***Building persuasive evidence***
***How can the social sciences support global anti-criminalisation advocacy?***
**Working paper prepared for 'HIV Prevention and the Criminal Law' workshop, Toronto April 26-28, 2013, by**
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## Introduction

Over the past decade, numerous national and international agencies have undertaken measures to increase understanding of and address the application of the criminal law to individual cases of alleged HIV non-disclosure, potential or perceived HIV exposure or transmission – 'HIV criminalisation' – through the commissioning of research, co-ordination of meetings, development of policy guidance, and publication of reports and other web-based resources.[1]

More recently important global summaries of the state of HIV criminalisation have been published, including those by the Global Network of People Living with HIV (GNP+) in 2010[2] and those produced for the Global Commission on HIV and the Law[3] and UNAIDS[4] in 2011.

The past 18 months in particular has seen significant international activities focused on evidence- and consensus-building, and advocacy, against HIV criminalisation, including: the Global Commission on HIV and the Law process and report (2010-2012)[5]; a major project led by UNAIDS (2011-2013)[6]; the launch of IPPF's 'Criminalize Hate, Not HIV' website (December 2011)[7]; the Oslo Declaration on HIV Criminalisation (February 2012)[8]; and the update and re-launch of both GNP+'s Global Criminalisation Scan website (September 2012)[9] and the HIV Justice Network's website and newsletter (November 2012)[10].

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[1]Important published work to date includes UNAIDS' Criminal Law, Public Health and HIV Transmission: A Policy Options Paper (2002) and the UNAIDS/UNDP Criminalization of HIV transmission Policy Brief (2008); Global Criminalisation Scans in 2005, 2008 and 2010 by the Global Network of People Living with HIV (GNP+); Verdict on a Virus (2008) by the International Planned Parenthood Federation, International Community of Women Living with HIV/AIDS, and GNP+; Ten Reasons to Oppose the Criminalization of HIV Exposure or Transmission by the Open Society Foundations (2008); 10 Reasons Why Criminalisation of HIV Exposure or Transmission Harms Women by the ATHENA Network (2009); and the 2010 Report to the Human Rights Council of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
[2]Cameron S & Reynolds L. The Global Criminalisation Scan Report 2010: Documenting trends, presenting evidence, GNP+, 2010.
[3] Weait M. The Criminalisation of HIV Exposure and Transmission: A Global Review'. *and* Working Paper prepared for the Third Meeting of the Technical Advisory Group, Global Commission on HIV and the Law, 7-9 July, 2011.
[4] UNAIDS. Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Background and Current Landscape, Geneva, 2011
[5]Available at: http://www.hivlawcommission.org/
[6] This project included the production of research materials and the holding of two international consultations in Geneva (31 August-2 September 2011) and in Oslo (14-15 February 2012).
[7]Available at: http://www.hivandthelaw.com
[8]Available: http://www.hivjustice.net/oslo/
[9]Available at: http://www.gnpplus.net/criminalisation/
[10]Available at: http://www.hivjustice.net/

However, despite these activities, inappropriate and overly broad new laws aimed at punishing and controlling people living with HIV continue to be proposed and/or enacted in Botswana,[11] Dominican Republic[12], Germany (Saxony-Anhalt[13]), Uganda[14] and the United States (Arizona[15] and Kansas[16]).

In addition, two important processes greatly anticipated by advocates working to end inappropriate HIV criminalisation produced disappointing results. In October 2012, the Supreme Court of Canada ruled that individuals who know they are HIV-positive are liable to criminal prosecution for aggravated sexual assault if they do not disclose this fact prior to sex that may risk a "realistic possibility of transmission of HIV", stating that the duty for an HIV-positive individual to disclose can be exempted, but only when a condom is used *and* the individual also has a low viral load.[17] The ruling was severely criticised as a "major step backwards for public health and human rights" by a coalition of civil society interveners in the two cases under appeal.[18]

Of note, the Supreme Court was not convinced by arguments highlighting a potential negative public health impact presented the interveners[19]:

*"Some interveners challenge the use of the criminal law in the case of HIV on the ground that it may deter people from seeking treatment or disclosing their condition, thereby increasing the health risk to the carrier and those he has sex with. On the record before us, I cannot accept this argument. The only "evidence" was studies presented by interveners suggesting that criminalization "probably" acts as a deterrent to HIV testing: see, e.g., M. A. Wainberg, "Criminalizing HIV transmission may be a mistake" (2009), 180 C.M.A.J. 688. Other studies suggest little difference in reporting rates in states that criminalized and did not criminalize behaviour: S. Burris, et al., "Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial" (2007), 39 Ariz. St. L.J. 467, at p. 501. The conclusions in these studies are tentative, and the studies were not placed in evidence and not tested by cross-examination. They fail to provide an adequate*

