THE INTERNATIONAL SOCIETY FOR THE REFORM OF CRIMINAL LAW

22ND INTERNATIONAL CONFERENCE

CODIFYING THE CRIMINAL LAW: MODERN INITIATIVES

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CRIMINALISATION OF HIV TRANSMISSION AND THE ROLE & LIMITS OF CRIMINAL LAW

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THE GLOBAL HIV/AIDS PANDEMIC

It is little more than a quarter of a century since the world first became aware of the illness we now call HIV/AIDS. The first cases of homosexual men with pneumocystic pneumonia, an unusual opportunistic infection, were reported in the United States of America in June 1981[1]. By 1982, the Centers for Disease Control and Prevention

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[*] Justice of the High Court of Australia 1996-. Member of the inaugural WHO Global Commission on AIDS 1988-1992. Member of the UNAIDS Global Reference Panel on HIV/AIDS and Human Rights, 2003-.

[1] United States, Centers for Disease Control (CDC) "Pneumocystis Pneumonia - Los Angeles, MMWR 30 (June 5, 1981): 250-252.

(CDC) established the term "Acquired Immuno-Deficiency Syndrome" (AIDS)[2].

Within two further years, Dr Luc Montagnier in France and Dr Robert Gallo in the United States isolated the human retrovirus that causes AIDS[3]. That retrovirus would later be named the Human Immuno-Deficiency Virus (HIV). In 1985, the US Food and Drug Administration (FDS) licensed the first test to measure the response of antibodies to HIV. The blood banks began screening blood supply in the United States and later world-wide[4]. Thus began the remarkable human encounter with a new, deadly and unexpected enemy - a tiny virus with a huge impact.

HIV has inflicted a terrible toll of death and suffering on human beings in every continent. It has resulted in many legal and policy responses, national and international, some only of which have been effective and well targeted. One of the greatest victims of the pandemic has been the belief, that had built up in the twentieth century, that scientific study of the variants of human sexuality, and the patterns of

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2 CDC, "Current Trends Update on AIDS" - US MMWR 31 (September 24, 1982): 507-514.

3 Luc Montagnier, "A History of HIV Discovery", *Science*, 298 (November 29, 2002): 1727-1728; Robert C Gallo, "The First Human Retrovirus", *Scientific American*, 255 (December 986): 88-98; Stanley Prusiner, "Discovering the Cause of AIDS", *Science*, 298 (November 29, 2002): 17-20.

4 C L Gostin, *The AIDS Pandemic* (Chapel Hill, 2005), Preface, xxiii.

human sexual conduct, would, over time, erode the irrational responses of various human cultures, religions, beliefs and laws targeted at adult, private consensual sexual conduct. However, amongst the least attractive responses to the HIV epidemic have been certain responses which, in the earliest days of the epidemic, I described as "the contagion of Highly Inefficient Laws" ("HIL")[5]. The present paper is about the ongoing phenomenon of HIL. It is intended as a warning to lawyers and law-makers against well-meaning but ineffective, and sometimes counter-productive, efforts of law reform when addressed to the complex socio-medial phenomenon of a world-wide epidemic, such as HIV/AIDS.

From the earliest days of the HIV/AIDS pandemic, the largest impact of infections fell, not on the mobile minority groups of homosexual men in North America and Europe who had first manifested with the symptoms of HIV but upon majority populations of heterosexual men and women in poorer developing countries. Only ten years after its first appearance, the position in 1992 was described in terms that have become much more aggravated in the years since: "Of all AIDS deaths, three quarters have been in Africa and nearly 20% in the Americas"[6].

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[5] M D Kirby, "The New AIDS Virus - Ineffective and Unjust Laws", unpublished paper for International Symposium on AIDS, Paris, 23 October 1987, reprinted *Washington Post*, 2 February 1988, 14.

[6] J Mann, D J M Tarantola and T W Netter (eds) *AIDS in the World*, Harvard, 1992, 125.

For the purposes of this paper it is not necessary for me to itemise with exactness the emergence and spread of the HIV virus; the perplexing puzzle of where it came from; the debates about whether it represented an accidental "cross-over" from the equivalent simian retrovirus (SRV); the differing manifestations of the virus; and the differential patterns as between developed Western countries (where infections of homosexual men and early infections from the blood supply predominated) and in developing countries (where infections through heterosexual contact and injecting drug use predominate).

