High Income Countries Issue Brief:

LAWS AND PRACTICES RELATING TO CRIMINALISATION OF PEOPLE LIVING WITH HIV AND POPULATIONS VULNERABLE TO HIV

For the High Income Countries Dialogue of the Global Commission on HIV and the Law

17 September 2011
Oakland (CA), USA
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High Income Countries
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Prepared for the High-Income Countries Dialogue of the Global Commission on HIV and the Law

Oakland (CA), United States of America, 17 September 2011
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Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ART  Anti-retroviral treatment
CEDAW  Convention on the Elimination of all forms of Discrimination Against Women
CDC  Center for Disease Control and Prevention
DCR  Drug Consumption Room
DTC  Drug Treatment Court
ECDC  European Centre for Disease Prevention and Control
EEA  European Economic Area
EFTA  European Free Trade Association
EU  European Union
GNP+  Global Network of People Living with HIV
HIV  Human Immunodeficiency Virus
IP  Intellectual Property
LGBT  Lesbian, Gay, Bisexual and Transgender
MSM  Men who have sex with men
NSP  Needle and Syringe Programmes
OHCHR  Office of the High Commissioner for Human Rights
OST  Opioid Substitution Therapy
STI  Sexually Transmitted Infections
SVM  Syringe Vending Machines
UK  United Kingdom
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV and AIDS
UNODC  United Nations Office and Drugs and Crime
WHO  World Health Organisation

Countries Included in the High-Income Dialogue:

Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Iceland, Israel, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, and United States of America (USA/ US).
1. Introduction

In response to the complex health and social issues raised by HIV and its transmission, States have relied on a balance between criminal law, public health law and other laws to protect society and promote the health of individuals and communities. Criminal law protects society from intentional, negligent or reckless behaviours that put people and economic interests either at risk of harm or that actually result in harm. It achieves this through incarceration and rehabilitation of those convicted of criminal offences, and through deterrence of criminal behaviour. Law and its enforcement plays a role with respect to the broader social determinants of health that impact HIV and may have both intended and unintended consequences with respect to public health objectives to mitigate the impact of HIV.\(^1\) Criminal and public health laws may seek to protect people and communities and further promote their health; or may have unintended consequences that undermine public health objectives such as prevention, treatment, care and support for all populations, including marginalised populations.

Many high-income countries have been working on the development of their HIV-response longer than countries in other regions of the world. Also, they are thought to have better developed comprehensive legal and police frameworks, which take into account the human rights of citizens and legal aliens. However, despite the highly developed legislative and policy framework related to HIV and AIDS in high-income countries, there are still a number of laws and policies that hinder successful HIV responses in high-income countries.\(^2\) There is a lack of protective laws that guarantee freedom from discrimination and provide effective protection of the human rights of key populations at higher risk such as men who have sex with men (MSM), transgender people, sex workers, people who use drugs and prisoners. Furthermore, there are reports of human rights violations, persistent stigma and discrimination against people living with HIV and key populations at higher risk. There is evidence that, as in other regions of the

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\(^2\) Out of 49 European and Central Asian countries which annually report on the implementation of the Dublin Declaration on HIV and AIDS, more than half (54\%) reported having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations (most commonly affected by these obstacles are people who inject drugs, prisoners and migrants).
world, HIV is driven by stigma and discrimination, and is spread predominantly among the poor, the marginalised, and the vulnerable. This brief therefore pays specific attention to the law enforcement aspects of the legal and policy framework. It will also devote attention to examples of good practices which take into account individual human rights and the broader public health perspective in order to achieve effective HIV responses and eliminate HIV-related discrimination and stigma.

This paper concentrates on the most significant challenges to an effective HIV response in high-income countries. As the data below shows, some populations are at a significantly higher risk of acquiring HIV than the general population. People who use drugs, MSM, transgender people, sex workers, people in prisons and migrants are among those who are most seriously affected by HIV in the high income countries. There is also evidence that Europe and North America have become the world leaders in criminalising people living with HIV through imposing criminal and other sanctions for HIV non-disclosure, exposure and transmission. As with key populations at higher risk, evidence shows that criminalisation of HIV exposure and transmission has a devastating effect on the lives of people involved and on the public health goals such as prevention, treatment and care related to HIV.
Structure, Methodology and Limitations

The Issue Brief is based on a desk review of literature, United Nations (UN) and other international organisations’ policy briefs, reports and analytical papers, analyses of selected statutes, judicial precedents and law enforcement practices. The study does not aim to provide a comprehensive overview of the legislation, policies and enforcement practices in all research countries. Rather, the aim of the report is to provide examples of positive and negative legal regulations, policies and enforcement practices, which serve as illustrations of supportive or punitive legal environments, and point out challenges faced by high income countries in relation to HIV, the law and human rights. A short explanation of why certain policies may be harmful to individual human rights and public health goals is provided, as well as links to international standards.

This Issue Brief explores the interconnection of an effective HIV response and the application of criminal law to people living with HIV and key populations at higher risk; and its impact on human rights and public health in high income countries. Each section of the brief presents the overview of criminal law and enforcement practices, analyses its public health impact and concludes with examples of good practices and law reform possibilities. After the background information provided in the first section of this brief, the second section examines the application of criminal law to HIV non-disclosure, exposure or transmission, principally in the context of sexual relations. The third section examines the use of public health law as an adjunct or alternative to address HIV non-disclosure prior to sex that results in HIV exposure or transmission. The fourth section examines the criminal law in relation to gay men, MSM, and transgender people, and laws that are intended to promote the equality of and prevent discrimination against these groups. The fifth section examines the criminal law in relation to sex work and sex workers. The sixth section examines the use of criminal law to regulate the use and possession of illicit drugs, the legal regulation of harm reduction programmes, and the impact on people who use drugs. The seventh section briefly explores the situation of law (criminal and other) and enforcement practices related to migrants, immigrants and people in prisons. In each section good practices in legislation, policy/guidance and practice/programming will be identified.
2. Background Information

Unprotected sex between men continues to be the main mode of HIV transmission in North America and Western Europe, where there is evidence of a resurgent HIV epidemic. Data from 23 European countries show that the annual number of HIV diagnoses among MSM rose by 86% between 2000 and 2006. The 3160 new HIV diagnoses among MSM in 2007 in the United Kingdom were the most ever reported up to that point. Similar significant increases appear in new HIV diagnoses between 2000 and 2005 among MSM in Canada, Germany, the Netherlands, Spain, and the USA. In the USA, new HIV infections attributed to unprotected sex between men increased by more than 50% from 1991–1993 to 2003–2006. In France, MSM account for more than half the men newly diagnosed with HIV, yet they represent only 1.6% of the country’s population. This means that men outnumber women among people living with HIV. In 2009, women comprised about 26% of the people living with HIV in North America and 29% in Western and Central Europe.

Injecting drug use and unprotected paid sex however also feature (especially in parts of southern Europe). The HIV epidemics are disproportionately concentrated in racial and ethnic minorities in some countries. In the USA, for example, African-Americans constitute 12% of the population but accounted for 45% of the people newly infected with HIV in 2006. African-American males are 6.5 times and African-American females 19 times more likely to acquire HIV compared with their Caucasian counterparts. In Canada in the mid-2000s, aboriginal people comprised 3.8% of the population but accounted for 8% of the cumulative people living with HIV and 13% of the people newly infected annually. Immigrants living with HIV have become a growing feature of the epidemics in several countries in Europe.

Two thirds (66%) of newly infected people inject drugs. Rates of new infections among people who inject drugs however have been falling overall, in Europe and North America, allegedly due to effective implementation of harm reduction services.

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4 This trend is associated with increases in higher-risk sexual behaviour. Researchers in Catalonia (Spain), have reported that one third (32%) of MSM had recently had unprotected anal sex with a casual partner, and surveys in Denmark and Amsterdam (the Netherlands) have reported similar findings. Ibid.
6 Ibid.
7 European Centre for Disease Prevention and control, Migrant Health (2011), HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA Member states, Technical report, ECDC.
8 Ibid.
9 Ibid.
3. Application of Criminal Law to HIV Non-Disclosure, Exposure & Transmission

The application of the criminal law to address HIV non-disclosure, exposure and transmission has been a global legislative and policy concern.10 A 2007 World Bank publication supporting legal and policy reform in relation to HIV summarised the key legal and policy issues implicated by the application of the criminal law in certain circumstances to sexual relations of people living with HIV:

Laws and policies that criminalize negligent or willful exposure seek to deter individuals whose actions lead to exposure of others to HIV and potential transmission. The legal ramifications of exposing an uninfected individual to HIV differ depending on (a) intent; and (b) whether transmission of HIV occurs, although each element can be difficult to prove legally or epidemiologically. Intent is tied to the type and severity of the offense and punishment. The intentional exposure of another to a communicable disease is deemed a crime in most jurisdictions under general criminal law (e.g., manslaughter, assault and battery, reckless endangerment, or attempts of each of these crimes).11

There has been a documented increase in the number of prosecutions and case law involving people living with HIV in high-income countries in the past decade.12 People living with HIV have been prosecuted and convicted under HIV-specific laws or under criminal laws of general application, principally in the context of sexual relations. In federal jurisdictions the law may be different in different states/provinces/territories/cantons. In general, across countries, criminal laws have been applied in three circumstances: (1) HIV non-disclosure followed by a sexual act that results in HIV transmission to a sex partner; (2) HIV non-disclosure followed by a sexual act that puts the sex partner at risk of HIV transmission; and (3) sexual acts that result in HIV

10 The Global Network of People Living with HIV (GNP+) (2010), The Global Criminalisation Scan Report 2010: Documenting trends, presenting evidence. As noted in Bernard EJ (2010), HIV & the Criminal Law, London: NAM/AIDSMAP: “Given the lack of formal mechanisms to identify, report and record HIV-related prosecutions, it is not possible to definitively determine the true number of arrests and prosecutions – or even HIV-specific criminal laws – for every country in the world.”
transmission or a risk of HIV transmission, regardless of HIV disclosure. Some laws require intent to transmit or expose another person to HIV; others do not.

Law enforcement: High-income countries lead the world in the number of criminal prosecutions related to HIV transmission and exposure. There have been many prosecutions for HIV-related exposure and transmission in Europe and in the USA, in countries with and without HIV-specific laws. Of the European countries that provided data to the Global Criminalisation Scan, Sweden has the most prosecutions (at 53 cases) and has also undertaken the most cases in the world per capita of people living with HIV. At least 40 people with HIV in Austria have been prosecuted, and at least 30 convicted. There have been at least 18 prosecutions in Denmark: at least ten involved non-Danish nationals, including seven people of African origin; at least eleven convictions for either sexual HIV exposure or transmission are reported. In England and Wales, there have been 13 prosecutions, all under section 18, resulting in 11 convictions (see below). It has been asserted that many more people have been investigated or arrested. 13 In Finland there have been at least 12 prosecutions and seven convictions. In Norway, at least 14 individuals have been prosecuted, all for heterosexual sex, and all prosecutions have resulted in convictions. Although in numerous countries, epidemiological data indicates most HIV transmission is between men, cases involving heterosexual exposure and transmission are over-represented in criminal prosecutions. 14 Similarly, in numerous countries (for example, Denmark, Norway and the United Kingdom - UK), men of African descent are over-represented as defendants (the accused). 15

According to the Global Network of People Living with HIV’s (GNP+) Global Criminalisation survey, Canada and the USA have convicted more people for HIV transmission or exposure than all other countries in the world put together. Canada has generally applied national assault and sexual assault laws against cases of HIV exposure and transmission. The application of those laws is based on a Supreme Court ruling that failure to disclose HIV-positive status prior to sex violates consent to anal or vaginal sexual relations. Other criminal laws have also been applied, including the recent successful application of a murder charge. There have been 96 prosecutions in Canada.

In the USA, more than 400 people have been prosecuted for HIV exposure or transmission. At least 300 of these have resulted in convictions. Prosecutions have taken place in at least 39

14 According to GNP+, a significantly disproportionate number of prosecutions in high-income countries (including the UK and Canada) have been of heterosexual migrant men. The suggested reasons may include “heterosexual populations’ failure to adopt the ‘mutual responsibility’ ethos embedded in safer sex messages, the tendency for women to more readily identify as victims in heterosexual relations, and men’s propensity to manipulate heterosexist power dynamics in their interests. It also seems likely that complex cultural factors, xenophobia, and class and race based assumptions have impacted how those individuals come to be charged and the ways their cases are conducted”, GNP+ (2010), Global Criminalisation Scan, at 32.
15 Ibid. at 16-18.
states. 24 states have HIV-specific laws. Additionally, in the USA, many prosecuted cases involve behaviours that include little or no transmission risk: a large number of cases have resulted in conviction and weighty sentencing for spitting and biting despite scientific evidence that such behaviour cannot transmit HIV.\(^\text{16}\)

Prosecutions for vertical HIV transmission are rare.\(^\text{17}\) Charges are known to have been brought in Sweden, the USA and Canada against women who did not disclose their HIV status or take anti-retroviral treatment (ART) when instructed, and who consequently transmitted HIV to their child.\(^\text{18}\)

### 3.1 Laws and Law Enforcement in European Countries\(^\text{19,20}\)

In the majority of analysed countries existing laws relating to grievous bodily harm are being used to prosecute HIV exposure and transmission: in Austria, existing laws that make it a crime to intentionally or negligently “commit an act likely to cause the danger of spreading a transmissible disease”. Disclosure of HIV-positive status prior to sex is not a defence.

Prosecution in Austria was first reported in 1990 under existing laws that make it a crime to intentionally or negligently “commit an act likely to cause the danger of spreading a transmissible disease”. Disclosure of HIV-positive status prior to sex is not a defence. At least 40 people with HIV have been prosecuted, and at least 30 convicted.

The first prosecution in Denmark was in 1993. Subsequently, the Supreme Court found in 1994 that the existing law under section 252 of the criminal law (“wantonly or recklessly endangering life or physical ability”) did not provide a clear legal base for conviction. The phrase “fatal and incurable disease” was added in 1994, and HIV was specified in 2001. There have been at least 18 prosecutions: at least ten involved non-Danish nationals, including seven people of African origin; at least eleven convictions for either sexual HIV exposure or transmission are reported.

Prosecutions in the England and Wales take place under existing assault laws. Two sections of the Offences Against the Person Act 1861, relating to “grievous bodily harm”, have been used

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\(^{16}\) Lazzarini et al found that 23% of US cases that had passed through the courts before 2001 were for spitting, biting, scratching or throwing body fluids. As a result of the ‘three strikes’ law, one HIV-positive man was sentenced to 35 years imprisonment for spitting at a police officer.

\(^{17}\) GNP+ (2009).

\(^{18}\) GNP+ (2010), *Global Criminalisation Scan* at 16-18.

\(^{19}\) The information in this section is drawn, with permission, principally from Bernard EJ (2010), *HIV & the Criminal Law*, NAM/AIDS MAP, in addition to comments on a first draft provided by Edwin J Bernard, on file with the Commission Secretariat.