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[11] Botswana's draconian Public Health Bill approved by Parliament, BONELA will challenge it as unconstitutional once President signs into law. HIV Justice Network, 5 April 2013.
[12] Bellocq JH Controversial AIDS law passed in Dominican Republic. International AIDS Alliance, 20 June 2012.
[13] State considers forced HIV and hepatitis tests. The Local, 30 November 2012.
[14] Bassude E. HIV/ AIDS bill almost ready. New Vision, 1 December 2012.
[15] Peick S. Bill seeks felony charge for intentionally exposing others to HIV, STDs. Cronkite News, 24 January 2013.
[16] Rothschild S. Protection from quarantine for HIV, AIDS patients is discriminatory, state senator says. Lawrence Journal-World, 3 April 2013.
[17] Bernard EJ. Supreme Court of Canada rules that condoms alone do not prevent a 'realistic possibility' of HIV transmission. Aidsmap.com 8 October 2012.
[18] Canadian HIV/AIDS Legal Network, HIV/AIDS Legal Clinic Ontario (HALCO), Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA), Positive Living Society of British Columbia (Positive Living BC), Canadian AIDS Society (CAS), Toronto People with AIDS Foundation (PWA), Black Coalition for AIDS Prevention (Black Cap),and Canadian Aboriginal AIDS Network (CAAN) See: http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=2055
[19] R v. Mabior, R v 'DC', Supreme Court Factum: Interveners

*basis to justify judicial reversal of the accepted place of the criminal law in this domain."* [20]

The same month, after spending almost two years examining every aspect – ethical, legal, medical, social and scientific – of the use of the criminal law to punish and regulate people with communicable diseases (with a specific focus on HIV) the Norwegian Law Commission recommended that Norway continues to essentially criminalise all unprotected sex by people living with HIV regardless of the actual risk and regardless of whether or not there was intent to harm. The only defence written into the suggested draft law is for the HIV-negative partner to give full and informed consent to unprotected sex that is witnessed by a healthcare professional.[21]

The Commission was also not persuaded by oral and written testimony and any existing research into the unintended public health and human rights impact of HIV criminalisation.

*"The Commission has found little scientific evidence of the effects of criminal regulation of infection transmission and exposure, and thus of the validity of some of the considerations and arguments that are mentioned. It is hard to find good research methods for answering such questions. This applies not only to the legal area in question, but also to the general intended and unintended effects of laws. Few or no studies have convincingly documented direct links between criminal regulation and infected persons' behaviour and perception of discrimination or stigmatisation, or links between criminal regulation and noninfected persons' (possibly undiagnosed persons') choice of protective strategies and willingness to undergo testing. This means that it is difficult to carry out a thorough assessment of the validity of the arguments, including the question of whether penal provisions of this nature have the intended general deterrent effect and/or a deterrent effect on individuals."*[22]

Persuasive evidence of the (unintended) harmful effects of HIV criminalisation to public health and human rights is central to advocating for changes in laws or policies relating to HIV and the criminal law.

Commonly cited unintended public health impacts of HIV criminalisation can be summarised as:

- Increasing HIV-related stigma
- Misunderstanding and overstating HIV-related risks and harms
- Creating a false sense that HIV is someone else's problem
- Providing a further disincentive to know one's HIV status
- Providing a further disincentive to disclose known HIV-positive status to sexual partners
- Providing a disincentive to disclose HIV-related risk behaviours to healthcare professionals

[20]Supreme Court of Canada. R.v.Mabior, 2012 SCC47 [2012] 2 S.C.R. 584 at [59]
[21]Cairns G. Viral load will be no defence against prosecution for HIV exposure or transmission in Norway. Aidsmap.com, 20 October 2012.
[22] Norwegian Law Commission. Of love and cooling towers. NOU 2012: 17 Vedlegg 3, p. 336

Commonly cited unintended human rights impacts of HIV criminalisation can be summarised as follows:

- Increasing HIV-related stigma
- Selective prosecution of HIV
- Arbitrary, *ad hoc* and inconsistent prosecution of people with HIV
- Disproportionate impact on women with HIV
- Potential for blackmail, control or abuse
- Inappropriate and insensitive police investigations
- Inappropriate and insensitive media reporting

However, not all evidence is equally persuasive and may be jurisdiction- or population- dependant. Given a lack of resources, any evidence gathered needs to not only show that HIV criminalisation does more harm than good in terms of its impact on public health and/or human rights, but also be relevant for case- or jurisdiction-specific advocacy.