A vivid description of the position reached by mid-2007 was given by a lawyer and judge who has good reason to know what he was talking about. I refer to Justice Edwin Cameron of the South African Supreme Court of Appeal. He is himself living with HIV. Indeed, he is one of the very few public officials in the epicentre of the epidemic, in Africa, who is open about his HIV positive status. He has expressed a feeling of a moral obligation to speak out and to demand action because of his realisation that it was his judicial income, his education, his access to technology and information and his training and rationality that led him to be an early beneficiary of the anti-retroviral drugs. They saved his life. He exhibits an obligation to share his knowledge and to help save the lives of fellow Africans and people everywhere - far from the seat of his court in Bloemfontein.

At an HIV/AIDS conference in Geneva in July 2007, Justice Cameron told the International Labour Organisation[7]:

> ""…[T]his epidemic is colossal. It is probably the biggest microbial pandemic to strike human kind in six centuries. Though the official figures are - rightly in my view - much contested, few deny that many tens of millions of people risk death from AIDS in the next decades - and that most of them are poor Africans.
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> UNAIDS estimates that nearly 40 million people world-wide are living with HIV - and perhaps 25 million have already lost their lives because of AIDS - in 2005 alone, an estimated 2.8 million. Changes in behaviour and prevention programmes (as well as the fact that the epidemic may have peaked) have reduced the incidence of HIV in many countries. Yet in the developing world, and particularly in Africa, the epidemic is still expanding. According to UNAIDS, Africa remains the global epicentre of the pandemic[8] …
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> Within Africa, the sub-Sahara region has the highest infection rates in the world. While only 10% of the world's population lives there, nearly two-thirds (about 25 million) of the world's population with HIV resides there. The dark shadow of AIDS mirrors Africa's overall burden of disease. And its darkest reflection is in the deadly toll of AIDS. In 2005 an estimated 930,000 people died of AIDS in Southern Africa alone[9]. Seen from some angles, the prevalence of my own country, South Africa, are the highest. 11% of the total population, 19% of the working-age population, and 33% of women aged 25-29 are infected with HIV. On every day of 2006, approximately 1400 people in South Africa were infected with HIV and 950 died of AIDS.
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> We must humble ourselves before this [epidemic] in considering policy interventions that might alleviate it".

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[7] E Cameron, "Legislating an Epidemic: The Challenge of HIV/AIDS in the Workplace", unpublished, 19 July 2007, International Labour Organisation, Geneva, 1-2 [3].

[8] UNAIDS, *Report on the Global AIDS Epidemic 2006*, Geneva, 5.

[9] *Ibid*, 15-23.

AN INTENSELY PERSONAL ENCOUNTER

Because of my own sexuality, from the beginning of the epidemic I found myself in the centre of the impact of HIV/AIDS in Australia. From 1985, I lost a number of close friends, several of them members of the legal profession. I witnessed the substantial helplessness of the medical profession in the early days of HIV. I watched the seeming miracle that came about when the expensive triple combination therapy of anti-retroviral drugs became available from about 2000. Like Justice Cameron, I was therefore a close witness to AIDS[10]. I therefore felt a similar obligation to do what I could to respond to the pandemic in a constructive fashion.

But what could a lawyer do that would be useful where the combined genius of medical science seemed so impotent and (even after new drugs became available) so disempowered from assistance because of the great expense, sophistication and difficulty of delivering such drugs in a world of so much poverty, discrimination, fear and denial?

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[10] E Cameron, *Witness to AIDS*, Tauris, Cape Town, 2005.

Because of past involvement in medico-scientific work within the Australian Law Reform Commission (ALRC) [11] and perhaps because of my sexuality, I was invited by the first Director of the Global Programme on AIDS, Dr Jonathan Mann, to join the inaugural World Health Organisation (WHO) Global Commission on AIDS. This led to later participation in initiatives of WHO, in concert with the UN Office for Human Rights (later the Office of the High Commissioner for Human Rights) concerned with guidelines to govern responses to HIV and AIDS which could be recommended to the international community[12].

Subsequently, I was appointed by the new inter-agency body established to coordinate United Nations responses to the pandemic, UNAIDS, to a Reference Group on the human rights aspects of the epidemic. Later still, in November 2007, UNAIDS, together with WHO and the United Nations Development Programme (UNDP), convened an international consultation on the particular subject matter of this paper, the criminalisation of HIV transmission. I chaired the closing session of that consultation. I later provided a summation[13]. On my return journey to Australia from Geneva, where the consultation had taken place, I

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[11] Australian Law Reform Commission, *Human Tissue Transplants* (1977) (ALRC 7), AGPS, Canberra.