\(^{20}\) Appendix A provides in table format an overview of the criminal law and its application (prosecutions and convictions) in European countries included in this Issue Brief.
to prosecute HIV transmission: section 18, “intentional transmission” and section 20, “reckless transmission”. A charge of “attempted intentional transmission” is also legally possible. There have been 13 prosecutions, all under section 18, resulting in 11 convictions. It has been asserted that many more people have been investigated or arrested. There have been no prosecutions in Northern Ireland.

The first prosecution in Finland was in 1989. Both HIV exposure and transmission are prosecutable under existing assault or homicide laws. There have been at least 12 prosecutions and seven convictions.

The first prosecution in Italy was reported in 1999, based on existing public health, assault, sexual assault and homicide laws. Judgments have established that non-disclosure before unprotected sex is considered a dolus eventualis, more or less equivalent to the standard of culpability characterised as “recklessness” in common law systems. Data are difficult to confirm, but there have been at least ten prosecutions and convictions, all but one for heterosexual sex, and all but one involving Italian nationals. Possibly the world’s first-ever homicide conviction for sexual HIV transmission took place in Italy in 2000, when an Italian man was found guilty of culpable homicide and sentenced to 14 years in prison for infecting his wife, who subsequently died.

The first prosecution in Norway was in 1991, under section 155 of the Norwegian Penal Code. Enacted in 1902, section 155 has only been used to prosecute sexual HIV exposure or transmission. The law essentially criminalises all unprotected sex by HIV-positive individuals even if their partner has been informed of their status and consents. At least 14 individuals have been prosecuted, all for heterosexual sex, and all prosecutions have resulted in convictions.

The first prosecution in Sweden took place in 1992. There have been least 50 prosecutions and 38 convictions since the first prosecution took place in 1992. These numbers suggest that Sweden leads the world in per capita prosecutions. In addition to the criminal law, Swedish public health laws require all HIV-positive individuals to disclose their status to sexual partners and to practice safer sex.

The first prosecution in Scotland took place in 2001, under the Scottish common law offence of “culpable and reckless conduct”. Since then, the reckless transmission of HIV alone, as well as HIV and hepatitis C together, has been prosecuted under this law, with a total of four prosecutions and three convictions. Prosecutions have been conducted in cases of exposure.

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The use of a condom in the absence of disclosure would be a defence even if transmission subsequently occurred.22

France’s Senate proposed an HIV-specific law in 1991, criminalising HIV transmission without disclosure, but the National Assembly deleted the amendment. The first criminal HIV-transmission cases were prosecuted in 1996 under existing “administration of dangerous substances” and bodily harm laws. Case law has now established that sexual fluids are not poisons, so the anti-poisoning law is no longer applied. Although HIV exposure without disclosure may also be subject to criminal sanctions, most of the 16 convictions have been for transmission without disclosure under the law criminalising “administering a harmful substance causing disability or permanent disability” (French Penal Code, Articles 222-15 and 223-1).

The first prosecutions in Germany took place in the state of Bavaria, in the former West Germany, under bodily injury and aggravated assault laws (German Penal Code, Articles 223 and 224), following a Federal Supreme Court decision in 1988 that unprotected sex without disclosure was attempted bodily injury. Since then, across Germany there have been at least 20 prosecutions and 15 convictions. The majority prosecutions have been brought against men.

The Netherlands first initiated prosecutions in 1989 under existing homicide and assault laws. Following two convictions, there was a gap of eleven years before a further 13 prosecutions with 12 convictions took place in the space of five years. In 2005, a Supreme Court ruling closely examined scientific evidence of sexual transmission risk and found that the per-act risk of unprotected sex did not create a “considerable chance” of transmission. This ruling substantially narrowed the scope of the law23 and as a result only intentional HIV exposure or transmission is now deemed a crime.24 In its 2005 ruling, the Supreme Court also suggested that if the state wanted to continue to prosecute reckless HIV exposure and transmission a new law would need to be created. A report25 on the role and impact of criminal law in addressing the HIV epidemic, produced by a collaboration of legislators, lawyers and civil society, recommended that the government focus on prevention rather than prosecution.26 Since 2005 there has been one prosecution in a case involving rape and forcible injection with HIV-infected blood.27

23 “AA” Case, Supreme Court of the Netherlands, 18 January 2005, Criminal Section No 02659/03 IV/SB.
25 Executive Committee on AIDS Policy & Criminal Law (2004), Detention or prevention? A report on the impact of the use of criminal law on public health and the position of people living with HIV.
Prosecutions in Switzerland have been based on non-HIV-specific laws to address HIV exposure or transmission. There have been 39 prosecutions and 26 convictions since 1989. Article 231 of the Swiss Criminal Code allows for prosecution for HIV exposure or transmission of anyone who attempts to, or in fact “deliberately spreads a dangerous transmissible human disease”. Disclosure of HIV-positive status or consent to unprotected sex does not negate the offence. A 2009 study from the Swiss National Science Foundation and the Swiss AIDS Federation, examining every criminal prosecution since 1989, found eight convictions under Article 231 for HIV exposure following disclosure and full consent of the HIV-negative partner. Prosecutions have also been brought under Article 122 of the Code, which treats unprotected sex without disclosure as “grievous bodily harm”; disclosure or consent to sex with a known HIV-positive person can be raised as a defence. Prison sentences for convictions based on HIV exposure have ranged between a twelve-month suspended sentences to two years imprisonment. Prison sentences for convictions based on HIV transmission have been for up to four years, plus a fine of up to 80,000 Swiss Francs.

There were two significant Swiss case law developments since 2008. In July 2008, Switzerland’s highest court ruled that a man who was unaware of his infection when he had unprotected sex that resulted in HIV transmission was still criminally liable under both Articles 122 and 231 of the Swiss Criminal Code. In February 2009, the Geneva Court of Justice quashed the conviction based on expert evidence that the risk of HIV transmission during unprotected sex from a person undergoing successful ART is so low that it is only hypothetical.

3.2 Laws and Law Enforcement in Canada and the USA

In Canada there is no specific offence in the Criminal Code that targets the transmission of sexually transmitted infections (STI) (including HIV). Existing offences may be charged where the elements of the offence are established. In Canada, police and prosecutors have relied on a variety of existing Criminal Code offences to prosecute alleged HIV non-disclosure to sexual partners, including common nuisance, assault, sexual assault, aggravated assault and aggravated sexual assault, murder, attempted murder, criminal negligence causing bodily harm, and administration of a noxious thing. The first prosecution of HIV non-disclosure was

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28 Pärli K, Payot PM (2009), Strafrechtlicher Umgang bei HIV/Aids in der Schweiz im Lichte der Anliegen der HIV/Aids-Prävention: Status quo, Reflexion, Folgerungen, Bern, Switzerland, Swiss National Science Foundation (English summary).
31 Within the elements of the offenses, sexual assault is a possible charge and the courts would focus on the vitiation of consent due to non-disclosure and that sexual activity without consent is a sexual assault. The police or Crown charge in accordance with the conduct those offences address.
reported in 1989. The leading case of Canada’s highest court, the Supreme Court of Canada, established that an HIV-positive person who knows his or her HIV status and does not disclose that information prior to engaging in sex that carries a “significant risk” of transmitting HIV can be charged with aggravated assault. The Supreme Court has also upheld a conviction under the offence of common nuisance. Lower courts have yet to clearly define what sex acts under what circumstances, carry a legally “significant risk” of HIV transmission. Canadian courts have stated that the “significant risk” test needs to be applied on a case-by-case basis, taking into account the particular circumstances of the case (i.e., gender of the partners; sexual role; type of sex involved, viral load of the HIV-positive partner; presence of absence of other STIs; use of condoms).

The legal environment of criminalisation of HIV related to sex in the USA is complex. Enforcement of criminal laws in the USA has traditionally been a matter handled by the states. All 50 states and the District of Columbia have their own penal codes, although Congress has used its jurisdiction to enact criminal law. In many states, people living with HIV have been or are susceptible to criminal sanctions for HIV non-disclosure, exposure or transmission. Some states have relied upon general criminal laws and offences such as reckless endangerment, assault, terroristic threats, homicide and attempted homicide. Many states have “communicable” or “contagious disease” control statutes that criminalise STI exposure, which can include HIV while other states have HIV-specific criminal laws. Thirty-four US states and two US territories explicitly criminalise HIV exposure through sex, shared needles or, in some states, exposure to “bodily fluids” that can include saliva. In addition, US military personnel have been prosecuted under the federal *Uniform Code of Military Justice*. Some states mandate disclosure prior to almost any type of sexual contact (Arkansas, Michigan, New Jersey, and Ohio). In contrast, California’s law criminalises undisclosed exposure to HIV only when the HIV-positive person engages in unprotected anal or vaginal sex with an

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32 Unless otherwise indicated, the information in this paragraph is from Mykhalovskiy E et al (2010), *HIV non-disclosure and the criminal law*. For background on the criminalisation of HIV in Canada, see generally the documents available from the Canadian HIV/AIDS Legal Network, available online via www.aidslaw.ca/criminal.

33 *R v Williams* 2003 SCC 41.


35 Uniform Code of Military Justice, 10 USC Chapter 47, article 128 (assault).

uninformed partner and does so intending to infect the partner. Proof of intent to transmit HIV, or actual transmission, typically are not elements of these prosecutions. Finally, HIV is as an aggravating factor under federal sentencing guidelines.

There is no single, recent, comprehensive analysis of criminal prosecutions in USA, although compendiums of laws and decided cases have been published. Analyses based on the case law have asserted that:

- Many state laws, and their enforcement, have been “overbroad” resulting in convictions where there was no scientific basis to conclude that there was a risk of transmission or endangerment.

- By defining prohibited conduct in terms of HIV-status and activity, individuals are prevented from demonstrating that their conduct was not sufficiently risky to merit criminalisation, and the laws are thus over-inclusive.

- Testimony of defendants with HIV is often discounted, particularly in cases where the “morally innocent” sexual partners whose trust has allegedly been betrayed by the nondisclosure of HIV status by a sexual partner.

- Prosecutions under HIV-specific statutes are particularly prone to targeting marginalised groups and reflecting jury prejudices.

### 3.3 Public Health Impact

The efficacy of the application of criminal law specific to HIV non-disclosure, exposure and transmission as a means to reduce the public and individual health risks of HIV transmission has been subject to debate, characterised primarily as “a moral and ethical one, with few data to back up either side”. There is limited evidence, and very limited empirical evidence, of the

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38 Ibid.


41 Ibid.

42 Ibid.

The research literature related to the use of the criminal law in relation to the sexual non-disclosure, exposure and transmission of HIV has recently been reviewed and summarised.

- In a comparison of two US States, disclosure and sexual behaviour were not influenced by existence or knowledge of the law criminalising HIV exposure/transmission, leading the authors to conclude that the criminal law does not appear to make people living with HIV change their behaviour, primarily because they already believed that HIV-status disclosure and safer sex were morally and ethically correct.
- In a US state with an HIV-specific criminal law that requires disclosure, despite high awareness of the law and understanding of the obligation, knowledge of the law did not appear to have an impact on HIV-related sexual risk taking.
- There are no studies regarding the effectiveness of incapacitation on reducing HIV transmission, or regarding the effectiveness of rehabilitation on reducing HIV transmission.
- There are few studies assessing the human rights impact of criminalisation; much of the evidence provided is necessarily anecdotal.
- There is no data suggesting that people are inclined to delay or avoid testing specifically due to fear of criminal or other legal consequences.


Bernard EJ (2010), HIV & the Criminal Law, NAM/AIDSMAP.


Bernard EJ (2010), HIV & the Criminal Law, NAM/AIDSMAP.

Ibid. WHO Europe is undertaking a project involving a pilot human rights audit of HIV-related criminalisation in five jurisdictions (England and Wales, Hungary, the Netherlands, Sweden and Switzerland) with a view to expanding the audit throughout all Council of Europe member states.

• Laws criminalising HIV exposure/transmission are not widely known or understood, even by communities of gay men, some of whom are HIV-positive.\(^{51}\)
• Among gay men who were aware of the law, some were more likely to disclose, some were less likely, because of the law.\(^{52}\)
• HIV-positive individuals report a reluctance to participate in studies where they disclose their sexual behaviour because of fears about the possibility that what they disclose could be used against them in criminal prosecutions.\(^{53}\)

There is limited research on the impact of criminalisation on the behaviour of people living with HIV, or the influence of criminalisation of HIV on service provider-client relationships. To date, research in this area has investigated the relationships between people living with HIV and service providers in the context of the criminal law related to HIV in the province of Ontario, Canada. In particular, one study examined the legal standard of “significant risk” that governs the application of the law of assault in circumstances of HIV non-disclosure in Canada. The qualitative research involved individual and focus group interviews with people living with HIV as well as individual interviews with service providers, including physicians, HIV clinic staff, public health nurses and officials, lawyers and front-line AIDS service workers noted the following:\(^{54}\)

• the concept of significant risk raises issues about risk communication in HIV counselling and can contribute to contradictory advice about disclosure obligations provided to people living with HIV by service providers;
• criminalisation may discourage openness by people living with HIV about HIV non-disclosure in counselling relationships;
• public health authorities’ interpretation of the significant risk disclosure obligation as requiring disclosure in all sexual circumstances regardless of the risk of HIV transmission, may influence

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the legal standard applicable in criminal prosecutions and whereby possibly influencing the criminal liability of people living with HIV.

3.4 Spitting, Biting and Scratching, and Vertical Exposure/Transmission

In Canada and the USA, an estimated quarter of prosecutions were for spitting, biting or scratching, with a few involving criminal complaints where a police officer or a corrections worker has been bitten or spit upon. Spitting, scratching and biting can constitute criminal offences regardless of the HIV status of the accused; in the USA, some states have enacted criminal sanctions specific to spitting and biting by an HIV-positive person. However, concern has been expressed that the HIV status of the accused has been used to justify more serious criminal charges, vigorous prosecution, and long sentences of incarceration, which are further argued not to be supported by evidence indicating risk of HIV transmission. For example, the US CDC has concluded that there exists only a “remote” possibility that HIV could be transmitted through a bite and such transmission would have to involve various aggravating factors including “severe trauma, extensive tissue damage, and the presence of blood.”

The extent of criminalisation of vertical exposure/transmission is unknown. There are a small number of reported criminal prosecutions of HIV-positive mothers in Europe, Canada and the USA for exposure/transmission to children, either during pregnancy or birth, or via breastfeeding. In addition, information has been reported about two cases for father-to-child transmission.

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55 For an analysis of US cases, see Bray SJ (2003), Criminal Prosecution for HIV Exposure: Overview and Analysis, Working Paper 3(1), New Haven: Connecticut: Yale University Center for Interdisciplinary Research on AIDS, which estimated that roughly 25% of prosecutions were for spiting, biting or other activities. See also Bennett-Carlson R et al (2010), Ending & Defending Against HIV Criminalization: A Manual for Advocates Vol 1, 1st ed. New York, New York, Positive Justice Project, Center for HIV Law & Policy.