In other words for such evidence to be fit for purpose we must ensure that any research into the impacts of HIV criminalisation is framed to provide maximum impact and delivered by the right people to the right people.

## Survey design

In order to better understand how advocates have used evidence to persuade policymakers and/or criminal justice system actors to repeal, reform and/or create improved outcomes for public health and/or human rights, leading advocates in four jurisdictions where such positive changes are taking place and/or have already occurred (Victoria, Australia; Denmark; England & Wales; and Iowa, United States) were asked to take part in a survey hosted on SurveyMonkey.com which asked the following eight questions.

1. Please briefly summarise the positive changes effected by you and other advocates in your country/state relating to HIV criminalisation.
2. How important was evidence from the social sciences (i.e. studies that showed a neutral or negative impact on HIV criminalisation on public health and/or human rights) in your ability to persuade policymakers and/or criminal justice system actors to make the positive change? [23]
3. How persuasive were generalised negative public health arguments (e.g. added disincentive to know or disclose HIV status, false sense of security regarding responsibility for HIV prevention) compared with more focused negative public health arguments (e.g. impact on healthcare workers' ability to effectively counsel patients)?
4. How persuasive were general negative human rights arguments (e.g. singling out people with HIV for unusually harsh punishment) compared with more focused negative human rights arguments (e.g. police or media not keeping individual complainant's confidentiality)?
5. Did you use social science evidence from outside of your own country or

[23] This required a response on a four-point scale. 1. Not at all. 2. Somewhat 3. Very 4. Invaluable.

state? If yes, please explain how you argued that it applied in your context. If no, please explain why you did not.
6. Were there gaps in the evidence for which you wished you had data? If so, what were they?
7. Did any evidence 'backfire' and/or result in unexpected or unwanted outcomes? (For example, did evidence that HIV criminalisation negatively affected HIV testing result in policymakers finding ways to potentially criminalise untested individuals.)
8. Is there anything else you'd like to share about your experience of using social science research in your HIV criminalisation advocacy?

## Advocating for Law Reform

Law reform is frequently a cumbersome process involving the establishment of relationships, the development of partnerships, and the formulation of evidence into arguments good enough to convince disparate politicians with a watchful eye on the views of the electorate.

Several agencies have developed strategies to argue for the reform of laws criminalising HIV non-disclosure, exposure and/or transmission. Their work included the development of media strategies to better educate the general public; community forums to increase understanding among key stakeholders; meetings with politicians and public servants to ensure they were informed of current evidence; development of networks to broaden the lobby base (including drawing clinicians into the fold); and the commissioning and publishing of evidence, including testimony from some who had been prosecuted. In some locales, their advocacy has produced impressive results. In others, the process continues.

### Denmark

In February 2011, Denmark suspended Article 252 of the Criminal Code pending an inquiry by a Government working group to consider whether the only HIV-specific law in Western Europe should be revised or abolished.[24]

There had previously been at least 20 prosecutions and at least fifteen convictions for either sexual HIV exposure or transmission under Article 252, including two as recently as 2008.[25] In August 2012, a man living with HIV who had previously been found guilty under the statute had his case reviewed due to the law's suspension and was subsequently acquitted. His prison sentence was reduced to six months based only his conviction for other, drug-related, offences. The courts are now in the process of reviewing all HIV-related criminal cases from 2007 – the year that National Board of Health informed the Ministry of Justice that HIV was no longer a life-threatening illness.[26]

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[24] HIV Justice Network. Denmark: Justice Minister suspends HIV-specific criminal law, sets up working group. February 17, 2011.
[25] Global Criminalisation Scan: Denmark. GNP+. October 2012
[26] HIV Justice Network. Denmark: Man convicted in 2007 under now suspended law acquitted; further cases to be reviewed. August 8, 2012.

