Kennedy, Executive Director of VAC/GMHC, who rejected the conclusions that the article seemed to be making: that the disclosure laws in Victoria needed reviewing (NSW laws require disclosure before sex).

Kennedy rightly pointed out that mandatory disclosure might encourage people to assume that no disclosure means negative status and that it might discourage people from being tested: 'You can only disclose if you know'. Compulsory disclosure has been soundly dismissed by educators and public health officials for many years because of the unfair onus it places on HIV-positive people to take the sole responsibility for safe-sex practices, the false assumption it creates for HIV-negative people that disclosure by an HIV-positive person would therefore always occur, and the fact that publically available HIV testing does not

identify the virus until some three months after transmission has occurred (so people test negative in the short term despite the potential of their infecting others if they engage in unprotected sex).

The effects of *The Age* feature article (emblazoned on the front page of the widely read Saturday Age 'Insight' section) on the debate can never be quantified, but we know it was read by enough HIV-positive people in Victoria to be raised in phone calls to the PLWHA Victoria office and to be mentioned at the legal forum held several months later. The 50% quoted statistic generated the most outrage from positive people who were acutely aware of the trauma that comes with an HIV diagnosis, and who felt that their reputation for responsible behaviour towards sexual partners, as validated in HIV social research, had been ignored.

It is also significant that a suburban weekly paper, St Kilda's *The Port Phillip Leader* (May 8, 2007) ran a front-page article about locals' objections to a planning permit for a gay sauna. Under the banner heading 'Sauna bid sleazy', the article quotes quite hysterical ideas from objectors about what may happen if the sauna is allowed to open at the Greyhound Hotel. One from a former owner of the hotel was particularly galling: 'She said "bug chasers" – people who get a thrill out of unprotected sex – and "bug-spreaders" – HIV-positive people who try to infect others – would make it their own'.

For such concepts as 'bug-chasers' or 'bug-spreaders' to have entered the general lexicon, undoubtedly fuelled by the recent media reports, was a real disservice to HIV-positive people. That such people existed or were significant enough in numbers to rate a mention was, HIV community commentators agreed, a fantasy or a wild idea held by a single court witness. That it was starting to be seen by some as a reality was, to say the least, very disturbing.

The McDonald case

In a piece of unfortunate timing, another case of alleged 'reckless HIV transmission' was also getting national media attention, this time from Adelaide. Also in April 2007, *The Adelaide Advertiser* ran a series of 'exposés' on the life of Stuart McDonald, who has been charged with recklessly infecting a number of people. Whatever the merits of the case for or against McDonald, it was surely a gross invasion of privacy to print photographs of the man's home (with a shot across the street to a children's playground) and to include a photograph of his Gaydar (internet gay dating site) profile and the details within.

The Advertiser campaigned for photographs of McDonald to be published, although he had actually not been proven guilty at that stage (or two years later as he is still awaiting trial as this monograph goes to print). The editorial (April 18, 2007) states:

A ban on the publication of photographs and other images of HIV carrier Stuart McDonald should be lifted . . . By suppressing McDonald's photograph, it is possible other men may be unaware that McDonald has been a sexual partner in the last year.

Further in the editorial *The Advertiser* said, 'While McDonald remains innocent until proven guilty, there may be other potential victims . . .' but even so this appeared a clear case of the media ignoring an individual's right to privacy and going dangerously close to pre-empting the result of a trial.

In 2007 the government in Adelaide had also begun a review of the public health laws after a number of parliamentarians had felt the need to crack down on so-called irresponsible behaviour by some people with HIV. Early drafts of the review suggested that the South Australian government would move to compulsory disclosure by HIV-positive people before sex. HIV sector agencies and other state public health officials were able to point out the public health implications of such an approach, and it was decided to leave the law on disclosure as it was.

To further exacerbate the media issue and contributing to the criminalisation issue becoming a national concern, a gay man (Reid) was tried and convicted in Brisbane on several charges, including knowingly infecting another man. Observers of this case in the HIV sector were disturbed that Reid was convicted largely on the testimony of his partner.