[12] See eg UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, 2006, consolidated version. Available at: www.ohchr.org/english/issues/hiv/guidelies.htm

[13] M D Kirby, "Criminalisation of HIV Transmission: What Have we Learned?", unpublished summation of Geneva Consultation of UNAIDS on Criminalisation of HIV transmission, 2 November 2007.

attended, at its invitation, the first meeting of the Inter-Parliamentary Union devoted to issues of legislation and AIDS.

In addition to these international activities, issues of HIV/AIDS are not strangers to the courts in many countries, including my own. A little more than a year ago, in the High Court of Australia, a criminal conviction for HIV transmission was the subject of an application for special leave to appeal[14]. Special leave to appeal was refused. However, the case reminded me, should I possibly have forgotten, that the issue of criminal sanctions for transmission of HIV and AIDS are likely before long to visit the courts and to require judicial attention, if they have not already done so.

CASES IN THE COURTS

Long before HIV came along, cases presented to courts of the common law tradition concerning transmission by an accused (usually a male) of a serious sexual condition or disease to an unknowing victim (usually a female).

Thus, in *R v Clarence*[15] a husband who knew that he was suffering from gonorrhoea, nonetheless, had sexual intercourse with his

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14 *R v Reid* [2006] 1 Qd R 64; (2006) 162 A Crim 677.

15 (1889) LR 22 QBD 23.

unsuspecting wife and passed the disease onto her. The husband was charged with inflicting grievous bodily harm and assault occasioning actual bodily harm[16]. He was convicted at trial. However, he appealed against his conviction. He succeeded in part because of the consent attributed to the wife to have sex with the husband and because that consent was held not to be vitiated by the husband's failure to disclose his illness in advance of sexual intercourse.

Over time, the decision in *Clarence* became controversial because of its reliance on the somewhat artificial, and increasingly outdated, fiction of the law that a married woman was, by virtue simply of her status as a wife, deemed to have consented to have sex with her husband. Considerable difficulty flowed from the suggestion in the case that fraud did not vitiate the consent unless it went to the nature of the act or the identity of the other person involved. This legal theory greatly confined the circumstances in which fraud would vitiate consent[17]. It reduced the operation of the criminal law as a sanction in such circumstances.

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[16] *Offences Against the Person Act* 1861 (UK), ss 20, 47; 24 & 25 Vict c 100.

[17] M Groves, "The Transmission of HIV and the Criminal Law" (2007) 31 *Criminal Law Journal* (Aust) 137; cf A P Simester and G R Sullivan, *Criminal Law, Theory and Doctrine*, Hart, Oregon (3rd ed, 2007) at 408; S Cameron, "HIV on Trial" in *HIV Australia*, Vol 5, No 4 (2006).

For more than a century after it was given, the decision in *Clarence* was somewhat controversial in England[18]. But the reasoning in the case became of increased importance in countries of the common law tradition when HIV came along. Self-evidently, the deliberate or intentional (or perhaps the reckless) transmission of HIV to an unsuspecting recipient was an extremely serious antisocial act. If it were performed with knowledge of the perpetrator's HIV status, with the deliberate purpose of infecting the recipient (or with reckless indifference as to whether the act of sexual intercourse would result in infection) such conduct might result in grave and possibly fatal health complications for the unknowing recipient, especially in the early days of HIV, before the anti-retroviral treatment became available.

In several jurisdictions cases began to present to the courts in which an accused, who was HIV positive and had unprotected sex with another person who became HIV positive, faced charges expressed in the traditional language of assault, or assault occasioning actual bodily or grievous harm. Such cases have arisen in the United States of America and in New Zealand[19], Canada[20], England[21] and Australia[22].

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18 *R v Linekar* [1995] QB 250.

19 *R v Mwai* [1995] 3 NZLR 149.

20 *R v Cuerrier* [1998] 2 SCR 371.

21 *R v Dica* [2004] QB 1257 at 1273.

22 *In re D* (1997) 21 *Criminal Law Journal* 40; *Mutemari v Cheesman* [1998] 4 VR 484, (1998) 100 *A Crim R* 397.