The law was suspended because the National Board of Health had informed the Ministry of Justice that HIV was no longer, as the law specified, a "life-threatening and incurable disease", citing data from a Danish cohort study published in 2007 which found that for people living with HIV in Denmark who are on treatment, HIV had become a manageable, chronic health condition.[27]

The working group confirmed in November 2011 that the legal basis for the current statute no longer existed and recommended its repeal. Although they suggested wording for a new law that would criminalise HIV non-disclosure unless "suitable protection" was used and recommended that the current maximum sentence of eight years in prison should be reduced to two years, no new law has been enacted to date.[28]

Of note, civil society advocacy, led by NGO AIDS Fondet and the Danish people living with HIV organisation, HIV Denmark, played an important part in the suspension of Article 252. Following the publication of the 2007 data on life expectancy, they developed a strategy to persuade the Government that scientific advances had made the law obsolete. Once the law had been suspended they focused their advocacy on ensuring that no new law replaced it. Their advocacy campaign covered a range of activities including:

- Building networks of 'friendly' medical HIV specialists and parliamentarians;
- Writing and placing articles in national newspapers in co-operation with parliamentarians and HIV clinicians;
- Meeting with, and writing to, ministers, parliamentarians and the National Board of Health;
- Organising a national conference with a panel debate on decriminalising HIV with parliamentarians in attendance; and
- Connecting to international networks working on the same issues and collecting signatures from 122 organisations from all over the world, endorsing a letter to the Minister of Justice and the minister of Health congratulating the ministers on their decision to suspend the Danish Penal Code and asking them to consider no replacement following its repeal. [29]

## Survey responses (Executive Director, AIDS Fondet)

1. Please briefly summarise the positive changes effected by you and other advocates in your country/state relating to HIV criminalisation.
   **The provision on HIV criminalisation was suspended Feb. 2011**
2. How important was evidence from the social sciences (i.e. studies that showed a neutral or negative impact on HIV criminalisation on public

[27]Lohse N et al. Survival of persons with and without HIV infection in Denmark, 1995-2005. Annals of Internal Medicine:146: 87-95, 2007.
[28]HIV Justice Network. Denmark: HIV to be removed from Article 252, but new statute wording may re-criminalise non-disclosure without "suitable protection". November 10, 2011.
[29]AIDS Fondet. Submission to Global Commission on HIV and the Law High Income Country Dialogue. Oakland, September 2011.

health and/or human rights) in your ability to persuade policymakers and/or criminal justice system actors to make the positive change?
**2. Somewhat**

3. How persuasive were generalised negative public health arguments (e.g. added disincentive to know or disclose HIV status, false sense of security regarding responsibility for HIV prevention) compared with more focused negative public health arguments (e.g. impact on healthcare workers' ability to effectively counsel patients)?
**Most persuasive was the argument on disincentive to know your HIV status.**
4. How persuasive were general negative human rights arguments (e.g. singling out people with HIV for unusually harsh punishment) compared with more focused negative human rights arguments (e.g. police or media not keeping individual complainant's confidentiality)?
**Singling out people with HIV was the more persuasive argument.**
5. Did you use social science evidence from outside of your own country or state? If yes, please explain how you argued that it applied in your context. If no, please explain why you did not.
**In recent discussions with politicians on the future of HIV criminalisation in Denmark I included social science from Canada and the US. Especially social science showing that criminalisation deters people from testing not least the ones having the most risky sexual behaviour and therefore exactly the ones we want to test the most. It was never questioned if this also applied in a Danish context.**
6. Were there gaps in the evidence for which you wished you had data? If so, what were they?
**Oh yes. We need much more evidence on how HIV criminalisation hinders prevention efforts, make people with HIV not want to disclose and how it leads to stigma of people with HIV.**
7. Did any evidence 'backfire' and/or result in unexpected or unwanted outcomes? (For example, did evidence that HIV criminalisation negatively affected HIV testing result in policymakers finding ways to potentially criminalise untested individuals.)
**[Not answered]**
8. Is there anything else you'd like to share about your experience of using social science research in your HIV criminalisation advocacy?
**Note on question 2: Social sciences could have been invaluable, but not much available at the time of suspension.**

## Iowa, United States

Iowa recently became the first state to introduce legislation that would change its 1998 HIV-specific statute, which currently allows for 25-year prison sentences and lifetime sex offender registration to anyone convicted of HIV non-disclosure, regardless of actual risk, intent or actual transmission. There have been at least 25 prosecutions and 15 convictions under this law[30], including that

[30] Global Criminalisation Scan: Iowa. GNP+. April 2012

of Nick Rhoades, whose appeal will be heard at Iowa Supreme Court later in 2013.[31]

Lobbying by a broad coalition of activists spearheaded by Community HIV/Hepatitis Advocates of Iowa (CHAIN) and NASTAD Chair, Randy Mayer, chief of the Bureau of HIV, STD, and Hepatitis for the Iowa Department of Public Health led to the February 2013 introduction of Senate File 215 by Senator Steve Sodders and Senator Matt McCoy which proposes modernising the statute.[32]