57 For a summary of the situation in Canada, see Canadian HIV/AIDS Legal Network (2011), Does Criminalizing HIV Non-disclosure Make Sense? Criminal Law and HIV Infosheet 3, www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1887. For a discussion of such cases in the USA, see Bennett-Carlson R et al (2010), Ending & Defending Against HIV Criminalization: A Manual for Advocates Vol 1, 1st ed. New York, New York, Positive Justice Project, Center for HIV Law & Policy; and The White House Office of National AIDS Policy (2010), National HIV/AIDS Strategy for the United States, which states at page 36, citing CDC information: “Some criminalize behavior like spitting and biting by people with HIV, and were initially enacted at a time when there was less knowledge about HIV’s transmissibility. Since it is now clear that spitting and biting do not pose significant risks for HIV transmission, many believe that it is unfair to single out people with HIV for engaging in these behaviors and should be dealt with in a consistent manner without consideration of HIV status.”


59 See for example Gluck F (2010), Mother who gave HIV to newborn gets probation. Herald Tribune (Sarasota), 2 October 2008; AIDS-Denying Mother Sentenced. The Austrian Independent, 7 July 2010. See also Csete J et al (2009), Vertical HIV transmission should be excluded from criminal prosecution Reproductive Health Matters
transmission. In France, a man was found guilty of "transmission of a harmful substance causing permanent disability" involving HIV transmission to two women and the child he fathered with one of the women. In the USA, a Colorado man was charged with child abuse resulting in serious injury. It is alleged that he infected his fiancée with HIV after she had tested HIV-negative in her first trimester, and the fiancée then unknowingly passed the virus on to her newborn.

3.5 Good Practice and Law Reform

Guideline 4 of International Guidelines on HIV/AIDS and Human Rights calls on States to “review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.” The commentary to Guideline 4 counsels against “specific offences against the deliberate and intentional transmission of HIV” in favour of applying “general criminal offences to these exceptional cases.” The commentary continues, “Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.

UNAIDS policy guidance published in 2008 recommends, among other things:

- Repeal HIV-specific criminal laws, laws directly mandating disclosure of HIV status, and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups.

- Apply general criminal law only to the intentional transmission of HIV—where the person knew that he or she was HIV-positive; understood how HIV is transmitted; did not disclose his or her HIV status to a sexual partner and did not honestly believe the sexual partner otherwise knew; did not practice safer sex or otherwise take steps to reduce the risk of transmission; and the sexual partner became infected with HIV.

17(34):154-162, which reports on prosecutions including those from Florida, USA and Ontario, Canada, and one case of sentence enhancement involving an HIV-positive pregnant woman in Maine, USA.


Ibid, para 21(a).

• Audit the application of general criminal law to ensure it is not used inappropriately in the context of HIV.

In 2010, the UN Special Rapporteur on the Right to Health called upon member states “[t]o immediately repeal laws criminalising the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalising intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases.”

In the USA, the National HIV/AIDS Strategy for the United States recommends that “[s]tate legislatures should consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV.” The National Association of State and Territorial AIDS Directors has also called for an end to HIV-specific criminal laws.

Recently, two European countries have committed to inquiring into the criminalisation of HIV. In February 2011, Denmark's Justice Minister Lars Barfoed 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. Similarly, Norway has established an independent commission to inform the ongoing revision of section 155 (willful or negligent infliction or exposure to a generally contagious disease) of the Penal Code. The Norwegian commission is expected to present its findings by October 2012.

In a recent Swiss case the prosecutor accepted, given progress in medical science related to the impact of treatment on reducing HIV viral load, that in the circumstances of the case that there was no risk of infection because the accused had an undetectable viral load.

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In 2008, the Crown Prosecution Service for England and Wales (CPS) published legal guidance on Intentional or Reckless Transmission of Sexual Infection.\textsuperscript{70} The CPS documents provide guidance regarding:

- offences under UK criminal law that can be applied to HIV transmission;
- what is meant by “transmission”;
- the weight and nature of scientific, medical and factual evidence required to be adduced by the prosecution;
- situations where the accused used safeguards against transmitting infection, and medical advice the accused was given about this;
- the public interest considerations Crown Prosecutors should take into account these type of cases;
- care for the interests of complainants and witnesses.

The CPS legal guidance requires that prosecutors seek out evidence at an early stage in order to determine the likelihood that transmission occurred from the accused to defendant in a given case. The guidance defines circumstances that are unlikely to result in a successful prosecution and identifies activities that prosecutors must undertake in advance of proceeding with a prosecution. The CPS conducted a review of the CPS legal guidance after it had been in effect for one year.\textsuperscript{71} The report on the review concludes that the “CPS policy and legal guidance to prosecutors on the sexual transmission of infection has proved to be broadly effective during the first 12 months following its publication.”

In 2010, the Association of Chief Police Officers (ACPO) adopted guidance to help police in England, Wales and Northern Ireland when investigating allegations of criminal transmission of HIV.\textsuperscript{72} The guidance provides police officers with basic facts about HIV and sets out advice on how to deal with complaints about reckless (or intentional) transmission of HIV in a fair and sensitive manner. The new guidance was developed by a working group that included police officers, representatives of the CPS and the National Policing Improvement Agency, and the National AIDS Trust. The Guidance is available to police officers via the Police Online Knowledge Area hosted by the National Police Improvement Agency. Police will be expected to follow this new guidance. The CPS and ACPO guidance could also serve as a basis for good practice in investigating and prosecuting criminal cases involving allegations of spitting, biting and scratching. In particular, in such cases it is crucial that police and prosecutors take into account the science of HIV and HIV transmission risk when exercising their discretion.


\textsuperscript{71} CPS (2009), \textit{A Review of the CPS Policy and Guidance to Prosecutors on the Sexual Transmission of Infection - One Year On}, at \url{www.cps.gov.uk}.

\textsuperscript{72} For more information, see \url{www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx}. 
In the USA, in August 2011 US Congresswoman Barbara Lee released for discussion legislation planned for introduction later in 2011 that would require a review of all federal and state laws, policies, and regulations regarding the criminal prosecution of individuals for HIV-related offenses. The Bill, which will be called the *Repeal HIV Discrimination Act*, would be the first to take on the issue of HIV criminalisation, and would provide incentives for states to explore the repeal or reform of laws and practices that may inappropriately target people with HIV for consensual sex and conduct that poses no real risk of HIV transmission.

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It has been suggested that public health legislation should be considered as an alternative to the use of the criminal law in cases where individuals fail to disclose their HIV-positive status to sex or drug equipment sharing partners.\(^7^4\) It has also been suggested that public health systems and laws are more flexible than criminal justice systems in addressing complex health-related behaviours; public health authorities may be more attuned to approaches to reduce risk behaviours based in an understanding of the determinants of health and the connection between health and human rights; and, public health systems can better protect the privacy and confidentiality of people living with HIV.\(^7^5\)

In many countries in Western Europe, and in Canada and the USA, comprehensive public health frameworks/ guidelines/ policies for working with individuals who fail to disclose their HIV-positive status to sex or drug equipment-sharing partners developed under the authority of public health legislation\(^7^6\) are relied upon to reduce the number of new infections, reduce the risk of HIV transmission, and protect and promote public health.


4.1 Laws and Law Enforcement

In many high-income countries, public health legislation commonly addresses the prevention of communicable diseases, including HIV and other sexually transmitted infections. In relation to communicable diseases, the three primary functions of public health legislation are to:

i. classify communicable diseases and specify the rules that apply to each class;
ii. place a legal duty on certain persons (e.g., doctors, nurses, lab technicians) to report known and suspected cases of infection with communicable diseases; and
iii. place a legal duty on and grant powers to public health authorities to prevent and treat people infected with, communicable diseases.

Public health laws in the context of HIV prevention in a number of high-income countries have been summarised as follows.⁷⁷

- In the 1980s, in some US jurisdictions, public health laws were amended, or new laws enacted, with the HIV epidemic in mind.
- In Canada, public health laws are drafted in sufficient generality to be applied to people living with HIV, either through regulatory definitions or through discretion of public health officials.
- In contrast, in the UK, legislation has provided only a narrow scope for the use of coercive public health measures. Legislation and regulations in England, Wales, and Northern Ireland require that a person be ‘suffering from’ AIDS in order to justify detention for failure to take ‘proper precautions’; HIV infection alone would not suffice to warrant public health intervention. Scottish public health law seems to make no mention of HIV/AIDS. As a result, confinement of people with HIV under public health laws seems to have been rare in the UK.

A general overview of the types of public health legislative powers in high-income countries is set out in Appendix B.

Countries of the European Community have established a network for surveillance and a European Centre for disease prevention and control, but have not passed regulations or

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guidance regarding use of public health law to control HIV.\textsuperscript{78} Public health laws in Europe have been described as “untidy, not comprehensive and in need of updating and streamlining” owing in part to the fact that “[m]uch existing public health law was originally drafted in the 19th century as a result of crisis measures taken to respond to a particular event rather than a comprehensive body of legislation”.\textsuperscript{79}

Legislation on public health issues in Austria provides for reporting, monitoring and prevention of infectious diseases.\textsuperscript{80} Such activities are the responsibility of the Federal Ministry of Health; the public health service (\textit{Öffentlicher Gesundheitsdienst}) which includes the district administration authorities (health authorities) and the health boards in the provinces (\textit{Landessanitätsrat}); and the Supreme Sanitary Council as an advisory body on the national level and the Food and Health Safety Agency. The handling of epidemics and infectious diseases in Austria is regulated in the Epidemics Act as well as the directive on notifiable transmittable diseases, published in 2004. Selected infectious diseases such as HIV/AIDS, tuberculosis, and sexually transmitted infections are regulated more closely in individual laws. Individuals diagnosed with AIDS (evidence of an HIV infection or an indicator disease according to the directive Vo BGBl. No. 35/1994) have to be reported to the Federal Ministry of Health within a week of diagnosis. Article 6 of the Epidemics Act includes measures to prevent the infection of others with the respective disease as well as measures to combat the disease (documentation of the case as well as the public communication/proclaiming of it and, if deemed necessary, the isolation of the respective person).

The European Court of Human Rights examined Sweden’s public health confinement powers in the \textit{Enhorn} case.\textsuperscript{81} Enhorn, who was HIV-positive, alleged that he had been deprived of his


\textsuperscript{81} \textit{Enhorn v Sweden} [2005] ECHR 56529/00. See also Martin R (2006), \textit{The Exercise of Public Health Powers in Cases of Infectious Disease: Human Rights Implications: Enhorn v Sweden}, Medical Law Review 14(1):132-143. Martin sets out the underlying facts as follows: “In the case of \textit{Enhorn v. Sweden} the applicant was a homosexual man, aged 56, infected with the HIV virus. In 1990 he had transmitted the virus to a 19-year-old man. Subsequently, the county medical officer issued instructions to the applicant under the \textit{Infectious Diseases Act 1988} (Sweden), requiring the applicant to comply with a list of requirements, such as that he inform sexual partners of his HIV status; that he use a condom; that he limit his alcohol intake; that he inform healthcare staff of his status when he sought medical treatment; and that he consult his physician on a regular basis. The applicant failed to comply with these requirements. The county medical officer then successfully sought an order from the County Administrative Court that the applicant be compulsorily detained in isolation for up to three months. The applicant absconded, was arrested and detained under the Order. He frequently absconded thereafter with the result that a series of court orders were made against him for further periods of detention over the following seven years. Medical evidence suggested
liberty pursuant to confinement orders issued pursuant to Sweden’s Infectious Diseases Act (1988), in breach of Article 5 of the European Convention. Article 5 provides, in part: “everyone has the right to liberty and security of person” and notes that “[n]o one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law for the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrant.” The Court was satisfied that the requirements of the Swedish Public Health Act were satisfied by public health authorities, and thus Enhorn’s confinement was in accordance with Swedish law. However, the Court found on the facts of the case that “the compulsory isolation of the applicant was not a last resort in order to prevent him from spreading the HIV virus because less severe measures had not been considered and found to be insufficient to safeguard the public interest ... the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant’s right to liberty.”

In the USA, the Supreme Court has upheld the use of involuntary civil commitment, although the use of this measure has certain requirements to remain within the bounds of the federal Constitution. Civil confinement laws have been applied to people living with HIV whereby a history of unprotected sexual contact (as admitted by a defendant or evidenced by contracting a sexually transmitted infection such as gonorrhea or syphilis) without disclosure of HIV infection is adequate to meet the statutory dangerousness standard for confinement.

The published, peer-reviewed empirical research on the use of public health confinement powers to address HIV risk behaviours tends to be from the period prior to the advent of combination HIV therapy. A 1993 survey found that the power to quarantine under newly created public health statutes in the USA had been used “very rarely.” The survey found that many states did not have formal public health mechanisms for dealing with people living with HIV who persistently failed to follow medical or legal instructions about risk behaviours or took no action upon receiving reports of risky practices. An examination of public health practice in five states (Colorado, Indiana, Minnesota, Missouri, and Washington) documented 450 cases of
people engaging in HIV risk behaviours, a greater number than the remaining 45 states and the District of Columbia. However, in no cases was there resort to criminal sanctions, and only the State of Indiana resorted to the use of confinement powers, used five times.  

4.2 Public Health Impact

While public health programmes aimed at reducing HIV risk behaviours (e.g., education, counselling, voluntary HIV & STI testing, voluntary partner notification, peer-based programmes and positive prevention initiatives) have been studied, public health law interventions aimed at reducing HIV risk behaviours of people living with HIV have not. The existing literature on public health law as a tool to address individual situations involving behaviours that risk transmitting HIV has largely focused on procedural safeguards, identification of threats to public health, and conformity to legal and public health principles including the principle of least restrictive means.  

A recent literature search of high-income countries found that the empirical literature was limited to evaluation of models based on education and counselling interventions and accessing social services. Research has seldom explored graduated models, where intervention escalates from education and counselling to use of public health or criminal law.

4.3 Good Practice and Law Reform

Guideline 3 of International Guidelines on HIV/AIDS and Human Rights calls on States to “review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.” The commentary on Guideline 3 calls for comprehensive public health responses to HIV, including a range of services for the prevention and treatment of HIV. The commentary continues.

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87 Ibid.
91 Ibid.
Public health legislation should ensure that people not be subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status. Where the liberty of persons living with HIV is restricted, due process protection (e.g. notice, rights of review/appeal, fixed rather than indeterminate periods of orders and rights of representation) should be guaranteed.\textsuperscript{92}

UNAIDS policy guidance from 2002 sets out the following preconditions for the use of coercive public health law interventions:

Public health laws and policies should provide for interventions in individual cases to prevent HIV transmission that: are appropriate to a disease such as HIV/AIDS that is not casually communicable and has no cure; protect confidentiality of the individual living with HIV/AIDS to the greatest extent possible; are flexible and can be adapted to address the individual’s circumstances related to ongoing risky behaviour; take a graduated approach that employs coercive measures only after less intrusive measures have proven ineffective; and incorporate procedural safeguards to avoid the misuse of such powers in violation of human rights.\textsuperscript{93}

A recent review of legislation and policy from jurisdictions in three high-income countries (New South Wales, Australia; the State of Texas, USA; Calgary Health Region, Alberta, Canada) revealed a number of common features of public health management of HIV infection pursuant to statutory powers:\textsuperscript{94}

- An individualised, case-by-case approach;
- Graduated (step-by-step) case management based on the “least intrusive, most effective” principle, setting out clear criteria and considerations for moving from one step of intervention to the next;
- Comprehensive assessment that focuses on the person’s mental capacity and mental health and the social determinants of health when examining the reasons underlying ongoing HIV risk behaviours;
- A central role assigned to supportive counselling as a tool to promote behaviour change – beginning with post HIV test counselling and education, followed by intensive counselling throughout case management;

\textsuperscript{92}Ibid.