In the English case of *Dica*[23], the Court of Appeal overruled the decision of *Clarence* for that country. It held that a recipient's consent to sexual activity was not necessarily consent to the possible consequential risk of contracting HIV. Nevertheless, the Court of Appeal concluded that consent could provide a defence to a charge of inflicting grievous bodily harm. That issue had been withdrawn from the jury by the trial judge in *Dica*. Mr Dica's conviction was overturned.

The difficulty of this reasoning was that it suggested that a person who was aware of an HIV positive status and who recklessly transmits the virus to another person may be guilty of an offence; but the issue will depend on the facts of the case. From the public health and preventive perspective, the obvious problem was that this development of the law imposed potentially adverse consequences for the accused depending upon the accused's state of knowledge of a part exposure to the infection. This, in turn, might discourage some persons from ascertaining their HIV status by submitting themselves to an HIV test. Most studies of the appropriate community response to HIV suggested the high desirability that persons in doubt should undergo personal testing to ascertain their HIV status. Not only does this provide a watershed in self and other-regarding protection if the person is tested negative. Where the test is returned positive, it can enhance the

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[23] [2004] QB 1257 at 1273.

protection of others and access to therapies that may both provide proper care for the infected and reduce viral levels that are relevant to the risks of ongoing transmission of HIV to others by unprotected sexual intercourse.

In many societies, including my own, special legislation has been enacted to impose on persons who are HIV positive the obligation to inform another person with whom sexual activity takes place, of the presence of the HIV virus in the body fluids of the sexual actor[24]. As well, in some jurisdictions, specific laws have been enacted to make it an offence to transmit a dangerous health condition.

Laws of this kind render it unnecessary to rely on traditional offences, expressed in general language, such as murder, manslaughter, assault or assault occasioning actual or grievous bodily harm[25]. Although in Australia, and doubtless in other developed countries, there is some recent evidence of an increase in HIV infections amongst a new cohort of patients not exposed to the levels of awareness of HIV that developed ten and twenty years earlier[26], and although such infections are controversial, sensitive and emotive,

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24 See eg *Public Health Act 1991* (NSW), s 13.

25 eg in *R v Reid* [2006] 1 Qd R 64 (2006) 162 *A Crim R* 377, the offence was against the Criminal Code (Qld) s 317(b) involving transmission with intent of a serious disease to the complainant.

26 "HIV rise linked to 'flawed' programs", *The Australian*, 5 November 2008, 5.

particularly in the hands of tabloid journalists, the criminal law has (by and large) in most countries played a relatively small part in the response of society to the HIV/AIDS epidemic. It seems likely that in most developed countries this will continue to be so.

Generally speaking, in developed societies, there has been a realisation of the lessons of the so-called AIDS paradox[27]. That paradox has taught such societies that, as a general rule, the most effective responses to limit and diminish the spread of HIV/AIDS are to be found in gaining the confidence and attention of those persons who are most at risk of infection. In that way, such persons are more likely to receive effective instruction about the dangers that they face to their lives and health. By these means, preventive measures (use of condoms, avoidance of more risky sexual activity, needle exchange measures, total and partial abstinence in risky sexual conduct and other risky behaviour etc) have brought new infection levels down to much lower levels than first appeared at the beginning of the epidemic.

In the absence of an effective vaccine and for want of a total cure that rids the body of HIV, the most powerful strategy for containment of the HIV virus throughout the world has been education; protection of vulnerable groups; involvement of those groups in their own health

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[27] Mann, Tarantola and Netter, above n 6, at 561 ff.

strategies; and use of legal measures only as a fallback for serious cases of deliberate (usually multiple) wrong-doing.

Until now, this has generally been the wisdom of those who have designed public health strategies intended to respond to HIV/AIDS. Legal and punitive laws have been kept in reserve because their aggressive deployment has generally been seen as counter-productive. This is so because of the typical ineffectiveness of criminal law as a response to activities important to individual identity and pleasure (such as sex and drug use). And because of common experience that the criminal law and agencies for its enforcement tend to drive persons at risk and those servicing their needs into 'underground' activity, out of the reach of safer behaviour messages essential to behavioural change and the protection of the self and others.