The proposed legislation takes actual HIV risk, risk reduction methods, and whether or not transmission occurred into account, and includes two states of mind – malicious intent and reckless disregard. The maximum sentence for transmission with intent would be 10 years. Exposure with intent would be subject to a maximum of five years in prison. The proposals have support from health care professionals, HIV/AIDS advocacy groups, law enforcement and the Iowa attorney general's office as well as from local media.[33]

In March 2013, the legislation passed the State Senate's Judiciary Committee, 11 to 2, picking up all seven Democrats and four of the six Republicans, demonstrating the feasibility of bipartisan support for these efforts.[34]

## Survey responses (Community Organizer, CHAIN)

1. Please briefly summarise the positive changes effected by you and other advocates in your country/state relating to HIV criminalisation.
   **In Iowa we have hosted four educational forums for legislators and general public throughout the state. We have been able to build an incredible coalition of Iowa partners to help us advocate for this change, including: Iowa Dept. of Public Health, Attorney General's office, ACLU, Family Planning Council, National Social Workers Association IA Chapter, Interfaith Alliance, Pharmacy Student Organization, and other key health organizations. So far Iowa has gotten our bill through the Senate Judiciary sub-committee and Judiciary committee. The bill is waiting to be debated on the Senate floor, but we have one individual who has introduced an amendment that is not acceptable to advocates or from a public health aspect.**
2. How important was evidence from the social sciences (i.e. studies that showed a neutral or negative impact on HIV criminalisation on public health and/or human rights) in your ability to persuade policymakers and/or criminal justice system actors to make the positive change?
   **3. Very**
3. How persuasive were generalised negative public health arguments (e.g. added disincentive to know or disclose HIV status, false sense of security regarding responsibility for HIV prevention) compared with more

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[31]See Lambda Legal: Rhoades v. Iowa
[32]See Iowa Legislature Senate File 215
[33]The Des Moines Register. It's time to rethink Iowa's HIV sex law. Feb 8, 2013.
[34]Personal correspondence between the author and Sean Strub. See also: AP. Bill reducing penalties for HIV exposure moves on. 6 March 2013.

focused negative public health arguments (e.g. impact on healthcare workers' ability to effectively counsel patients)?
**Iowa was unique in that the Iowa Dept. of Public Health was able to speak out and attend the community forums, not lobbying for the bill, but providing reasoning for changes necessary for public health. This has been very important to us.**

4. How persuasive were general negative human rights arguments (e.g. singling out people with HIV for unusually harsh punishment) compared with more focused negative human rights arguments (e.g. police or media not keeping individual complainant's confidentiality)?
**The harsh punishment argument has worked in Iowa since ours is the worst in the nation. But confidentiality has not been an argument that has gotten through to legislators or public.**
5. Did you use social science evidence from outside of your own country or state? If yes, please explain how you argued that it applied in your context. If no, please explain why you did not.
**We used mostly US statistics, but I left that up to the Iowa Dept. of Public Health. That was really their expertise, so I couldn't tell you all sources they used.**
6. Were there gaps in the evidence for which you wished you had data? If so, what were they?
**One thing that we really need is how secondary disclosure can hurt people who are positive when someone takes that information and uses it as a manipulation, or just to spread it around the community.**
7. Did any evidence 'backfire' and/or result in unexpected or unwanted outcomes? (For example, did evidence that HIV criminalisation negatively affected HIV testing result in policymakers finding ways to potentially criminalise untested individuals.)
**No, not criminalize HIV-negative people, but one amendment has been to charge people for lying about their status.**
8. Is there anything else you'd like to share about your experience of using social science research in your HIV criminalisation advocacy?
**I have had advice from SERO, the Iowa Dept. of Public Health, and many other groups,. I am a 'lay person' and reading long research studies is not my cup of tea. If someone could write a short summary or highlights for those of us who do not have the time and the ability to completely understand technical science research [that would be very useful]. Basically, 'dummy down' reports for those of us who want to read this info, but will not or cannot read lengthy reports.**

## Addressing Legal Processes & Enforcement

Policing policies, procedures and workforce cultures influence the likelihood of cases involving HIV non-disclosure, exposure or transmission proceeding to court as well as the experiences of accused and witnesses. Prosecutors influence not only whether cases proceed but also how they are run. The expertise of lawyers, judges and magistrates directly impacts the course and outcome of cases – affecting scrutiny and analysis of evidence, instructions to juries,

sentencing, and future trials - through the use of precedents. While prosecutions must be 'in the public interest', the public interest is not always clearly defined.[35]

In numerous settings, advocates have endeavoured to influence and improve legal processes in a number of different ways. Their work has included: lobbying for the development of strong prosecutorial guidelines limiting the application of criminal law to cases of HIV non-disclosure, exposure or transmission; undertaking community-based research on the impacts of HIV criminalisation; creating policy statements and other materials to help educate the criminal justice system on HIV-related risk, harm and proof, as well as the potential negative public health impacts of inappropriate prosecutions; and providing expert evidence to influence the outcome of individual cases (and any precedents they set).