• A role for case conferencing and regional advice and expertise, involving individual experts or expert panels;
• Public health collaboration with other supports and services (e.g., healthcare, mental health and social work, community-based organisations and peer-led programmes) to address the range of determinants of health;
• Clear procedures for the use of coercive public health law interventions including behaviour orders and confinement orders.
5. Gay Men and Men Who Have Sex With Men

It has been suggested that the criminalisation of consensual sexual conduct between adults in private constitutes direct state interference with respect to private life and violates the right to equality and nondiscrimination.\(^5\) Criminalisation of consensual conduct between adults can proscribe sexual practices (i.e., sodomy, ‘unnatural’ offences), sexual conduct between same-sex partners, sexual conduct between unmarried partners, and sexual conduct outside of marital relationships. Criminal law has been perceived to be used selectively to enforce certain moral, religious or cultural standards.

Numerous UN bodies and civil society organisations have documented, analysed and commented upon the ways that criminalisation of homosexuality and of same-sex activity not only infringes international human rights, but also impedes HIV prevention, care, treatment and support, thereby exacerbating HIV epidemics.\(^6\) According to the commentary on Guideline 4 of the International Guidelines on HIV/AIDS and Human Rights, “Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.”\(^9\)

Many European states have a long tradition of respecting privacy, out of which flowed the decriminalisation of same-sex conduct—by the end of the nineteenth century France, Italy, Spain, Portugal, Belgium, and the Netherlands had all decriminalised same-sex sexual conduct among consenting adults.\(^8\) The Council of Europe and the EU have strongly condemned the...
penalisation of consensual same-sex behaviour. A recent report reviewing the legal status of homosexuality and homosexual acts globally reported that same-sex sexual acts are legal in all of the high-income countries under consideration. Except in Canada and the State of Nevada in the USA, the age of consent for homosexual acts is equal to that of heterosexual acts. Moreover, numerous countries have enacted criminal laws under which hate crimes based on sexual orientation are considered an aggravating factor in sentencing: Belgium, France, Denmark, the Netherlands, Portugal, Spain, Sweden and Canada, as well as 30 states in USA and the District of Columbia.

Although same-sex sexual activity between consenting adults is not subject to criminal penalties, cases at the European Court of Human Rights have addressed the use of criminal sanctions against group sex between men and consensual sado-masochistic sex between men. In the former case, a gay man in the United Kingdom had been charged with gross indecency. The European Court found that his right to private life under section 8 of the European Convention had been infringed. Following the decision, the United Kingdom passed the Sexual Offences Act 2003, which abolished the crime of gross indecency and decriminalised group sex in private. In the latter case, a domestic court in the United Kingdom convicted a number of gay men of assault and wounding arising out of sado-masochistic sexual activities. The European Court dismissed the men’s application, finding no violation of Section 8 since the state had a legitimate interest in the protection of health (including actual or potential harm) and morals.

5.1 Law enforcement

Despite decriminalisation of same sex relationships, and guaranteeing equal rights in some (but not all) spheres of life, there is evidence that human rights violations and lack of equality in civil matters for same-sex couples persists. The instances where equality is not achieved, includes restrictions on adoption by lesbian, gay, bisexual or transgender (LGBT) couples in many research countries, limited protection against hate speech and hate crime, restrictions on recognition of same sex marriages in many countries, limited international protection of LGBT


asylum seekers (many EU states continue to consider that asylum seekers seeking protection from persecution because of their sexual orientation or gender identity are not entitled to it if they can live in their own countries without ‘revealing themselves’). There are reports that lack of comprehensive education in Canadian schools, and gaps in protection of LGBT youths lead to frequent bullying and harassment of LGBT students in educational institutions. In order to decrease stigma and discrimination, the recognition of same sex civil rights and stronger protection from intolerance, violence, discrimination and other human rights violations are necessary in all research countries.

Transgender people: Some research countries recognise prohibition of discrimination based not only on sexual orientation, but on sexual identity and gender status (i.e. the Netherlands). However transgender people face a complex set of interrelated problems, such as difficulties accessing appropriate and timely psychological or medical assistance, or not being able to pay for the cost of certain medical procedures that are not covered by their insurance. Additionally, they may face many difficulties in recognising their status: in the majority of the research countries, legal recognition of the gender identity of transgender people is made conditional on medical interventions such as sex reassignment surgery (SRS) and sterilisation. The Dutch Civil Code allows trans people to request the court to order their birth certificate to be amended in order to bring their registered sex into line with their gender identity, and where necessary to register new first names. However, the conditions imposed by the law for legal recognition of transsexual people’s gender identity are burdensome: 1) they must show that their body has been altered so as to resemble a body of the opposite sex by means of hormone therapy and SRS; 2) they must prove that they have become irreversibly infertile. Only in Portugal and the United Kingdom, can transsexual people change their registered gender by submitting an expert statement to a competent authority to the effect that the applicant is indeed transsexual, but without having to provide proof of either SRS or infertility. Furthermore, transgender people may experience discrimination in the workplace, when

105 Wood, M (2011), Gay Students Bear ‘cycle of hate’: Enduring constant homophobic slurs and bullying takes huge toll, Toronto Star.
106 FRA (2010), Homophobia, transphobia and discrimination on grounds of sexual orientation and gender identity: Comparative Legal Analysis.
107 Transgender people, or trans people, are people whose gender identity or gender expression differs from the sex they were assigned at birth on the basis of their bodily characteristics. Understanding the experiences of trans people means recognising how gender is not the same as biological sex. Biological sex is the classification of bodies as male or female on the basis of biological factors, including hormones, chromosomes, and sex organs. Gender describes the social and cultural meanings attached to ideas of “masculinity” and “femininity.”
109 Ibid.
110 Ibid.
applying for jobs, or in accessing services. They may also encounter harassment, aggression, and even physical violence as a result of their gender expression.\textsuperscript{111}

\begin{flushright}
\textsuperscript{111} FRA (2010), Lesbian, Gay, Bisexual and Transgender (LGBT) Rights in the European Union.
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6. Legal Regulation of Sex Work, Sex Workers and Clients

In high-income countries, sex work is regulated by a range of laws such as criminal laws, public health laws, health and safety laws, property zoning ordinances, and anti-social behaviour orders enacted by various levels of government. Such laws have generally been enacted to protect community health, safety and uphold a certain moral standard. In some instances laws have been enacted with the goal of protecting sex workers (the majority of whom are female) or their clients (the majority of whom are male).\textsuperscript{112} These laws and their application by police and other state authorities may have unintended negative consequences for sex workers’ health and safety, especially the most marginalised among them (e.g., sex workers who use illicit drugs, are homeless/ migrants/ transgender). When examining the use of the criminal law, both the expression of moral condemnation and the intention of preventing harm to health and life such that “[d]isentangling questions of who is being harmed and who is doing harm, and how to prevent harm in the sub-cultures of commercial sex, is work in progress and will be so for many years to come”.\textsuperscript{113}

States have relied on criminal law to address the public order, public health and legal issues presented by sex work and prostitution. Three main types of criminal laws exist: (1) criminal prohibition of the selling of sexual services, with the imposition of penalties upon sex workers; (2) criminal prohibition of the various practices around sex work: not limited to, keeping a brothel; recruiting for or arranging the prostitution of others; living off the proceeds of sex work; and facilitating sex work through the provision of information or assistance; (3) criminal prohibition of the purchase of sexual services, with the imposition of penalties upon the purchaser.

\textsuperscript{112} A 2008 mapping of sex work in Europe found that 87% of sex workers were female, 7% male and 6% transgendered. Brussa L (ed) (2009), Sex Work in Europe: A Mapping of the Prostitution Scene in 25 European Countries, TAMPEP International Foundation.

\textsuperscript{113} Berer M (2009), Criminalization, Sexual and Reproductive Rights, Public Health and Justice, Reproductive Health Matters 17(34):4-9, at 4.
6.1 Laws and Law Enforcement in European Countries

A study prepared for the European Parliament in 2005 categorised regulation of prostitution in the EU based on indoor and outdoor prostitution:114

- Portugal, Spain: Outdoor and indoor prostitution are not prohibited. Prostitution by adults is not subject to punishment, but profiting from another person’s prostitution is, however, criminalised.
- Belgium, Denmark, Finland, France, Italy: Outdoor and indoor prostitution are not prohibited, but brothels prohibited by law.
- Ireland, Sweden: Outdoor and indoor prostitution are prohibited. Parties involved in prostitution can be liable to penalties, including in some cases, the clients.
- Austria, Germany, Greece, The Netherland, and United Kingdom: Outdoor and indoor prostitution are regulated by the State and are therefore not prohibited when exercised according to this regulation. Prostitutes are often registered by local authorities and are in some cases obliged to undergo medical controls.

Prostitution or related activities are criminalised in Belgium, Finland, France, Italy, Ireland, Italy, Norway, Portugal, Spain, Sweden and the United Kingdom.115 It is beyond the scope of this brief to examine the legislative and regulatory framework in each jurisdiction; however three examples of legislation are described below.

In England and Wales, over 30 laws criminalise various aspects of prostitution with the main legislation contained in the Sexual Offences Act 1956, the Street Offences Act 1959, the Sexual Offences Act 1985, and the Sexual Offences Act 2003. The 1956 Act relates mainly to off-street prostitution, the 1959 and 1985 Acts to street prostitution and “kerb crawling”.116 Local by-laws and acts related to public order have been relied upon to shape the practices of sex work. Police, local authorities and magistrates also use Anti-Social Behaviour Orders against sex workers and clients, created by the Crime and Disorder Act 1998 and typically ban the subject

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of the order from an area, which may include the sex worker’s home, as well as the premises of agencies sex workers need to access for health and welfare services.

In France the purchase or sale of sex is not illegal. However, the Penal Code’s Chapter on “Violations of Personal Liberty” prohibits\(^\text{117}\); procuring, in extremely broad terms; financial involvement with or operation of a place of prostitution or vehicle used for prostitution; public solicitation by any means including passive conduct; and soliciting, accepting or obtaining the sexual services of a minor.

In Sweden the criminal law prohibits the purchase or attempted purchase, but not the sale, of sexual services.\(^\text{118}\) Throughout the 20\(^\text{th}\) century, many of the activities associated with prostitution, but not the physical act of prostitution itself, were criminalised and combined with a gradual evolution in the regulation of prostitution. Over time, there has been increased emphasis placed on the provision of social services which provide for legal and health support to women involved in prostitution. On 1 January 1999, an Act Prohibiting the Purchase of Sexual Services\(^\text{119}\) came into effect, thereby amending the Swedish Penal Code to make illegal the purchase or attempted purchase of sexual services. The Swedish Penal Code\(^\text{120}\) also prohibits the following prostitution-related activities: procuring, trafficking human being for sexual purposes, disorderly conduct in a public place, purchasing a sexual act from a child, and allowing premises to be used as a brothel.\(^\text{121}\)

Austria, Denmark, Germany, Greece, Iceland, the Netherlands and Switzerland have largely removed criminal prohibitions on prostitution and related activities, and rely on other forms of regulation – commonly referred to as “legalisation” or “regulation”. In Austria and Greece, sex workers are subject to mandatory health checks.\(^\text{122}\)

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\(^{117}\) Articles 225-5 to 225-12.


\(^{120}\) Ds 1999:36.


6.2 Laws and Law Enforcement in Canada and the USA

With the exception of 11 counties in the State of Nevada, prostitution or prostitution-related activities are criminalised in the USA. Where prostitution is illegal, including the 49 states, the District of Columbia and counties of Nevada, criminal laws prohibit a wide range of activities such as: advancing prostitution; knowingly engaging in prostitution; profiting from prostitution; managing, supervising, controlling or owning a prostitution enterprise; promoting prostitution; committing acts of prostitution; procuring or soliciting a prostitute; enticing a person for the purpose of prostitution; causing a spouse to become a prostitute; pandering; and pimping.\textsuperscript{123} The Federal government has jurisdiction over, and has prohibited by law, the involvement of non-civilians in prostitution near military or naval establishments.\textsuperscript{124}

In some states with HIV-specific criminal laws, it is a crime to engage in prostitution if an individual is knowingly HIV-positive.\textsuperscript{125} In many states enhanced sentences are imposed upon HIV-positive people convicted of prostitution-related offences. Moreover, criminal defendants charged with prostitution may be required to submit to an HIV test.

In Canada\textsuperscript{126}, prostitution, the exchange of sex for money and other valuable consideration, is legal. However, four sections of the \textit{Criminal Code} (sections 210 to 213) make many activities related to prostitution illegal. Sections 210 and 211 respectively make it illegal for a person to keep a “bawdy-house or to transport a person to such a place. Section 212 makes it illegal to encourage or force people to participate in prostitution (also known as procuring), or to live on the money earned from prostitution by someone else (also known as living on the avails of prostitution). Section 213 makes it illegal for sex workers and customers to communicate in public for the purposes of prostitution. This includes stopping or attempting to stop a vehicle, impeding pedestrian or vehicular traffic, stopping or attempting to stop a person, or in any other manner communicating with a person for the purposes of engaging in prostitution or obtaining sexual services.

Sex workers are currently challenging the \textit{Criminal Code} prohibitions on prostitution-related activities in court on the basis of rights guaranteed under the \textit{Canadian Charter of Rights and Freedoms}. In 2010, a lower court in the Province of Ontario decided that three provisions of the \textit{Criminal Code} – keeping a common bawdy house, living on the avails of prostitution, and communicating in public for the purposes of prostitution – unjustifiably infringed sex workers’ constitutional rights to liberty, security of the person, and freedom of expression, and struck

\textsuperscript{123} For a list of US State and Federal prostitution laws, see \url{www.ProCon.org}.
\textsuperscript{124} Federal Code, Title 18, Part I, Chapter 67, s. 1384.
down those provisions. The Government of Canada has appealed the case to the Ontario Court of Appeal, which has heard the case but has yet to render its decision.

In addition to the Criminal Code provisions related to prostitution, provincial and municipal laws are relied upon to address prostitution. Regarding street-based prostitution, provincial highway traffic legislation and related municipal by-laws may be enforced against sex workers. Municipalities have enacted by-laws that mirror provincial highway traffic laws, as well as by-laws that prohibit soliciting in public without a licence, loitering and refusing to circulate. Under these provincial and municipal laws, police can issue tickets to sex workers whom they believe to be in violation of these laws and should the sex worker fails to pay the fine associated with the violation, he or she can be arrested and jailed for non-payment of the fine.

