

**In forthcoming issues:**

- Post-Exposure Prophylaxis
- The condom debate—continuing controversy?

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## **Criminalising HIV Transmission**

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It is a basic principle of a human right approach to HIV and AIDS that the person with the infection should be able to decide how and when to tell other people about it. Advice from all types of HIV organisations has consistently emphasised the need to consider any disclosure of HIV positive status carefully, to do so only when appropriate and when the person with HIV feels fully prepared or supported. However, the last year has seen a number of successful prosecutions brought against people with HIV in England for infecting their sexual partners with the virus. The most high profile of these cases has involved a successful appeal against the conviction and the granting of a retrial. This briefing hopes to look at some of the issues raised by these events and to examine their implications both for people with HIV and for the health professionals who come into contact with them.

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### **What does the law now say about HIV transmission?**

HIV transmission has been occurring in the UK for over 20 years but it is only in the last year that there have been any prosecutions for it in England and Wales. In Scotland, a man was convicted in 2001 for 'recklessly injuring' his female partner by passing on the virus to her. In England the prosecutions have all been brought under the Offences Against the Person Act of 1861 (OAPA) and all convictions have been under section 20 of that Act, recklessly causing grievous bodily harm (GBH). So far, none of the cases have resulted in a conviction under section 18 of the Act, the more serious charge of causing GBH with intent.

The Dica case of October 2003 resulted in a prison sentence of eight years but this was overturned on appeal in March 2004. The judge in the original trial had instructed the jury to ignore the issue of consent, on the grounds that he believed it to be impossible to consent to infection with a disease, but the Appeal Court judges determined that this was wrong in law. This new judgement has had three effects; firstly it has separated the consent of a partner to sex from consent to any risk that the sex might entail; secondly it allows consent to risk of transmission to be a defence against section 20 of the OAPA (recklessly causing GBH); and thirdly it places the burden of responsibility squarely on the person with HIV to disclose their status

before sex occurs. It would appear then that the courts now believe that if someone knows they are HIV positive, is aware of the risk of onward transmission and has unprotected sex without disclosing their status, they are potentially open to prosecution for recklessly causing grievous bodily harm.

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### **Questions, questions, questions...**

One of the other cases, that of Kousaai Adaye, is unique in that Mr Adaye was convicted without having had a positive HIV diagnosis at the time of the incident at which transmission occurred. The prosecution was able to prove that Mr Adaye's wife in Africa has told him that she was HIV positive, and the Court found that this was sufficient grounds for him to have known he was also HIV positive, and therefore to have informed his subsequent sex partners. This creates a very wide spectrum of conditions under which someone is expected to know they are HIV positive.

Also, none of the cases has provided any clarity on what knowledge is required to establish consent to the risk of HIV transmission. For instance, does the positive partner have to have made an explicit disclosure of status, or does membership of a high risk group suffice for their partner to evaluate a risk? Does a large number of previous sexual partners count as an indicator, or does consent to unprotected sex imply consent to any concomitant risk? There is also the issue of condom failure or oral sex risk. Where transmission occurs in those circumstances, could the defendant be accused of the same level of recklessness?

Should HIV be the only sexually transmitted infection covered by the OAPA? Hepatitis C can also be fatal, and chlamydia can render women infertile; surely infection with these diseases constitutes GBH? As the law stands it would be possible to prosecute your partner for transmission of either of these, so why is HIV being singled out?

These questions should be clarified by the Government in such a way as to uphold the human rights of people with HIV while protecting others from the small but real risk of deliberate intentional transmission of a serious disease.

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### **What does the Government say?**

In 1998, the Government's consultation paper, *Violence: reforming the Offences Against the Person Act*, concluded that the 140-year old act gives the Police and the judiciary enough powers to secure convictions in cases of intentional transmission of HIV and that:

*'The Government therefore proposes that the criminal law should apply only to those whom it can be proved beyond reasonable doubt had deliberately transmitted a disease intending to cause a serious illness... ..This aims to strike a sensible balance between allowing very serious intentional acts to be punished whilst not rendering individuals liable for prosecution of unintentional or reckless acts'.*