The limited role of the courts, through criminal prosecutions, in responding effectively to the public health crisis of HIV was recognised by the English Court of Appeal itself in *Dica*[28]:

> "The problems of *criminalising* the consensual taking of risks … include the sheer impracticability of enforcement and the haphazard nature of its impact. The process would undermine the general understanding of the community that sexual relationships are pre-eminently private and essentially personal to the individuals involved in them. And if adults were to be liable to prosecution for the consequences of taking known risks with their health, it

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[28] [2004] QB 1250 at 1271.

> would seem odd that this should be confined to risks taken in the context of sexual intercourse, while they are nevertheless permitted to take the risks inherent in so many other aspects of everyday life".

The general effectiveness in most developed countries of the foregoing strategy built around the "AIDS paradox", and the down-playing of criminal law as a major player in the strategies against new HIV/AIDS in those countries, has largely accompanied the fall-off in new HIV/AIDS infections in those countries. Whether such strategies would continue to be followed, if the cases of sero conversion were to increase significantly in developed countries is another question.

In many such countries, in recent years, there have been statistically significant increases in cases of HIV infection, including amongst homosexual men. Various explanations may be given: the absence of the reinforcement which attending funerals experienced by their counterparts in earlier decades; the mistaken belief that anti-retroviral therapy means the end of the mortal danger of HIV; and the weariness of the target audience of the messages of self-protection and community protection which proved so successful in the immediate post-1984 years, at least in developed countries.

Strangely enough, in Australia, there are significant differences between the incidence of increases in new HIV infection in different

States[29]. Victorian rates and those in Queensland are considerably higher than those in New South Wales. This suggests the presence of differing causative factors such as governmental spending on and support for HIV education. However that may be, the general overall success of the strategies adopted in developed countries presents them with a significantly different picture to that in developing countries, as described (in the African context) by Justice Edwin Cameron in his above remarks. This calls attention to a new development involving an increasing reliance on the criminal law as a significant strategy against HIV/AIDS, particularly in developing countries and especially in Africa.

THE N'DJAMENA "MODEL LAW" 2004

Since 2001, Zimbabwe, Lesotho and Swaziland, along with Uganda, have adopted special laws addressed to HIV[30]. In addition, draft laws of Sierra Leone and Kenya, common law countries from other regions of Africa, have since come into force. Attitudes of anger, frustration and retribution have entered into the statute books of Africa in response to the perceived challenge of HIV.

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[29] "NSW still leads HIV prevention", *Sydney Star Observer*, 5 June 2008 (Issue 921).

[30] C Willyard, "Africa's HIV Transmission Laws Based on Questionable Science", *Nature Medicine*, Vol 13, No 8 (August 2007), 890.

In September 2004, a small project, Action for West Africa Region - HIV/AIDS, held a workshop in the city of N'djamena in Chad. This body receives USAID funding which is implemented by Family Health International with additional funding from US-based organisations such as Population Service International and Constella Futures Group[31].

The stated purpose of the workshop in N'djamena was to agree upon a model general law on HIV. Parliamentarians from the region attended. A draft model law, proposed for the meeting, was ultimately accepted by the workshop. The result, since 2005, has been the adoption of seven such national HIV laws in Benin, Guinea, Guinea-Bissau, Mali, Niger, Togo and, as stated, Sierra Leone, based on the N'djamena draft. As well, by December 2007, a further six countries were reported as considering similar legislation.

Commentators have noted several positive features of the N'djamena draft law, including provisions guaranteeing pre- and post-HIV test counselling; protections for medical confidentiality; and general prohibitions on discrimination based on HIV status or presumed status. So the draft is not all bad news.

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[31] See News Release of Constella Futures, Constella Group, 17 July 2007 at <www.constellagroup.com/news/impact/2007/HIVaidsmodellaw081707.php>

Nevertheless, concern has been expressed for some features of the draft model N'djamena law that depart from the respect for, and protection of, the human rights of people living with HIV, which respect and protection has hitherto been an essential ingredient in the WHO/UNAIDS/UNDP measures recommenced to respond to the HIV/AIDS epidemic. These are the strategies that have been found to work most successfully in (developed) countries.

Thus, article 26 of the N'djamena model law requires a person diagnosed with HIV to disclose to his or her "spouse or regular sexual partner" as soon as possible (and at most within six weeks of the diagnosis) his or her HIV status. This obligation of disclosure is not related to specific sexual conduct but instead to particular relationships. In many (perhaps most) of the countries concerned, such disclosure can lead to severe stigma, discrimination, violence and even deadly abuse, targeted particularly at women, as well as infringements of privacy and basic rights that are disproportionate to the outcome thus secured.