6.3 Public Health Impact

The report for the UN Special Rapporteur notes that criminalisation of sex work poses challenges to the realisation of sex workers’ right to health, in the following ways:

- Criminalisation of sex work may act as a barrier to accessing services, establishing therapeutic relationships and continuing HIV treatment regimes, leading to poorer health outcomes for sex workers, as they may fear legal consequences or harassment and judgment. This is particularly concerning given that HIV has been noted to disproportionately affect sex workers in many regions.
- Raids, cautions and arrests generally result in a shift of the sex worker population, often towards unsafe areas, putting sex workers at higher risk of infection and reduced safety.
- Criminalisation has been noted to diminish the “bargaining power” of sex workers in choosing clients and negotiating condom use.
- Laws criminalising or onerously regulating sex work were noted to compound the stigmatisation experienced by sex workers, adversely affecting health outcomes, often without justification on the grounds of public health.

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129 Report to the General Assembly of the UN Special Rapporteur on the right to the highest attainable standard of health, Anand Grover, 27 April 2010. A/HRC/14/20, at paras 36-50. For a review of international approaches to decriminalisation and legalisation of prostitution, including grey and published literature evaluating aspects of various jurisdictions’ approaches, see Mossman E (2007), International Approaches to Decriminalising or Legalising Prostitution, New Zealand Ministry of Justice.
The criminalisation of sex work often means that sex workers feel unable to enforce their basic rights, as their status and work are illegal. As a result, sex workers “live in fear” of police and clients, and feel unable to report crimes against them due to fear of arrest. Sex workers have reported that they are highly vulnerable to police harassment, particularly in the forms of (a) sex by deception and coercion, (b) extortion, and (c) discrimination.

Equally, it has been argued that the physical, emotional and social harms of prostitution are not decreased by legalisation or decriminalisation and, that “state-sponsored prostitution endangers all women and children in that acts of sexual predation are normalised.”

An analysis of the operation of the Swedish law criminalising the purchase of sex, based on original research and a literature review, concluded:

- Clients are less willing to assist as witnesses in cases in which profiteers who exploit the sexual labour of others are prosecuted, since they now find themselves guilty of a crime.
- Sex workers report that they experienced an increased stigmatisation after the introduction of the Sex Purchase Act.
- Sex workers feel less trust in social authorities, police and the legal system, and are less likely to seek help.
- Sex workers experience higher levels of vulnerability because clients now have higher negotiating powers, which erode sex workers’ bargaining power, including the power to demand safer sex practices, earnings, and ability to assess clients.

There is limited research evidence describing the implications of mandatory HIV/STI testing for sex workers and whether it is effective at reducing the incidence of HIV/STIs. Two recent studies have examined the mandatory policy requiring HIV testing every three months and monthly testing for three other STIs among sex workers in Victoria, Australia. One study suggested that, given the low prevalence and incidence of STIs among sex workers, it would be a more effective use of resources to base HIV testing on local STI epidemiology and not locked by legislation. The other study concluded that the current legislation requiring monthly STI testing is compromising the access for higher-risk individuals to sexual health, and suggested that other jurisdictions contemplating mandatory testing should consider the influence that the

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frequency of testing has on access to sexual health services for high-risk groups.\textsuperscript{134} A German study concluded that, “an STD [sexually transmitted disease] department providing comprehensive services anonymously and free of charge will reach a broader range of highly vulnerable persons in comparison with an obligatory [venereal disease] check of prostitutes.”\textsuperscript{135}

Migrant sex workers find themselves in an especially vulnerable position among sex workers.\textsuperscript{136} It has been asserted that the conflation of sex work with human trafficking has made migrant sex workers more likely to be subject to the attention of state authorities having been noted that “migrant sex workers are seen as victims without agency and find their rights constantly violated.”\textsuperscript{137} Migrant sex workers experience a disproportionate level of violence and abuse, at times from state officials, and of exploitative and unsafe working conditions.\textsuperscript{138}

\section*{6.4 Good Practice and Law Reform}

The \textit{International Covenant on Economic, Social and Cultural Rights} protects the right to freely chosen, gainful work (article 6), which the state must take appropriate steps to safeguard. Article 6 of the \textit{Convention on the Elimination of All Forms of Discrimination against Women} calls for the suppression of “all forms of traffic in women and exploitation of prostitution of women.”\textsuperscript{139} Guideline 4 of \textit{International Guidelines on HIV/AIDS and Human Rights} calls on States to “review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.”\textsuperscript{140}

Regarding adult sex work that does not involve victimisation, the commentary on Guideline 4 calls on States to review laws with the aim of decriminalising, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including

\begin{thebibliography}{99}
\bibitem{134} Samaranyake A et al (2009), \textit{Legislation requiring monthly testing of sex workers with low rates of sexually transmitted infections restricts access to services for higher-risk individuals} Sexually Transmitted Infections 85(7):540-542.
\bibitem{135} Nitschke H et al (2006), \textit{Anonymous STD counselling versus mandatory checks for prostitutes - what is effective in STD prevention?}, Gesundheitswesen 68(11):686-691.
\bibitem{136} See generally TAMPEP (2009), \textit{Sex Work, Migration, Health: A Report on the Intersections of Legislations and Policies Regarding Sex Work, Migration and Health In Europe}.
\bibitem{138} See generally TAMPEP (2009), \textit{Sex Work, Migration, Health: A Report on the Intersections of Legislations and Policies Regarding Sex Work, Migration and Health In Europe}.
\bibitem{139} Report to the General Assembly of the UN Special Rapporteur on the right to the highest attainable standard of health, Anand Grover, 27 April 2010. A/HRC/14/20, at para 30.
\end{thebibliography}
support for safe sex during sex work. The commentary cautions that criminal law should not impede provision of HIV prevention and care services to sex workers and their clients.

Appendix C briefly summarises recent legal reform of laws related to prostitution in New Zealand, which may be relevant to the legal and policy environment of the research countries.

A number of reports suggest and document best practices for programming to improve the health and safety of sex worker, specifically in the context of HIV and human rights. The literature review, however, did reveal a limitation in available published resources in which to raise issues relating to the benefits and implications of the application of criminal and public health laws with respect to sex work to outline a balanced discussion of good practice interventions.

7. Legal Responses to Illicit Drug Use

Illicit drug use has significant negative effects on individual and public health, and upon communities in which illicit drug use is concentrated. The predominant response to the negative effects of illicit drug use and markets has been an approach based on interdiction, both at the international and country levels. Interdiction is not capable in itself of responding in a human rights based manner to the complex health and social circumstances surrounding illicit drug use and addiction. For those people addicted to illicit substances, consideration should be given to the role of health legislation, policy and services to achieve positive health and safety outcomes. Internationally, UN conventions criminalise the possession, use and manufacture of illicit drugs.142 The aim of the UN drug control mechanisms is to protect the global population, and youth in particular, from becoming addicted to narcotic drugs – i.e. the protection of basic human health and to protect society from the violent, health and socio-economic consequences of drug abuse and trafficking.143

The research countries have all ratified the UN Drug Control Conventions.144 The Conventions are not self-executing, meaning that signatory countries are required to transpose them into domestic law in accordance with the principles of their law – in good faith, while respecting the general objectives of the Conventions – by way of national legislation. The Conventions provide that the use of all drugs (under control) must be limited to medical and scientific purposes. They specify punishable offences, such as possession, acquisition, distribution or offering for sale, and recommend that certain of these should be serious offences punished with deprivation of liberty. Despite the law enforcement approach, the Conventions do not prohibit harm reduction approach, and interventions such as needle and syringe programmes (NSPs), opioid substitution therapy (OST), condom distribution and others.145

It has been argued that drug interdiction and law enforcement and associated expenditures have been associated with high rates of incarceration, the spread of HIV and hepatitis among injection drug users, deaths related to drug overdose, and violence.\textsuperscript{146} “Harm reduction” developed in response to the negative health consequences of injection drug use. “Harm reduction” encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use on individuals, communities and societies.”\textsuperscript{147} At a programmatic level, harm reduction may include, depending on the legal and policy environment in a jurisdiction: NSPs, OST, supervised injection sites or drug consumption rooms, and low-threshold services for people who use drugs. Harm reduction services have proved contentious in many jurisdictions, and different states have different conceptions of what constitutes harm reduction measures.

This section will not consider the legal status of cannabis or other non-injected drugs. It will focus on opiates and narcotic drugs that are injected since this behaviour of drug use has played a central role in the HIV epidemic.

7.1 Laws and Law Enforcement in European Countries

A 2005 report by European Monitoring Centre for Drugs and Drug Addiction on the legal status of drug use in EU Members states arrived at the following conclusions:\textsuperscript{148}

- In the EU Member States, with exceptions, there is a trend to conceive the illicit use of drugs (including its preparatory acts) as a relatively “minor” offence, to which it is not adequate to apply “sanctions involving deprivation of liberty”.

- Even though use and possession of drugs for personal use are among the majority of drug-related offences reported to the judiciary, indeed the courts seems to prefer treatment, other social support measures and to a certain extent sanctions not involving deprivation of liberty, such as discontinuance, suspension of proceedings, cautioning and fines, in particular and for very small quantities, when simple use of drugs is not accompanied by aggravating circumstances.

- It would be a mistake to define the above as a trend in a “relaxation” or a “softening” of the drugs laws in Europe. All the countries that have recently modified their laws stress

\textsuperscript{146} Wood E et al (2009), \textit{The War on Drugs: A Devastating Public Policy Disaster}, The Lancet 373(9):989-990.
\textsuperscript{148} European Monitoring Centre for Drugs and Drug Addiction (2005), \textit{Illicit Drug Use in the EU: Legislative Approaches}.
that their intention is not to regulate use, let alone to legalise it, but to modify and adapt the State’s response to conduct that remains illegal and subject to sanctions. Moreover, some governments do not intend to modify their laws based in prohibition and penalisation of drugs use (i.e., France, Sweden) and others are moving in that direction (i.e., Italy).

Most research countries do not explicitly criminalise use of illicit drugs. However, most countries continue to criminalise possession of illicit drugs for personal use and offer treatment and other diversion programmes as an option or an adjunct to the criminal justice system. Some countries have crafted specific treatment programmes for repeat offenders of drug-related crimes (whether crimes under drug control laws or crimes committed to ultimately acquire drugs); while some other countries distinguish between distribution (also known as trafficking) to pay for an addiction versus trafficking on a large scale for profit. Below are six countries’ legislative approaches to illicit drug use and possession. Complete information for all research countries is available from the European Monitoring Centre for Drugs and Drug Addiction. Of note, Portugal has decriminalised personal drug use and possession.

In Austria, on 1 January 1998 the Narcotic Substances Act (Suchtmittelgesetz) entered into force. The consumption of controlled drugs is not mentioned as a specific offence by the Austrian law, however, the possession of illicit drugs is a crime. Austrian drug law makes a distinction between possession of drugs for personal use and possession for trafficking. The criteria taken into account to divide the two illegal acts when prosecuting are: the quantity, the frequency of use by the person, and the nature of the substance. The public prosecutor is obliged to suspend proceedings for a probationary period of two years if the person is charged with illegal acquisition or possession of a small amount of drugs for personal use, conditional on the opinion of the health authority whether the offender needs health-related treatment. If during the period of suspension, the person commits another crime foreseen in the same drug law, or a crime, by reason of his addiction, to obtain the drug, or if the person refuses to continue the therapeutic programme or the psychological counselling, normal prosecution takes over. If not, the case will be closed when the offender proves to the public prosecutor the successful conclusion of the programme. If the person has been prosecuted and sentenced for a drug law offence not higher than two years the court is obliged to suspend the execution of the sentence if the person shows his will to undergo the necessary therapeutic treatment.

Belgian drug law is based on three main domains: prevention, treatment and law enforcement. Belgian law punishes possession of drugs other than cannabis by imprisonment, but diversion to medical treatment is available in some circumstances. A 26 May 1993 directive made a distinction between occasional users, regular users and dealers. Regular users are to be given every possible opportunity to seek and obtain treatment. The gravity of the offence committed,
the repetitive nature of the offence and the offender’s intentions are taken into account when
determining whether the offender is imprisoned or given the opportunity to access treatment.
Treatment is well defined in law as an option for drug addicts who have committed small drug
offences. A judicial contract (la probation prtorienne) dating back to the 1950s is still the
principle under which to treat the drug addiction of small crime offenders rather than relying
on judicial proceedings. This contract aims to stop the enforcement of justice if the user agrees
to change his behaviour (not to use any drugs, not to refuse urine tests, to look for a job, to
have active leisure time, to get in treatment aiming to definitely stop with drug use with a
provision of its proof). If the user decides to agree, the deputy public prosecutor transfers the
file directly to the responsible health service. In 1994, a new law offered additional diversion
measures for drug-use offences: reparation (apologies, indemnity), work for the benefit of the
community, or the order to enter treatment for those needing it (injonction therapeutique).

In Denmark, the main law regulating narcotic drugs offences is the Euphoriaists Act of 1955, as
amended. Drug use in itself is not a crime, whereas possession even of small quantities for the
purpose of one’s own use is an offence. As mentioned above, the Euphoriaists Act was
amended in 1996 to the effect that the main emphasis is no longer on the total amount of the
substance but on the number of deals (or attempted deals). A deal is defined as "sale or
possession for the purpose of a single sale of between 0.01 and 0.02 grams of heroin or
cocaine". Municipalities are responsible for prevention and medical treatment of drug
addiction. According to section 78 in the Act on enforcement of sentences, drug dependent
offenders can be allowed to serve their prison sentence or part of it in a treatment facility
outside the prison system, based on the principle of equivalency of treatment of substance
abuse. Recent changes have made Danish law more stringent. Act No. 445 of 2004 amended
the Euphoriaists Act of 1955 to emphasize that possession of and sale of drugs is illegal and has
clear penal consequences, such that warnings will normally no longer be issued, when a person
violates the Act. Under Act No. 526 of 6 June 2007 (higher fines in drug cases) amending section
3 in the Euphoriaists Act, the level of fines for possessing narcotics for one’s own use has been
increased by 400%.

The current legal framework concerning France’s policy on drugs dates back to 1970 and has
three main objectives: to severely repress trafficking, to prohibit the use of narcotics yet also
propose alternatives to the repression of use, and to ensure free and anonymous care for users
who seek treatment. In most cases, drug use alone merits a warning, which may be
accompanied by a request to contact a social or health service, without obliging the person to
undergo treatment or counselling. Public or private use alone is mainly dealt with by
therapeutic alternatives. Therapeutic orders (injonction thérapeutique) stipulate that the
offender must voluntarily enter and complete a drug rehabilitation programme to avoid prison.
Health authorities are responsible for the choice, organisation, and control of the execution of
the treatment programme. They must inform the prosecution in cases where the user refuses
to continue the programme, whereupon the prosecutor can re-open the criminal proceedings.
Implementation of the law permitting diversion is not uniform. It varies from metropolitan to rural area or from court to court. A judge can also order a user to undergo detoxification treatment. If the user successfully completes detoxification treatment, the court has no further authority over the case. These measures are used extremely rarely. Possession of illegal drugs is a criminal offence under French law. The law does not distinguish between possession for personal use or for trafficking; possession can be tried as a trafficking offence.