## Victoria, Australia

For some time, the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) and Living Positive Victoria have worked to develop greater understanding of the predominance of Victorian prosecutions. Their efforts have been slowed by a relative disconnect between the health sector (where their expertise lies) and the legal sector (where trials are initiated and progressed). Further, the Victorian health department faced strong public criticism for their handling of a 2009 case, where it was argued the case should have been referred earlier for prosecution. Following three independent reviews, that criticism was generally shown to be unwarranted, with only minor amendments made to elements of the management system. Still, the handling of cases of individuals who put other at risk of HIV infection continues to be politically sensitive.

In late 2011, VAC/GMHC and Living Positing Victoria secured a meeting with staff of the Office of Public Prosecutions Victoria (OPP) to begin a dialogue about prosecutions for HIV exposure and transmission. In 2012, VAC/GHMC successfully secured funding from the Legal Services Board to develop a project to inform legal practice in this area. The project, to be rolled out during 2013, will educate prosecutors on current HIV epidemiology and the rapidly developing field of HIV science and medicine. It aims to enhance the public interest by ensuring cases proceed only on the basis of the strongest available evidence.

The project will consult with prosecutors, defence counsel, and providers of expert evidence to identify knowledge gaps effecting HIV trials. It will then commission scholarly peer reviewed articles on the application of science, medicine and epidemiology in HIV trials. Training materials will be drafted and training provided to Victorian prosecutors. The project also aims to develop stronger networks between the OPP and the HIV community sector to provide prosecutors with a resource and contact point when the cases arise.

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[35] Cameron S. Australian Federation of AIDS Organisations. Sydney. 2011.

### Survey responses (Former President, Living Positive Victoria)

1. Please briefly summarise the positive changes effected by you and other advocates in your country/state relating to HIV criminalisation.
   **Building awareness of the issue, developing dialogue with justice agencies, monitoring cases, direct advocacy, education of prosecutors.**
2. How important was evidence from the social sciences (i.e. studies that showed a neutral or negative impact on HIV criminalisation on public health and/or human rights) in your ability to persuade policymakers and/or criminal justice system actors to make the positive change?
   **4. Invaluable**
3. How persuasive were generalised negative public health arguments (e.g. added disincentive to know or disclose HIV status, false sense of security regarding responsibility for HIV prevention) compared with more focused negative public health arguments (e.g. impact on healthcare workers' ability to effectively counsel patients)?
   **We have made these arguments and they have been received warmly, but the lack of strong empirical evidence is a constant problem. Hard evidence showing a direct link between criminalisation and negative public health outcomes is very hard to come by.**
4. How persuasive were general negative human rights arguments (e.g. singling out people with HIV for unusually harsh punishment) compared with more focused negative human rights arguments (e.g. police or media not keeping individual complainant's confidentiality)?
   **Not applicable in our case.**
5. Did you use social science evidence from outside of your own country or state? If yes, please explain how you argued that it applied in your context. If no, please explain why you did not.
   **We have to! The research hasn't been done locally. We are hoping to get some local data soon.**
6. Were there gaps in the evidence for which you wished you had data? If so, what were they?
   **The widespread view that HIV criminalisation reduces testing, disclosure and increases stigma has limited evidence to support it.**
7. Did any evidence 'backfire' and/or result in unexpected or unwanted outcomes? (For example, did evidence that HIV criminalisation negatively affected HIV testing result in policymakers finding ways to potentially criminalise untested individuals.)
   **Not yet.**
8. Is there anything else you'd like to share about your experience of using social science research in your HIV criminalisation advocacy?
   **[Not answered]**

## United Kingdom

Almost 25 prosecutions have taken place in the United Kingdom under existing assault laws since 2001. These are similar for England, Wales and Northern Ireland; Scotland has completely different laws. The first prosecution took place

in Scotland in 2001, followed by England (2003) and Wales (2005). There have been no prosecutions to date in Northern Ireland.