Article 36 of the N'djamena model law addresses criminalisation. It creates an offence of "wilful transmission" which is defined as transmission of HIV "through any means by a person with full knowledge of his/her HIV status to another person". Concern has been expressed that this provision is also over-broad. Potentially, it imposes criminal liability although a person may practise safer sex which reduces or eliminates actual risk of transmission to a sexual partner; takes steps to disinfect injecting or skin piercing equipment; or involving mother to child

transmission of HIV regardless of the actual risks involved in the particular case[32].

In a Canadian comment on the N'djamena model law, the author, Richard Pearshouse, says[33]:

> "The pressure on legislators and governments in jurisdictions across the globe to produce a legal response to HIV is enormous. However, laws pertaining to HIV, even those dressed in the garb of human rights, are not always progressive. These laws can be instrumental in promoting effective initiatives to address the HIV/AIDS epidemic, but they can also impede such initiatives. …
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> To contribute constructively to reducing the impact of HIV, national laws need to establish a genuinely supportive environment for people living with the virus or those most vulnerable to infection. Far too often this point seems to have been ignored in recently adopted HIV laws in Western Africa".

THE GENEVA CONSULTATION 2007

A similarly cautious and sceptical approach about the growing pressure for criminalisation of HIV transmission was taken by the group of intergovernmental experts of UNAIDS who considered the matter in

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[32] *Ibid*.

[33] UNAIDS and the Inter-Parliamentary Union, *A Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999. A second edition was published in 2007, available at <http://www.ipu.org/english/handbks.htm#aids07>

Geneva in November 2007. As stated, I was a member of that group. Amongst the questions considered by the group were:

- Is criminalisation of HIV transmission generally desirable?
- Does it constitute a rational and timely response to the challenge of HIV/AIDS?
- Does it introduce unwanted consequences that make such a response counter-productive?
- Is research necessary to explore a refinement of any criminal law that would be more effective, so as to exclude laws that are not effective or counter-productive?

The Geneva consultation built on earlier consideration of like questions by UNAIDS and WHO[34]. It also drew upon technical consultation documents prepared by WHO[35] and a report of a civil society consultative meeting on criminalisation of the wilful transmission of HIV held by leading organisations in Southern Africa[36].

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[34] UNAIDS, *Criminal Law, Public Health and HIV Transmission*, UNAIDS, 2002/02.12E.

[35] World Health Organisation, 2006 (Copenhagen). In consultation with the European AIDS Treatment Group and AIDS Action Group.

[36] Arasa/Osisa Civil Society Consultation, 2007. See also S Burris *et al*, "Do Criminal Laws Affect HIV Risk Behaviour? An Empirical Trial", (2007) *Arizona State Law Journal* (forthcoming). A Evans, "Critique of the Criminalisation of Sexual HIV Transmission" (2007) 38 *Victoria University Wellington Law Rev* 517; I Brady, K Vigas and N Behan, "The Law of Living Longer" (2008) 6 *HIV Australia* No 2, 21 at 24 (disclosure).

The participants in the Geneva November 2007 consultation emphasised the need to recommend and adopt an approach that would actually contribute affirmatively to the containment of the spread of HIV. Without exception, the participants favoured an empirical approach to the evaluation of laws addressed to HIV rather than a purely moralistic or political approach, given the tendency of the latter approaches sometimes to prove counter-productive to the strategy of containment.

Generally speaking, those countries that have adopted a human rights respecting approach to the HIV/AIDS epidemic have been far more successful in containing the spread of HIV than those countries that have adopted punitive, moralistic, denialist strategies, including those relying on the criminal law as a sanction. Of course, such success might be no more than coincidental. It might be related, in part at least, to other factors such as general education levels, availability of healthcare, better community organisation and improved media outlets. However, the success of strategies designed to win the confidence and attention of audiences at greatest risk of HIV infection has been widely seen as important for those societies that have been most successful in controlling and reducing levels of HIV infection. It has lessons for other countries as well.