The basic framework for drug control in the Netherlands is the Opium Act of 1919, which was fundamentally amended in 1976 to distinguish between “hard” and “soft” drugs. Drug use does not constitute a crime in legal terms; rather regulation of use is situation-specific and left to the authority of localities. The possession of small quantities of drugs for personal use is accorded a much lower priority. Anyone found in possession of less than 0.5 grammes of Schedule I, hard drugs, will generally not be prosecuted, though the police will confiscate the drugs and consult a care agency. The Dutch Public Prosecution Service determines whether to refrain from prosecution in the general interests of society. Arrested drug addicts may opt for treatment by suspension of preventive custody. Provided they enter clinical treatment and complete the programme, they will be granted permission by a judge to leave the prison to be admitted to an addiction clinic as soon as they have served at least half their sentence, up to a maximum of six months. Moreover, part of a prison sentence may be substituted for alternative sanctions (e.g. socially useful work that must be fulfilled in a certain number of hours). The performance of such work is supervised by probation agencies. The Placement in an Institution for Prolific Offenders law was introduced in 2004 to provide for the treatment of criminal drug users in prison-like institutions. Drug addicts who have committed a small offence are increasingly pressured to participate in treatment programmes.

In Sweden, the main law regulating narcotic drugs offences is the Narcotic Drugs Punishments Act (1968:64). Accordingly, it is an offence to possess, use or have any other involvement with narcotic drugs. An offence could be considered as “minor” with respect to the nature and quantity of drugs and other circumstances, yet should be reserved for the very mildest of offences, involving personal use or possession for personal use. Since 1998 persons with drug addiction problems who have committed a drug offence can be sentenced to treatment according to a “treatment contract” if less than two years imprisonment is foreseen as the penalty. The person must fulfill certain conditions: the person must need treatment; must be motivated to undergo treatment; must be found to be engage in harmful drug use; and the person’s drug habit must have contributed to the crime for which the person is being prosecuted.

7.2 Laws and Law Enforcement in Canada

In Canada, the federal government is responsible for enacting criminal law. The main drug-
control law is the *Controlled Drugs and Substances Act*, which came into force in 1997. The Act sets out various categories of controlled substances and establishes the rules that apply to each category. For example, methadone (an OST) has been authorised for sale under the *Food and Drugs Act* as it is considered to be a controlled substance under the *Controlled Drugs and Substances Act*. The use of illicit drugs is not illegal under the Act. The possession of any drug or narcotic listed in the Act is an offence unless the person is authorised pursuant to regulations to possess that drug or narcotic. The Act also establishes penalties, which vary depending on the classification and amount of substance involved. Further, in Canada, the sale of syringes through pharmacies is legal.

Canada’s National Anti-Drug Strategy, initiated in October 2007, has three components – prevention, treatment and enforcement – with an action plan for each component.\(^{150}\) The Prevention Action Plan focuses on preventing illicit drug use among young people, and will provide information to those most affected by drug use, including parents, young people, educators, law enforcement authorities, and communities. The Treatment Action Plan supports innovative and effective approaches to treating and rehabilitating those with illicit drug addiction who pose a risk to themselves and the community. The Enforcement Action Plan bolsters law enforcement efforts to investigate and prosecute drug crimes, and will increase law enforcement’s capacity to combat marihuana grow operations and synthetic drug production and distribution operations.

Six federally funded diversion programmes - drug treatment court (DTC) - pilot sites were established and are administered in partnership with other levels of government and health and social services. DTCs provide judicially supervised treatment in lieu of incarcerating individuals who have a substance-use problem that is related to their criminal offences (e.g., drug-related offences such as drug possession, use, or non-commercial trafficking and/or property offences committed to support their drug use). Typically, formal admission into a DTC programme requires the individual to plead guilty to his or her charges. If an individual fails to comply or participate in all aspects of the DTC programme, consequences range from an official reprimand or revocation of bail to termination in the programme and handing down of custodial and/or community supervision sentences.\(^ {151}\)


7.3 Legal Status of Measures to Respond to Health Harms of Illicit Drug Use

High-income countries examined in this brief have legal and policy environments that are generally supportive of a broad array of harm reduction measures and programmes: have explicit supportive reference to harm reduction in national policy documents, have NSPs (with the exception of Iceland), and have opioid substitution programmes. Drug consumption rooms (DCRs) exist in Germany, the Netherlands, Norway, Spain, Switzerland and Canada. Within countries access to harm reduction programmes and measures depends upon funding, as well as laws and policies.

Countries in Europe

Availability and scope of NSPs are limited in some countries. Pharmacy-based NSPs are more common than non-pharmacy based programmes in France, Spain, Portugal and the UK, and there is almost an equal number of each in Belgium. Most recently Stockholm City Council introduced NSPs into the city. Even in countries where NSPs are widely available, barriers may exist in accessing these services. The availability of other injecting equipment such as cookers, sterile water, filters and alcohol pads is becoming more common. Syringe vending machines (SVMs) exist in Austria, Denmark, France, Luxembourg, the Netherlands, and Norway. The number of SVMs almost equals the number of non-pharmacy-based NSPs in France, the country with the majority of SVMs in the region.

Western Europe offers a wider variety of OST options than other parts of the world. Methadone and buprenorphine are approved throughout the region for treating addiction, and one or both are prescribed as substitution therapy in all countries where injecting drug use has been reported. Some countries also offer slow release codeine. Others include injectable opioids among their drug treatment options (the UK, Switzerland and the Netherlands) and the use of heroin-assisted treatment is becoming more common in the region. The extent of OST provision varies greatly across the region. The majority of OST recipients are in the UK (154,573), France (99,446), Italy (96,972), Spain (83,469) and Germany (61,000). This may be partly due to the variety of service provision sites (including through general practitioners in France, Germany and the UK). Injectable heroin (diamorphine) has been used and/or tried as a substitution therapy in Belgium, Germany, the Netherlands, Spain, Switzerland, and the UK.

153 Catherine Cook (ed) (2010), The Global State of Harm Reduction 2010, at Table 1.1 (Countries or territories employing a harm reduction approach in policy or practice), pp. 8, 9.
There are ninety operational DCRs across fifty-nine cities in the Netherlands, Germany, Luxembourg, Norway, Spain and Switzerland. In 2006, plans to establish a safer injecting facility in Portugal were approved by government. The International Narcotics Control Board in its 2008 Annual Report stated: “The Board urges all Governments to refrain from establishing ‘drug consumption rooms’ and to pursue alternative ways to increase access to health and social services, including services for the treatment of drug abusers.”\textsuperscript{154}

\textit{Canada and the USA}

Canada and the USA have key harm reduction programmes in place and support harm reduction in some aspects of national policy. Coverage of NSPs and OST programmes for people who inject drugs in North America is much lower than in Australasia and most Western European countries.\textsuperscript{155}

Many harm reduction programmes in Canada are supported through provincial, regional and municipal levels of government. As of 2007, the Ministries of Health in ten provinces and two of three territories were providing support for NSPs. In Canada, the sale of syringes through pharmacies is legal. Methadone has been authorised for sale under the \textit{Food and Drugs Act} as it is considered to be a controlled substance under the \textit{Controlled Drugs and Substances Act}. Physicians who wish to provide methadone to their patients must obtain a special exemption from Health Canada. Buprenorphine was authorised for sale in May 2007 and became available in December of that same year.

Canada has North America’s first and only supervised injection facility. In September 2003, the federal Minister of Health granted Insite, the supervised injection site, an exemption under section 56 of the \textit{Controlled Drugs and Substances Act} as a pilot scientific research project. The exemption was originally granted for a three year period and then extended twice. Before the exemption expired, a legal action was launched challenging the constitutionality of the

\textsuperscript{154} International Narcotics Control Board (2008), \textit{Report of the International Narcotics Control Board for 2008}, United Nations. E/INCB/2008/1 at para 709. See also recommendation 29: “The Board remains concerned that, in a small number of countries, “drug consumption rooms” and “drug injection rooms”, where persons can abuse with impunity drugs acquired on the illicit market, remain in operation. The Board urges Governments to terminate the operation of these drug abuse rooms and similar outlets and to promote the access of drug abusers to health, social and drug abuse treatment services.”

\textsuperscript{155} See Mathers BM et al for the 2009 Reference Group to the UN on HIV and Injecting Drug Use (2010), \textit{HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage}, The Lancet 375(9719):1014-1028: “In western Europe where, compared with other regions, there is relative homogeneity in prevalence of IDUs and a stable HIV epidemic, coverage of HIV services in IDU populations seemed to be high, particularly ART access for HIV-positive IDUs. There seems to be a similar situation in Australasia. By contrast, less certainty exists for North America: we were unable to measure the national response in Canada, despite known HIV epidemics of substantial scale in some cities, because of the absence of national data collection (data collection is undertaken by provinces, and not gathered systematically at a federal level). Coverage of NSPs and OST in IDUs in the USA was much lower than that in Australasia and most western European countries. Data for provision of ART for IDUs could not be found nationally for the USA or Canada.”
possession and trafficking offenses in the Controlled Drugs and Substances Act. In May 2008, the Supreme Court of British Columbia ruled that the possession and trafficking offences were contrary to section 7 of the Canadian Charter of Rights and Freedoms.156 On appeal, the British Columbia Court of Appeal held that the laws against possession and trafficking did not apply to Insite. On 29 September 2011, the Supreme Court of Canada ruled to order the federal Minister of Health to issue an exemption from the Controlled Drugs and Substances Act, meaning that the facility will be able to stay open. The International Narcotics Control Board has stated in relation to Insite that “drug injection rooms” violate UN international drug control treaties, and has called on governments to terminate the operation of such facilities.157

In the USA, in late 2009 Congress lifted the ban on federal funding for NSPs. Many states have introduced legislation to allow NSPs to operate legally and to provide funding support for their implementation. As of 2009, it has been reported that a total of 186 NSPs were operating in thirty-six states and the District of Columbia.158 Some states have laws and regulations that limit the purchase syringes from pharmacies, or have laws making the possession of a syringe illegal under drug paraphernalia laws.159 In addition, eight states also require prescriptions in order to purchase syringes legally. Pharmacy regulations or guidelines in 23 states may have the effect of restricting the sale of syringes to people who inject drugs. Access to OST in the USA remains geographically inconsistent.160 In October 2002, the Food and Drug Administration approved buprenorphine.

7.4 Public Health Impact

A number of empirical studies in high-income countries have examined the relationship between law, law enforcement, HIV, illicit drug use or access to harm reduction measures. There are very little review or systematic analyses in this area. Individual studies have found, suggest or assert that:

156 Section 7 of the Charter of Rights and Freedoms states: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
159 Cook C, Kanaef N (eds) (2008), The Global State of Harm Reduction 2008, at page 80. See also, Burris S et al (2011), Racial Disparities in Injection-related HIV: A Case Study of Toxic Law, Temple Law Review 82(5):1263-1307, where the authors state at page 1303: “… states have plenty to do in reforming their syringe-related laws to eliminate barriers to access. New Jersey and Delaware, the last hold-outs, should press forward to remove their prescription requirements. States whose paraphernalia laws include syringes can amend the law to exclude syringes, and complete the deregulatory process by repealing pharmacy regulations that unnecessarily impede those in need from buying syringes. The many states where SEPs operate without claim to legal authority can eliminate any doubt by positively authorizing the intervention. Drug possession laws should be amended to preclude arrest or conviction based on drug residues detected in used syringes. As legal barriers are removed, states can positively promote pharmacy syringe sales through interventions like New York’s Expanded Syringe Access Program.”
Deterrence-based approaches to reducing drug use seem not to reduce injection drug use prevalence. Alternative approaches such as harm reduction, which prevents HIV transmission and increases referrals to treatment, may be a better foundation for policy.\(^{161}\)

A police crackdown on an open heroin drug scene did not alter the price of drugs or the frequency of use, nor did it encourage enrollment in methadone treatment programmes. Several measures indicated displacement of injection drug use from the area of the crackdown into adjacent areas of the city, which has implications for both recruitment of new initiates into injection drug use and HIV prevention efforts.\(^ {162}\)

A significant geographic relationship exists between a heavily concentrated core area of health and syringe availability and avoidance of physical settings due to violence and policing by 198 women in street-level sex work. Displacement of sex work to primarily industrial settings and side streets pushes women further from health and social supports and reduces access to safer injection and drug use paraphernalia.\(^ {163}\)

Legislative efforts to decriminalise the operation of syringe exchange programmes without concurrent decriminalisation of syringe possession may result in higher odds of arrest among NSP clients, with potentially deleterious implications for the health and well-being of people who inject drugs. More comprehensive approaches to removing barriers to accessing sterile syringes are needed if public health goals for reducing new HIV/HCV infections are to be obtained.\(^ {164}\)

There are high levels of syringe-related arrests in two Mexican-US border cities and an independent association between these arrests and risky injection practices. Public health collaborations with law enforcement to modify the risk environment in which drug use occurs are essential to facilitate safer injection practices.\(^ {165}\)

People who inject drugs who are most affected by street-level policing tend to possess various characteristics, such as homelessness, that place them at heightened risk for various adverse health outcomes. The confiscation of drugs and/or needles and syringes

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through discretionary policing practices has the potential to exacerbate drug market activity or prompt increased syringe borrowing.\textsuperscript{166}

- Drug-related mortality increased during times of more intense street-level law enforcement, and the number of drug-related deaths predicted the number of heroin possession offences two years later. Substitution treatment had a protective effect on drug-related mortality.\textsuperscript{167}

- A significant association between drug law enforcement and drug market violence exists. Increasing drug law enforcement is unlikely to reduce drug market violence. Instead, the existing evidence base suggests that gun violence and high homicide rates may be an inevitable consequence of drug prohibition and that disrupting drug markets can paradoxically increase violence.\textsuperscript{168}

A review of the literature from United States, Australia, and countries of Western Europe on the impact of law enforcement practices on HIV/AIDS prevention, care and treatment for people who use illegal drugs highlighted the following consequences of police action:\textsuperscript{169}

- Reluctance of people who use drugs to carry syringes and unsafe disposal of injecting equipment;
- Hurried preparation and injection of drugs;
- Displacement of people who use drugs away from access to health, harm reduction and social services and supports;
- Dangerous drug storage and concealment;
- Switch from smoking to injecting drugs, with concomitant increase in HIV and HCV risk;
- Increased incarceration of people who use drugs, where access to harm reduction measures is limited of non-existent and HIV/HCV risk behaviours are more prevalent;
- Exacerbation of stigma, marginalisation and fear;
- Unspecified HIV risk associated with intensive policing.

7.5 Good Practice and Law Reform

Guideline 4 of International Guidelines on HIV/AIDS and Human Rights calls on States to “review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.” The commentary on Guideline 4 states that criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. High-income countries have relied upon a range of legal and policy responses – involving civil, public health and criminal law measures – to address the criminal and public health aspects of illicit drug use, addiction and related public health and public order issues. In general, these responses fall into four broad categories: prevention; treatment; harm reduction; and law enforcement. Policy-makers have been urged to support evidence-based drug policies, including comprehensive harm reduction services for people who use drugs. A number of high-income countries have initiated law and policy initiatives that may help inform other countries seeking legal and policy solutions to the complex issues raised by illicit drug use and addiction. We set out a few examples of such initiatives.