The sense of 'intentional' here is meant to apply to a situation such as one where a person uses a syringe filled with HIV infected blood as a weapon, and

clearly not to the situations described in the three English prosecutions. However, it should be noted that in two of the three cases the original charge was one of GBH with intent on the grounds that both defendants had lied about their HIV status to their partners. Intent, however, could not be directly inferred from this, but the obtaining of consent by fraudulent means muddied the waters in both these cases and it is noteworthy that the application of section 18 of the OAPA in these cases was at the initiative of the Police and the Crown Prosecution Service. In Mr Dica's case, much of the media reporting focussed on his alleged status as an asylum seeker when in fact he was a refugee and had successfully applied for leave to remain in the UK on that basis. It was alleged that he had also lied about his intention to marry one of the women, and about having had a vasectomy to the other. This added to the weight to the argument that he had intended to deceive the women and in turn this intent to deceive was conflated with an intent to infect when there was in fact no evidence to support that claim.

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## **Public Health Implications**

Using criminal law to try to control sexual HIV transmission clearly has implications for public health policy and the spread of HIV in the UK. There appear to have been no discussions between the CPS and the HIV sector before these prosecutions, and to date there has been no statement either from the CPS or from Government on how this prosecution policy impacts on the objectives of the National Strategy for Sexual Health and HIV.

At a session of the CHAPS Conference in Liverpool in March 2004, a presentation was given by legal and health promotion experts which concluded that the possible negative outcomes of such a law are that it would:

- ◆ exacerbate the stigma around HIV;
- ◆ ignore the complex social context of disclosure and denial;
- ◆ be a disincentive to test and hinder access to services;
- ◆ undermine the notion that people with HIV are not solely responsible for HIV prevention and thus create a false sense of security among those who are at risk of infection and the undiagnosed, as people will inevitably assume that fear of prosecution will deter people with HIV from having unprotected sex;
- ◆ undermine health promotion efforts to increase safer sex practices, HIV testing and related service uptake, and decrease stigma, all of which form part of the Government's National Strategy for Sexual Health and HIV;
- ◆ possibly provide an incentive for 'revenge prosecutions' in the case of broken relationships where one partner had infected the other;
- ◆ cause panic and confusion among all sections of the community, but especially migrants;
- ◆ and lastly contradict the findings of the Government's 1998 consultation.

In general terms, it is highly likely that this kind of prosecution would contribute to an increase in HIV related stigma and thus put many people off testing. In all three cases it is clear that the courts had little understanding of or sympathy for the difficulties faced by people with HIV in disclosing their positive status to others. HIV related stigma and discrimination make disclosure difficult at the best of times, however, in communities or contexts where discrimination and even violence against people with HIV are commonplace, disclosure may be extremely problematic and even dangerous. Furthermore, there is no guarantee that a disclosure of HIV positive status will remain only with the sexual partner. If it becomes generally known in a community, this could have serious implications for that person's relationships, employment and personal safety.

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### **What does this mean for professionals?**

The confusion, and in some cases panic, that has accompanied these prosecutions has left many people with HIV from all affected communities under the impression that the prosecutions have created a duty to disclose. This is not actually the case, as a new law would be required to do so. However, the ruling of the Appeal Court in the Dica case has set the precedent that the best available defence would be to establish consent to risk of transmission and it seems obvious that disclosure of positive HIV status is the strategy most likely to facilitate that..

The implications for clinicians regarding the confidentiality of discussions are clear, and it is worth taking time to consider what, if any, of the content of any conversations with people with HIV needs to be recorded or kept on file. Also, how records are kept and how they attach to patients' notes might need to be re-evaluated in the light of the Courts' desire to subpoena this information when pursuing a prosecution. Health professionals might therefore like to consider providing people with HIV the opportunity to discuss their concerns about disclosure in a confidential (or even anonymous) context rather than a clinical setting where they may have concerns about notes. Services such as the EHH Gay Men's Project's sexual health advice line (see previous briefing sheet), local Youth Projects, PACE, Naz, THT Direct and the West London Living Well Project are all possible points of referral which may prove useful.

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For further information on Professional Briefings from the EHH Gay Men's Project, contact:  
Russell Fleet  
c/o WLCC  
137A Coningham Road  
LONDON  
W12 8BU  
Phone: 020 8749 8429  
Fax: 020 8743 8366  
Email: russellfleet@btclick.com

#### **Sources:**

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**PLEASE PHOTOCOPY AND PASS ON AS NECESSARY**