HIV policy organisations in the United Kingdom (NAT and THT), lobbied the Crown Prosecution Service (CPS, with jurisdiction over England and Wales) and later the Association of Chief Police Officers (ACPO, with jurisdiction over England, Wales and Northern Ireland) to create the first-ever sets of prosecutorial policy[36] and guidance[37] (first published in 2008 and updated in 2011) as well as police guidelines (published in 2010)[38] relating to HIV and the criminal law.

These guidelines have not only clarified the exact circumstances under which prosecutions might be warranted, thereby reducing the number of cases reaching court, but their development also led to closer relationships being established between the HIV sector and the criminal justice system fostering improved advocacy and mutual understanding.[39]

In May 2012, following lobbying from the same HIV organisations (with the addition on HIV Scotland) Crown Office and Procurator Fiscal Service (COPFS) published their Guidance for Scotland on 'Intentional or Reckless Sexual Transmission, or Exposure to, Infection'.[40] The guidance states that prosecution will be unlikely where the following circumstances apply:

- The accused did not know that he/she was HIV positive.
- The accused did not understand how HIV is transmitted.
- The accused disclosed his or her HIV positive status to the victim.
- The accused took reasonable steps to reduce the risk of transmission, for example, by using recommended precautions or avoiding higher risk acts.
- The accused was receiving treatment and had been given medical advice that there was a low risk of transmission or that there was only a negligible risk of transmission in some situations or for certain sexual acts.

It notes that prosecution will be likely where the following circumstances apply:

- The accused deliberately misled or concealed information from the victim.
- The accused did not attempt to reduce the risk of transmission, for example by failing to take prescribed medication or by failing to follow particular medical advice.

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[36] See: http://www.cps.gov.uk/publications/prosecution/sti.html

[37] See: http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/

[38] See: http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx

[39] In July 2012, the HIV Justice Network produced a 30 minute educational and advocacy video documentary, 'Doing HIV Justice: Clarifying criminal law and policy through prosecutorial guidance', which demystifies the process of how civil society worked with the Crown Prosecution Service of England and Wales to create the guidelines

[40] See: http://www.crownoffice.gov.uk/Publications/2012/05/Sexual-Transmission-or-Exposure-Infection-Prosecution-Policy

- The victim was particularly vulnerable in some way.
- There is evidence that the accused had intentionally embarked on a course of flagrant conduct .

As well as being helpful in Scotland, such guidance should also be a useful educational and advocacy tool for the many other jurisdictions globally that prosecute potential or perceived HIV exposure as well as transmission.

### Survey responses (A. Director of Policy and Campaigns, NAT; B. Policy Director, THT; C. Professor of Law and Policy, Birkbeck College, University of London)

1. Please briefly summarise the positive changes effected by you and other advocates in your country/state relating to HIV criminalisation.
   **A. There is both prosecution and investigation guidance in place which takes account of evidential issues, science and reasonable expectations around safer sex and transmission risk.**
   **B. Clarification and codification of prosecution guidelines; clarification and codification of police procedural guidelines; change from most people pleading guilty to multiple not guilty pleas and verdicts where evidence was not conclusive; and improved understanding of the issues by PLHIV, communities at risk, HIV workers & clinicians and to some extent lawmakers.**
   **C. Consciousness-raising about criminalisation among clinical and social care providers, and policy makers, through talks / research projects / events; production of informed prosecution guidance; police awareness.**
2. How important was evidence from the social sciences (i.e. studies that showed a neutral or negative impact on HIV criminalisation on public health and/or human rights) in your ability to persuade policymakers and/or criminal justice system actors to make the positive change?
   **A. 2. Somewhat**
   **B. 2. Somewhat**
   **C. 2. Somewhat**
3. How persuasive were generalised negative public health arguments (e.g. added disincentive to know or disclose HIV status, false sense of security regarding responsibility for HIV prevention) compared with more focused negative public health arguments (e.g. impact on healthcare workers' ability to effectively counsel patients)?
   **A. The public health argument was perhaps effective in deterring the CPS from also prosecuting those who 'should have known' because of their degree of risk - it was made clear this would criminalise tens of thousands. They limited undiagnosed culpability to those who can be deemed actually to know.**
   **B. Public health arguments have not been useful at all because criminal justice does not take regard of public health; what has been useful is concrete evidence of poor practice and miscarriages of justice, along with detailed challenges to the scientific reports for the prosecution. The only argument that in any way succeeded was**

**the somewhat spurious claim (without evidence at that point) that needing an HIV test before a prosecution could succeed would lead to people avoiding testing - which made them specify that you didn't need to have been tested to be prosecuted; a potentially retrograde step!**
**C. Not generally persuasive. Risk taking and non-disclosure are associated with moral responsibility.**