Portugal is the only EU member state to reform its laws to explicitly decriminalise illicit drug possession and use. On July 1, 2001, a federal law decriminalised all drugs, including cocaine and heroin. While drug possession for personal use and drug usage itself are still prohibited by law, they are not prohibited under the criminal law. Rather, violations are in nature, and dealt with, outside of the criminal justice system. Drug trafficking continues to be prosecuted as a criminal offense. Since Portugal decriminalised illicit drugs, treatment programmes have improved substantially by way of level of funding and the willingness of the population to seek services. This has been accompanied by enhanced harm reduction services at the state and local level. As a result, the percentage of drug users among rates of newly infected HIV-positive individuals continues to decline and the number of newly reported cases of HIV and AIDS among drug addicts has declined substantially every year since 2001. In a joint statement, the

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United Nations Office and Drugs and Crime (UNODC) and International Narcotics Control Board has indicated that the UN drug control conventions permit the consideration of alternatives to imprisonment for addiction, but not towards legalisation of drug use.  

Switzerland experienced an open injection drug market and drug use in several cities beginning in the 1980s and was hard-hit by the HIV epidemic. Swiss officials at various levels of government and within various institutions adopted an approach to addressing the health and social consequences of problematic drug use, based on a “four pillars” approach (policing, prevention of drug use, treatment of drug use, and harm reduction). As heroin was the main drug being injected, the Swiss authorised low-threshold methadone maintenance therapy programmes, needle exchanges and safe injection rooms on a large scale. In addition, the Swiss Federal Office of Public Health oversaw a pioneering experiment in prescribing heroin. Services were evaluated, and the results fed back into the policy debates and programmatic revisions. A review undertaken for the Swiss Federal Office of Public Health concluded:

The assessment of harm reduction programs should be in terms of their own goals, namely improving the health and social functioning of those who continue to use, and reducing the damage they cause others. The continued monitoring of HAT [heroin assisted therapy] participants indicate that the gains observed in the initial trials continue; a population of dependent heroin users at great risk of high rates of relapse, blood borne disease and crime are doing better in terms of health and crime outcomes. The much larger MMT [methadone maintenance therapy] population also benefits in the same way. Drug Consumption Rooms may well have contributed to the declines in DRDs [drug related deaths] and drug related HIV.

The Swiss electorate in 2008 voted in favour of ratifying a federal law on narcotics that established, in legislation, the four pillars principle.


178 Loi fédérale sur les stupéfiants et les substances psychotropes, LF 812.12, as amended by ch. I de la LF du 20 mars 2008, en vigueur depuis le 1er juillet 2011 (RO 2009 2623, 2011 2559; FF 2006 8141 8211). The purpose of
In the USA, the Yale Center for Interdisciplinary Research on AIDS, with funding from the National Institutes of Mental Health, convened a two-day summit of practitioners from the criminal justice and public health sectors to share experiences and ideas with academic researchers and funders from the public health and criminal justice sectors. The primary goals of the event were to explore a common understanding of the dual epidemic of drug abuse and HIV, to learn about ongoing innovative efforts to harmonise criminal justice with disease prevention, and to identify and operationalise steps for further research, evaluation, and programmatic action. The summit was designed to build a common understanding of the issues facing the two sectors, reviewing case studies of collaboration, and sketching out a research agenda that can generate an evidence base around lessons learned from criminal justice-public health alignment activities.

the Act are set out in Article 1: La présente loi a pour but: a. de prévenir la consommation non autorisée de stupéfiants et de substances psychotropes, notamment en favorisant l’abstinence; b. de réglementer la mise à disposition de stupéfiants et de substances psycho- tropes à des fins médicales et scientifiques; c. de protéger les personnes des conséquences médicales et sociales induites par les troubles psychiques et comportementaux liés à l’addiction; d. de préserver la sécurité et l’ordre publics des dangers émanant du commerce et de la consommation de stupéfiants et de substances psychotropes; e. de lutter contre les actes criminels qui sont étroitement liés au commerce et à la consommation de stupéfiants et de substances psychotropes.

8. Additional Considerations

In addition to the described above links between HIV and criminal law, there are other aspects of legal and policy framework which could act as hindrances to the effective HIV response in the high income countries. Among them are legal and policy frameworks related to: 1) Access to health care for migrants. 2) Residence and citizenship restrictions for migrants and asylum seekers living with HIV (which impact people’s access to HIV testing and treatment); and 3) Higher HIV burden and lack of adequate response to HIV in prisons.

8.1 HIV and migrants

A number of studies describe higher HIV prevalence among migrant populations in the high income countries of Europe and North America. Some refer to higher HIV prevalence among migrants originating from countries with a high prevalence of HIV; others - to higher HIV prevalence in specific groups – including people from sub-Saharan African in Europe; Latinos in the US; and black African and Caribbean populations in the UK. The literature also suggests that female migrants from sub-Saharan Africa in Europe suffer from a disproportionate burden of HIV infection. The research suggests that many migrants acquire HIV in the country of destination, i.e. there is evidence showing that people of sub-Saharan African origin are becoming infected by HIV in the EU countries: in the UK, a quarter of HIV infections diagnosed among heterosexuals and half of infections among men who have sex with men from sub-Saharan Africa may have been acquired in the UK. There is also evidence of acquisition of HIV infection in Europe among men from Latin America and the Caribbean who have sex with men. In Spain, seroconversion studies indicate that a large proportion of HIV-positive Latin American MSM have been infected in Spain.

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181 Usually, high HIV prevalence among migrants is attributed to two factors: 1) epidemiological patterns in countries of origin with HIV infection acquired in the country of origin; 2) risk behaviour and vulnerability with HIV infection acquired in the country of destination.

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The literature identifies a range of social, economic, cultural and legal factors that increase vulnerability to HIV infection among migrants. Increased vulnerability is mainly related to high-risk behaviours and the lack of access to health services. Legal factors that exacerbate vulnerability of migrants include lack of entitlement to health services for undocumented migrants in some countries, and fear that disclosure about HIV will adversely affect legal status or visa application processes. In the US, undocumented status and lack of health insurance are highlighted as barriers to accessing healthcare, which increases vulnerability of migrants to HIV.

According to law and policies in the European countries and Canada, everybody legally present on the territory has access to health care services, including ART. In reality, in the majority of countries, the extent to which a person is eligible for services is explicitly linked to their immigration status. In some countries, specific categories of migrants (i.e. temporary residents in Finland) do not have access to free health care services. In Israel, Jewish immigrants have free and immediate access to medical services and treatment in the same way as all citizens. Documented immigrants are medically insured, but usually the insurers prefer to fly them back to their country of origin rather than paying for their treatment in Israel. Undocumented immigrants are generally not entitled to treatment, but only to free counselling and testing. Exceptions are pregnant women and children born in Israel to HIV-positive mothers. Even if they are undocumented immigrants, they are insured and have access to therapy. In Norway, the Communicable Disease Control Act gives all people residing in Norway the right to free HIV testing, counselling and treatment. Thus, even illegal immigrants by law have the right to access ART. In Switzerland, all immigrants with valid legal status are required to subscribe to medical insurance, like all Swiss citizens. With medical insurance, everybody enjoys full access to ART. Problems exist for illegal, non-declared immigrants. In the UK, any HIV-positive individual legally living in the UK is eligible for HIV-related care and treatment from National Health Service clinics. This includes refugees and asylum seekers.

Undocumented migrants lack access to free health care. Some countries (for example, Germany and Switzerland) provide health services through insurance schemes. By definition, undocumented migrants do not usually belong to such schemes. In other countries, undocumented migrants are afraid of using health services for fear of being detected and

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183 Social factors include stigma, lack of community support and isolation, racism and discrimination. Economic factors include unemployment, limited education and poverty. Cultural factors include language barriers, religion, cultural beliefs about health and HIV, the roles of men and women and sexual behaviour, attitudes towards homosexuality, and perceptions about health services. Low self-perception of HIV risk is also noted.


185 Ibid.

186 ECDC, Monitoring the Dublin Declaration, p. 115-117.
removed from the country. In some cases homeless people may lack access to health insurance cover because they do not have a permanent address.

Even if free health care is provided and a migrant has the required documents, legal and administrative status in the country of destination is a high priority for migrants. This means that concerns about the implications of an HIV-positive test result are cited as the main barrier to HIV testing in studies from Canada, the US, Spain and the UK. In contexts where a diagnosis of HIV may adversely affect legal status, visa or residence application processes or there is a fear of deportation, migrants are reluctant to be tested for HIV.

In order to achieve universal access to HIV prevention, treatment and care for all, experience of some European countries needs to be examined more closely. For example, a few European countries – for example Italy and Portugal – make a clear commitment to provide ART to undocumented migrants who need it.

8.2 Entry and Residence Requirements

Most of the research countries have eliminated entry restrictions for people living with HIV (including HIV test for visa purposes.) However in several countries the HIV test requirement remains for the purposes of receiving a work permit, permanent residence and citizenship.

In Europe, HIV testing for migrants and asylum seekers is offered prior to entry in some countries, as part of general health screening. HIV testing is mandatory for migrants and asylum seekers entering Canada. Routine HIV testing is required for all applicants who are 15 years of age and over and are seeking entry to Canada for a period longer than six months (i.e. students, workers, visitors, those applying for immigration and refugee status, etc.), and resided in a designated country for six consecutive months within a 12-month period immediately preceding entry into Canada. The majority of HIV-positive foreigners do not have access to a residence or work permit. Legal foreign workers are tested for HIV in Israel. The Ministry of Interior reserves the right to deny entry to HIV positive aliens. HIV tests may be requested in certain states in Germany for visa applications that exceed three months. It is within the discretion of the local departments for foreigners to ask for medical certificates that exclude active tuberculosis, infectious syphilis or HIV infection. Checks for individuals wanting to work in Greece cover TB and hepatitis B but not HIV. Sex workers wishing to work in Greece are the only group subjected to HIV tests.

187 Ibid.
188 Ibid.
190 Ibid.
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In 2008, the Secretary General of the United Nations, Ban Ki-Moon, asked the countries of the world to waive HIV-related entry conditions. He called these regulations an affront against humanity. Discrimination like this, he said, will drive the virus underground, where it will spread in the darkness. In 2008, The EU Civil Society Forum on HIV adopted a policy paper to request a change of legislation by those countries in Europe that still have discriminatory restrictions in place. The 2009 Communication from the European Commission’s Action Plan to combat HIV in Europe 2009–2013 explicitly condemned HIV-related entry restrictions: “HIV/AIDS as an issue of concern for migrants is addressed differently across Europe. Several European countries maintain restrictions on entry, stay and residence based on HIV status. These provisions are discriminatory and do not protect public health”. In the UK and Switzerland following energetic civil society involvement the governments renounced their plans to introduce restrictions on entry and asylum for HIV positive foreigners.\footnote{Ibid.}

After lengthy efforts by international intergovernmental organisations and civil society groups, on 30 October 2009, US President Barack Obama announced that all restrictions affecting people living with HIV from entering or migrating to the United States will be lifted. On 2 November 2009, CDC posted a ‘final rule’ that removed HIV infection from US immigration screening, stating that HIV infection does not pose a public health risk to the general population through casual contact. This rule went into effect in 2010 and the travel ban against HIV-positive persons was lifted.\footnote{Ibid.}

8.3 HIV in Prisons

In the high-income countries of Europe and North America as in other countries of the world HIV prevalence in prisoners is higher than among the general population. It is estimated from 1.5% in Belgium and 2.5% in Italy, to 4.3% in Sweden, and 7.3% in Portugal, and 7.8% in Spain. The majority of these countries provide incarcerated people with adequate health care services and prevention of HIV and STI. The transmission of HIV in prisons happens due to injecting drug use, unsafe sex and other unsafe practices such as tattooing. Evidence from many countries show that no country has managed to stop sexual relations among prisoners as well as injecting drug use in prisons. Many prisoners have history of drug use; many are incarcerated for offences related to drugs. Even in the high income countries, prisoners living with HIV sometimes receive substandard treatment and care, and are especially vulnerable to specific prison conditions such as overcrowding and poor sanitation and ventilation. Some form of harm reduction services (such as NSPs), opioid substitution treatment (OST), safer tattooing
programmes and distribution of condoms) in prisons are provided in almost all research countries, but the coverage is far from sufficient.

The *Universal Declaration of Human Rights*, which elaborates on UN member states’ human rights obligations under the UN Charter, states that “everyone has the right to a standard of living adequate for health and wellbeing, including medical care and necessary social services.” A number of international legal instruments address specifically the issue of the human rights of people in prisons. The UN Standard Minimum Rules for the Treatment of Prisoners contain provisions regarding fundamental rights of prisoners and provides a set of guidelines designed to ensure respect for prisoners’ rights, including adequate health care, treatment and living conditions. The UN Basic Principles for the Treatment of Prisoners state that prisoners shall not be subject to discrimination on a variety of grounds, including health status, and that they shall not have their human rights limited other than those necessarily limited by the fact of incarceration. The document also provides that prisoners shall have access to the medical and health services available in their country of incarceration without discrimination based on their legal status. This means that prisoners have the right to receive health care, including preventative measures, equivalent to that available in the general community. The WHO Guidelines on HIV Infection and AIDS in Prisons confirm that prisoners have the right to access health care and to HIV prevention strategies in prisons.\(^{193}\)

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All research countries offer some HIV prevention measures in their prisons. Finland, Italy, Luxembourg, the Netherlands, Norway, Spain, Sweden and the United Kingdom have OST in all their prisons. In Greece OST is not available in prisons. Several research countries make NSPs available in their prisons. Luxembourg and Portugal identified the provision of needle and syringe exchange in prisons as one of their most significant prevention achievements.

Spain has 79 prisons with over 40,000 prisoners. Up to half of those in prison have a history of injecting drug use. In 2000, HIV prevalence among prisoners was found to be 16.4%. HIV prevention programmes in prisons, including HIV counselling, education, bleach, condoms, methadone started between 1990 and 1993. The first pilot NSP in a prison began in 1997 in Bilbao and other prisons have followed since then. The mode of provision of sterile injecting material is through hand to hand distribution, respecting the confidentiality of the people and allowing the possession of one syringe per inmate. To acquire the first syringe and needle, the prisoner requests one anti-AIDS kit, containing a syringe, needle, swabs and water for injection,

from the NSP team. Further anti-AIDS kits are obtained by exchanging the used needle and syringe.\textsuperscript{194}

However, research show that many countries institute compulsory HIV testing prior to the entry into prison (i.e. Germany and Israel). Compulsory HIV testing infringes on the right to security of the person, the right to privacy and the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment. According to research, coverage by HIV prevention measures almost in all prisons of the region is inadequate. In Canada, despite the evidence of their effectiveness in preventing HIV transmission, harm reduction measures are very limited and neither condoms nor NSPs are available in federal prisons.