As a general conclusion, the consultation in Geneva considered that what was mainly needed in the struggle for containment of the spread of HIV, in the developing countries where the spread is most

rampant, are initiatives of *decriminalisation*, not initiatives of *criminalisation*. Amongst the essential decriminalisation strategies emphasised by the Geneva consultation, as most likely to work in practice in the effort for containment, were:

- Removal of criminal sanctions on commercial sex work in order to promote empowerment of sex workers in all of their activities including the use of condoms and safer sex practices;
- Enactment of anti-discrimination laws protective of people living with HIV and AIDS, imputed to be infected and at risk of infection;
- Promotion of education and the availability of condoms and other strategies designed to reduce HIV infections, including provision of sterile syringe exchange which has had a radical effect in reducing infections by this vector of the population in those countries that have adopted this strategy;
- Removal of criminal sanctions upon adult private consensual same-sex activity; and
- Adoption of widespread education to ensure community information to all persons at risk of HIV transmission including advice to children and young persons on means of self-protection (eg by the use of condoms, sterile injecting equipment etc).

The Geneva consultation recognised that the foregoing strategies were unlikely to be popular in many of the developing countries that are most at risk in the HIV/AIDS pandemic. Yet unless such strategies or others like them are taken, resort to criminal sanctions will act only as a

bandaid or minor palliative. They will give legislators the warm feeling of doing something whilst adopting laws that are ineffective as a community strategy, very costly and sporadic in enforcement, and counter-productive because alienating relevant persons from the safer sex messages that are needed to prevent the spread of the virus. Those persons are those who are most at risk of HIV infection.

The participants in the Geneva consultation recognised a taxonomy into which conduct relevant to transmission of serious diseases might be divided. Obviously, at the highest level of culpability is intentional, purposeful, deliberate (and particularly repeated) transmission. Lower in the scale of culpability is reckless transmission. Lower still is negligent transmission. Lowest of all is transmission without knowledge or reason to know of HIV status presenting danger to others. All participants agreed that, in any criminal offence involving transmission of a disease, the ingredient of intentional conduct, in the sense of wilful, deliberate and knowing behaviour was essential. The relevant intention on the part of the accused was ordinarily an attribute of serious criminal offences (*mens rea*). It represented the moral element that marked off criminal conduct and distinguished it from other conduct not deserving of criminal culpability. The consultation concluded that this element of international conduct causing established harm should remain an essential ingredient for any offence of transmission of a disease, specifically of HIV.

A CRISIS OF "CRIMINALISATION"

Much debate amongst participants in the Geneva consultation centred on the attributes of the will that lay between deliberate and purposeful intention to infect others with HIV and mere negligence or ignorant carelessness or indifference. All participants were concerned about the risk of a "crisis of criminalisation", as Justice Edwin Cameron, a participant in the consultation, described it.

The proliferation of criminal statutes, especially in Africa, and the diversion of HIV-responsive energies into such legislation constituted, in the opinion of most of the Geneva participants, strategies at this stage in the epidemic that were unlikely to be effective. Indeed, they may be seriously dangerous because of the disincentive that is thereby introduced for ordinary individuals to take the vital step (HIV testing) which is often a most critical moment in self-protection and thereby in community protection.

At this conference in Dublin on codification of criminal law, it is important to have regard to the new N'djamena code on HIV law and similar codes in common law countries which are designed to provide comprehensive legislation in respect of HIV/AIDS transmission. It is true that there are some advantages in such legislation, certainly outside the criminal offences for which they provide. But, obviously, the devil is in the detail. Codification of the law itself is not enough. The benefit of codification, self-evidently, depends upon the content of the resulting code.

In dealing with the contemporary challenge of HIV transmission, with its devastating consequences for individuals and societies, nations face a sensitive and difficult problem with huge personal, community, economic and national implications. Taking the effective measures is not always popular. As the list recommended by the Geneva consultation illustrates, what is effective is sometimes politically very difficult. Yet taking punitive measures, depending on their terms and enforcement, is, on current information, unlikely to succeed in the environment where there is no effective vaccine and no curative therapy which can be offered to persons living with HIV and AIDS.

Clearly, this topic is one of the most important challenges for the criminal law facing all countries. But it is specially important for developing countries. It is therefore appropriate that this international conference in Dublin on the reform of criminal law should address the significant challenge presented by the growing moves for criminalisation of HIV transmission.

We should be aware of the very different messages coming out of N'djamena and Geneva for the future shape of the criminal law in this respect. In effect, these differing messages pose anew the fundamental questions about the role, effectiveness and limits of the criminal law. About what criminal law works and what does not. About what is essential to constitute a crime and what is not. And about some crimes

that are against society's best interests, however much they may be popular with lawmakers and with the general populace.

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