4. How persuasive were general negative human rights arguments (e.g. singling out people with HIV for unusually harsh punishment) compared with more focused negative human rights arguments (e.g. police or media not keeping individual complainant's confidentiality)?
**A. I think there was a broadly effective line that the equality, human rights and discrimination issues linked to prosecutions were so serious that great care had to be taken in identifying an appropriate approach to these prosecutions. The view that reasonable approaches to safer sex for HIV positive people was not directly a matter for determination by the courts but rather for identification by prosecuting authorities/courts from the clinical consensus/practice can be seen as a view sensitive both to human rights and public health.**
**B. Not at all so far, though we persist. There is a basic misunderstanding from social scientists about how much the criminal justice system "must" be swayed by their general arguments. Politicians might be, but lawmakers seldom are. They respond much more to clear evidence of malpractice or wastes of time and money. They respond most of all to losing cases because the evidence was inadequate.**
**C. See answer to 3.**
5. Did you use social science evidence from outside of your own country or state? If yes, please explain how you argued that it applied in your context. If no, please explain why you did not.
**A. No.**
**B. Seldom.**
**C. Not really. Liability for non-disclosure and exposure raise different issues / questions from those associated with transmission.**
6. Were there gaps in the evidence for which you wished you had data? If so, what were they?
**A. Not really.**
**B. Huge gaps; the genuine measurable impact (as opposed to anecdotal focus groups of concerned individuals) of prosecutions; being able to directly examine police/prosecutorial case notes.**
**C. Impact of criminalisation on testing and access to services; impact of criminalisation on disclosure.**
7. Did any evidence 'backfire' and/or result in unexpected or unwanted outcomes? (For example, did evidence that HIV criminalisation negatively affected HIV testing result in policymakers finding ways to potentially criminalise untested individuals.)
**A. Yes there was a concern to allow in exceptional cases of prosecution of an undiagnosed person as a way to address the**

**disincentive to testing argument. More recently, in relation to herpes, the challenge as to the degree of seriousness involved in herpes transmission, has moved the CPS to consider using lesser assault charges to address minor STIs.**
**B. See above - you have it in one. Also, ensuring that HIV was not singled out from other STIs, while correct in human rights terms, has led to a real tangle in prosecutions for other STIs, particularly herpes, with individual miscarriages of justice.**
**C. No.**

8. Is there anything else you'd like to share about your experience of using social science research in your HIV criminalisation advocacy?
   **A. I don't think the issue has been one of public health but one of justice so arguments around public health impact have not really been that relevant. Particularly given the lack of evidence of seriously harmful impacts on public health.**
   **B. Hard evidence of miscarriages of justice and how much police and prosecutorial time is being wasted has been more useful in changing practice so far. Social science based arguments have mostly been useful for getting other liberals on board with the agenda, which in itself is useful. However, too few advocates try to put themselves in the shoes of the law enforcement side and thus fail to understand why these arguments seldom sway them.**
   **C. That there is not enough, that what there is has too narrow a base, that it does not engage sufficiently with "hard" science.**

## Concluding thoughts

Advocates around the world continue to address the criminalisation of HIV non-disclosure, exposure and transmission in many different ways appropriate to their jurisdiction(s). Their work is not only varied in terms of the complex intersection of laws, policies and practices but also in terms of their unique social, epidemiological and cultural contexts.

Despite the many incremental successes of the past 18 months, much more work is required to strengthen advocacy capacity. HIV criminalisation is a complex issue. It entails a detailed understanding of diverse aspects of the criminal justice system; collection and analysis of evidence of the scope and impact of prosecutions across local and national boundaries; articulation and argument about complex moral and ethical issues of trust, blame and responsibility; and inclusion of HIV prevention and human rights priorities.

Development of strategies against HIV criminalisation relevant to each individual jurisdiction requires time, effort and the involvement of multidisciplinary experts. This report represents only the tip of the iceberg: each entry a brief synopsis of the countless hours and many decisions individuals and agencies have dedicated to advocacy for greater justice. Their work is crucial to building an effective HIV response and the possibility of a world free from HIV-related stigma and discrimination.

More attention to the experiences of those who have survived HIV criminalisation is also required, as well as the impact of HIV criminalisation on the experiences of all people living with HIV. People living with HIV are central to advocacy against HIV criminalisation. They must be resourced to develop sophisticated understanding of HIV criminalisation issues and to lead conversations with their governments and with other civil society organisations that continue to advance HIV justice for all.

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