Appendix A: Criminal Laws Applied to Sexual Non-disclosure, Exposure and Transmission / Selected European Countries, Canada and the USA\textsuperscript{195}

<table>
<thead>
<tr>
<th>Country</th>
<th>Applicable Law, Activities Criminalised, Relevant Sections</th>
<th>Prosecutions</th>
<th>Convictions</th>
<th>Information Updated</th>
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</thead>
</table>
| Austria | • Austrian Penal Code, general provisions applicable to transmissible diseases  
          • Transmission & exposure  
          • Disclosure of HIV status not a defence  
          • Section 178, intentionally cause danger of spreading transmissible diseases (max 3 years penalty; fine)  
          • Section 179, negligently cause danger of spreading transmissible disease (max 1 year penalty; fine) | 30 to 40 | 30 | 14/01/09 |
| Belgium | • Belgian Penal Code, general provisions  
          • Transmission  
          • Sections 402, voluntarily causing sickness or incapacity to work; giving substances that can cause death or greatly alter health (3 months to 5 year penalty)  
          • Section 418, negligent injury  
          • Section 421, involuntarily causing sickness or incapacity to work; giving substances that can cause death or greatly alter health (penalty of 8 days to one year; fine) | 3 | 1 | 13/06/11 |
| Denmark | • Danish Criminal Code & Order No. 547 (15 June 2001), HIV-specific law  
          • Transmission & exposure  
          • Section 252: reckless exposure to danger of being infected with fatal and incurable disease (max penalty 8 years)  
          • Order No. 547: HIV/AIDS specific for the purposes of s 252 | 18 | 11 | 31/05/11 |
| *Law suspended February 2011.* | | | | |
| Finland | • Finnish Penal Code, Chapter 21, general criminal law of homicide and bodily injury (max 10 years)  
          • Transmission & exposure | Approximately 12 | Approximately 8 | 22/12/10 |

\textsuperscript{195} Unless otherwise noted, the information on laws and prosecutions in the countries presented in the table comes from the following sources: Nyambe M (2005), *Criminalisation of HIV transmission in Europe: A rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights.* GNP+, Terrence Higgins Trust, [www.gnpplus.net/criminalisation/index.shtml](http://www.gnpplus.net/criminalisation/index.shtml); GNP+ (2010), *The Global Criminalisation Scan Report 2010: Documenting trends, presenting evidence,* [www.gnpplus.net/criminalisation](http://www.gnpplus.net/criminalisation); Bernard EJ (2010), *Criminal HIV Transmission,* [http://criminalhivtransmission.blogspot.com](http://criminalhivtransmission.blogspot.com); Bernard EJ (2010), *HIV & the Criminal Law.*
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<th>Convictions</th>
<th>Information Updated</th>
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<tr>
<td>France</td>
<td>• French Penal Code, general provisions&lt;br&gt;• Transmission &amp; exposure&lt;br&gt;• Article 221-5: attempt to kill using poison&lt;br&gt;• Article 221-15: administering a dangerous substance&lt;br&gt;• Article 223-1: exposing someone to death or risk of injury which lead to injury or handicap&lt;br&gt;• Article 223-6: refusal to assist a person exposed to danger</td>
<td>Approximately 18</td>
<td>18</td>
<td>29/03/11</td>
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<tr>
<td>Germany</td>
<td>• German Penal Code, general provisions&lt;br&gt;• Transmission &amp; exposure&lt;br&gt;• Article 223: bodily injury&lt;br&gt;• Article 224: aggravated assault&lt;br&gt;• Article 229: negligent bodily injury</td>
<td>18</td>
<td>14</td>
<td>17/08/10</td>
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<tr>
<td>Greece</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Iceland</td>
<td>• Icelandic Penal Code, general provisions&lt;br&gt;• Transmission &amp; exposure&lt;br&gt;• No 19/1940, section 175: spreading contagious disease (max 3 years)&lt;br&gt;• No 19/1940, section 220(4): Places lives or health of others in danger (max 4 years)&lt;br&gt;• No 19.1997, Section III Communicable disease: incumbent upon all persons to take precautions and to do one’s best to avoid infecting oneself and others</td>
<td>0</td>
<td>0</td>
<td>15/01/09</td>
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<tr>
<td>Ireland</td>
<td>• Non Fatal Offences Against the Person Act, general provisions&lt;br&gt;• Transmission, possibly exposure&lt;br&gt;• Section 4: intentional or reckless cause serious harm to another (max life)&lt;br&gt;• Section 13: intentionally or recklessly engages in conduct which creates substantial risk of death or serious harm (max 7 years; fine)</td>
<td>0</td>
<td>0</td>
<td>15/01/09</td>
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<tr>
<td>Italy</td>
<td>• Italian Penal Code, general provisions&lt;br&gt;• Transmission &amp; exposure&lt;br&gt;• Article 582: bodily harm&lt;br&gt;• Article 583: aggravated bodily harm&lt;br&gt;• Article 589: culpable homicide</td>
<td>10+</td>
<td>10+</td>
<td>01/12/08</td>
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<td>Country</td>
<td>Applicable Law, Activities Criminalised, Relevant Sections</td>
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| Netherlands | • Criminal Code, general provisions  
  • Since 2005 intentional transmission alone criminalised; exposure not liable to prosecution.  
  • Article 82: grievous bodily harm includes illness with no chance of complete healing, likely to result in continuous disability, spontaneous abortion, or death  
  • Article 300: Singular physical abuse (max 2 years or fine) causing grievous bodily harm (max 4 years or fine), causing death (max 6 years or fine); intentional detrimental effect on health is abuse  
  • Article 301: Planned physical abuse (max 3 years or fine), grievous bodily harm (max 6 years or fine), causing death (max 9 years or fine)  
  • Article 302: Intentional grievous bodily harm (max eight years or fine), causing death (max 10 years or fine)  
  • Article 303: grievous bodily harm with premedication (max 12 years or fine), causing death (15 years or fine) | 15           | 14          | 19/01/09           |
| Norway    | • Norwegian Penal Code, general provisions  
  • Transmission & exposure  
  • Section 155: Willful (max 6 years) or negligent (max 3 years) infliction or exposure to a generally contagious disease | 14           | 14          | 21/06/09           |
| Portugal  | • Portuguese Penal Code, general provisions  
  • Transmission  
  • Article 144: Injury to body or health by permanent illness provoking danger to life  
  • Article 177: Sexual assault resulting in transmission of HIV that creates danger for life or death  
  • Article 183: Dissemination of contagious disease by willful conduct (5 years or fine) negligence (max 3 years or fine) | ‘At least 2’  | n/a         | 15/01/09           |
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<tr>
<th>Country</th>
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<th>Prosecutions</th>
<th>Convictions</th>
<th>Information Updated</th>
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</table>
| Spain               | • Criminal Code, general provisions  
• Transmission  
• Article 147.1: Bodily injury affecting integrity, mental or physical health when injury requires medical or surgical treatment beyond initial assistance (max 3 years) | 0            | 0           | 15/01/09            |
| Sweden              | • Swedish Penal Code, general provisions  
• Transmission & exposure  
• Chapter 3, section 5: Infliction of bodily injury, illness or pain is an assault (max 2 years)  
• Chapter 3, section 6: Gross assault, serious illness, ruthlessness or brutality (Min 1, max 10 years)  
• Chapter 3, section 8: Carelessly causes another to suffer illness or bodily injury of not a petty nature (6 months max), if crime is gross (max 4 years)  
• Chapter 3, section 9: Expose another through gross carelessness to mortal danger or danger of severe bodily injury or illness (max 2 years) | 52-57        | 52-57       | 22/06/10            |
| Switzerland         | • Swiss Penal Code, general provisions  
• Transmission & exposure  
• Disclosure of HIV status or consent to sex with HIV-positive person not a defence  
• Article 122: Intentionally injury in a life-threatening way, makes a person incapable of working, intentionally causes grievous bodily injury to human being or physical or mental health (6 months to max 5 years)  
• Article 231: Intentionally spread of dangerous transmissible human disease (1 month to max 5 years); negligent spread of dangerous transmissible human disease (prison or fine) | 39           | 26          | 08/12/10            |
| UK -- England & Wales | • Offences Against the Person Act, 1861, general provisions  
• Transmission and intentional exposure  
• Article 18: Intentionally causing grievous bodily harm  
• Article 20: Recklessly causing grievous bodily harm | 19           | 15          | 01/08/11            |
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<tr>
<td>UK -- Scotland</td>
<td>• Common law offence of “culpable and reckless conduct”, general law</td>
<td>4</td>
<td>3</td>
<td>01/10/10</td>
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<tr>
<td></td>
<td>• Transmission &amp; exposure</td>
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<tr>
<td></td>
<td>• Criminalises acts that cause injury to others or create risk of injury</td>
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<td>UK -- Northern Ireland</td>
<td>n/a</td>
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<th>Prosecutions</th>
<th>Convictions</th>
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<td>• Transmission &amp; exposure</td>
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<td>• Section 180: Common nuisance endangering the life, health, safety of the public, causing physical injury to another person (max 2 years)</td>
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<td>• Section 221: Criminal negligence causing bodily harm by showing wanton or reckless disregard for the lives or safety of others persons (max 10 years)</td>
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<td>• Section 245: Administering a noxious thing intending to endanger life (max 14 years)</td>
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<td>• Section 265: Assault where person applied force intentionally to another person without consent (max 5 years)</td>
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<td>• Section 268: Aggravated assault where assault wounds, maims, disfigures or endangers the life of the complainant (max 14 years)</td>
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<td>• Section 271: Sexual assault (max 10 years)</td>
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<td>• Section 273: Aggravated sexual assault (max life)</td>
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<td>• Section 269: Unlawfully causing bodily harm (max 10 years)</td>
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<td>• Section 231: First degree murder (max life), or attempted murder</td>
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<td>USA</td>
<td>• State and federal laws.</td>
<td>350 (illustrative, non-exhaustive account)</td>
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Appendix B: General Overview of Public Health Law Powers

In high-income countries legal duties imposed and powers granted under public health legislation in relation to HIV (and other communicable diseases, including sexually transmitted infections), may include:

**Reporting of cases of HIV/AIDS:** Medical professionals (and under some laws other people) are required to report known and suspected cases of HIV (and sometimes AIDS) to public health authorities. Public health authorities use this information for disease surveillance at a population level and for monitoring individual cases of infection.

**Partner notification** (also known as partner counselling or contact tracing): A public health measure designed to prevent the spread of communicable disease by encouraging people who may have been exposed to such a disease to seek medical care, including testing and treatment if necessary. When someone (sometimes referred to as the “source person” or “index case”) tests positive for a blood-borne or sexually transmitted infection, that person’s sexual and drug injecting partners who may have been exposed to the infection are contacted and encouraged to seek medical care, including counselling and testing. Depending on the jurisdiction, partner notification may be voluntary or may be required by law.

**Behaviour orders:** Where a public health official reasonably believes, on the basis of credible evidence, that a person living with HIV is engaging in behaviours that put someone else at risk of acquiring HIV, the public health official can issue a written order against the person living with HIV. Such an order will usually set out how the person must behave e.g., disclose HIV status before sex involving penetration; use condoms for sex involving penetration; provide public health with the names of sexual and injecting drug partners; participate in education and counselling sessions; enter into and remain under the care of a physician. Orders also routinely set out the behaviours the person living with HIV is prohibited from engaging in e.g., do not share injecting equipment; do not donate blood, tissues or other organs. The power to issue orders is usually only given to senior public health officials.

**Examination, testing & treatment orders:** Under certain circumstances, when legal preconditions are met, a public health official can order a person who is suspected of having HIV to undergo medical examination and testing. Where a person has HIV, the authority can order the person to undergo examination and treatment for the purposes

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of reducing or eliminating the risk of HIV transmission. The law may permit public health officials to enlist law enforcement officials to apprehend the person and take him or her for medical examination, testing or treatment. Sometimes legislation requires that the public health official receive approval from an independent administrative body or court before making this type of order.

**Detention orders for the purpose of treatment** (sometimes referred to as civil confinement orders): A public health official can order a person living with HIV to be confined to a secure institution (e.g., a forensic hospital or other secure hospital setting) for a period of time. Sometimes legislation requires that the public health official receive approval from an independent administrative body or court before making this type of order. Also, the public health official may be required to apply to an independent administrative body or court for approval to extend the order beyond the original period of time.
Appendix C: New Zealand’s Legal and Policy Reforms Related to Prostitution

Although New Zealand was not included within the ambit of the Issue Briefs for the High-Income Countries Dialogue, it is a high-income country, and in 2003 undertook a significant legal reform of prostitution-related law and policy. Prior to the passage of the Prostitution Reform Act 2003\(^{197}\), prostitution was not illegal per se in New Zealand, though many of the activities surrounding it were.

The Act’s stated purpose is to decriminalise certain activities related to prostitution and to create a framework that: safeguards the human rights of sex workers and protects them from exploitation; promotes the welfare and occupational health and safety of sex workers; is conducive to public health; and prohibits the use in prostitution of persons under 18 years of age. It permits and regulates the business of prostitution, and distinguishes between “brothels” and “small owner-operated brothels”. Restrictions are placed on advertising and local governments are given the power to regulate the location of brothels and signage advertising commercial sexual services. Non-citizens cannot get work permits for the business of prostitution.

The Act contains provisions intended to minimise the transmission of sexually transmitted infections and otherwise protect the health of sex workers and clients. The Act does not require sex workers to undergo medical examinations or provide health certificates. The Department of Labour published A Guide to Occupational Health and Safety in the New Zealand Sex Industry.\(^ {198}\) In addition, the general Health and Safety in Employment Act 1992 applies to sex workers.

A committee conducted a mandatory statutory review of the legislation in 2008. The committee made the following findings:\(^ {199}\)

- PRA has had a marked effect in safeguarding the right of sex workers to refuse particular clients and practices, chiefly by empowering sex workers through removing the illegality of their work.

\(^{197}\) Public Act 2003 No 28 (PRA).


- There is a high level of awareness of Occupational Health and Safety requirements in the sex industry, but compliance cannot be measured as there is no system of regular inspections of brothels by Medical Officers of Health or the Department of Labour.
- The majority felt sex workers surveyed were now more likely to report incidents of violence to the Police, though willingness to carry the process through to court is less common.
- There has been some improvement in employment conditions, but this is by no means universal. Generally, brothels which had treated their workers fairly prior to the enactment of the PRA continued to do so, and those which had unfair management practices continued with them.

The Committee recommended that the sex industry, with the help of the Department of Labour and others, moves towards written, best practice employment contracts becoming standard for sex workers working in brothels.
“Every day, stigma and discrimination in all their forms bear down on women and men living with HIV, including sex workers, people who use drugs, men who have sex with men, and transgender people. Many individuals most at risk of HIV infection have been left in the shadows and marginalised, rather than being openly and usefully engaged... To halt and reverse the spread [of HIV], we need rational responses which shrug off the yoke of prejudice and stigma. We need responses which are built on the solid foundations of equality and dignity for all, and which protect and promote the rights of those who are living with HIV and those who are typically marginalised.”

- UNDP Administrator Helen Clark

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