The increase in the number of countries introducing harsh new penalties for HIV-positive people who have sex (sometimes even if they use condoms, have not been tested for HIV or in fact do not have HIV³) has frightened HIV-positive observers here as well. The concept of using genotyping of the virus to supposedly track down an individual's RNA for use in criminal trials has been equally alarming, even though it seems the technology is far from foolproof and would be unlikely to stand up in a court of law except as a method of discounting one person's close connection to another's HIV status.

As if to top off the sense of siege the HIV-positive population was feeling through this time, the intervention of the then prime minister, John Howard, on a radio station in April that year was most unwelcome. Responding to a question from an announcer as to whether Australia should allow HIV-positive immigrants into the country, Howard responded that, apart from a few humanitarian cases, he would not support it. This was despite a generally compassionate attitude taken by the Department of Immigration and Citizenship up to that time for at least a small percentage of HIV-positive immigrants who offered suitable skills or who were partners of Australia's citizens. This issue played out through the year, including at the International AIDS Conference in Sydney in July, where HIV-positive travellers to this country worried about whether they would be able to get tourist visas to this country. Fortunately, immigration rules have remained unchanged.^{4, 5}

It has been interesting to observe the press response to the Neal trial in August 2008. It was a closed court, so little reporting occurred and there were few new details the press could extract anyway. When Neal was convicted in January 2009, the trial judge suggested Neal wanted to be his own 'Grim Reaper' such was his desire to infect others and create a larger pool of sex partners. Those of us who remember the stigmatising Grim Reaper campaign were not so impressed that this image was used. The risk of HIV infection to most non-gay Australians is minimal. As Sendziuk noted of the Grim Reaper campaign, 'it served a political purpose that exceeded its usefulness as a public health campaign, and should be judged accordingly' (2003). The same might be argued of media salaciousness that passes as acceptable journalism for feature article purposes. The prosecution's success in establishing a legal precedent where the crime of 'intention to infect another with a serious disease' was upheld in the conviction of Neal should be monitored closely for its legal implications for future trials of people with HIV.

Current situation and challenges

If public health and other government officials had bowed to the pressures of a small number of conservative politicians to introduce a more punitive regime against people with HIV, then the criminalisation of HIV in Australia might have become a bigger problem than it has been so far. Australia's successful response to HIV has been based on the delicate act of maintaining the confidence of the affected communities in managing the public health implications associated with HIV. This includes respecting the confidentiality and privacy of HIV-positive people, particularly their dialogue with medical professionals. It includes the promise that public health measures, rather than criminal law, will be the first port of call for the small number of people who persistently fail in their sexual responsibilities to others. We need to see that balance doesn't threaten to tip towards criminalisation, as it did in 2007.

The confidence of HIV-positive people, that they can have robust and honest discussions with their practitioners about sexual matters, has also been sorely tested by this episode and the police response.^{vi} How the various GP and counselling practices respond to requirements around mandatory disclosure of details where individuals are believed to be placing others at risk of HIV infection needs to be considered carefully, as the VAC/GHMC did with their requests for records over the Neal case. The potential for individuals to lose trust in their practitioners, who have been considered essential partners in the care and support plans of many people with HIV, cannot be underestimated, and the public health response to HIV in Australia will be much the poorer if these matters are not handled with care.

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Endnotes

- 1 In fact it is blatantly contrary to existing research.
- 2 See also the persuasive arguments and research cited in chapters 7 and 8
- 3 See, for example, US prosecutions identified by Bray (Cameron 2008)
- 4 Including those relating to short-term visits to Australia, which do not require HIV testing or disclosure.
- 5 At this point, I note the intention of the Australasian Society for HIV Medicine (ASHM) to develop a publication better informing general practitioners of the current state of play regarding the intersection of HIV and the criminal law. That publication is due for release in late 2009.

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