

Bareback Sex in the Age of Preventative Medication: Rethinking the 'Harms' of HIV Transmission

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Abstract

The experiences of people living with HIV have been transformed over recent years. Advances in medical science have made the virus a manageable chronic condition, while eliminating the risk of onward transmission for those with access to treatment, something referred to as TasP (treatment as prevention) or U=U (undetectable equals untransmissible). More recently, the availability of PrEP (pre-exposure prophylaxis), alongside PEP (post-exposure prophylaxis), through the NHS has created the conditions for condomless sexual encounters to take place without the fear of HIV transmission associated with previous decades. Despite this, the criminal law has continued to frame HIV in terms of personal responsibility and bodily autonomy within the dominant narratives of danger, disease, and out-dated science. Doctrinal law has failed to keep pace with social and scientific change. Therefore, in this article, we provide a re-examination of the criminal issues relating to HIV transmission within this new landscape, arguing that it necessitates a shift in attitude, policy and doctrine. We specifically argue that HIV transmission does not meet the appropriate harm threshold to constitute GBH and that if criminal law is ultimately about preventing or regulating harm, the ongoing criminalisation of HIV transmission is counter to that aim.

Keywords

Bareback sex, grievous bodily harm, HIV, PEP, PrEP, responsibility, risk, TasP

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Introduction

It is during another global pandemic—that of COVID-19¹—that the UK Government has announced significant changes to the availability of HIV pre-exposure prophylaxis (PrEP)² in England,³ moving from limited availability via ‘trials’,⁴ to routine availability for the general population via the National Health Service (NHS).^{5–7} As the search for effective responses (e.g. vaccines) to one pandemic continues to be the focus of policymakers and scientists, PrEP has become more widely available in efforts to prevent new HIV diagnoses. This sits alongside pre-exposure prophylaxis (PEP)⁸ and treatment as prevention (TasP)⁹ as an important pharmaceutical tool which has the potential to halt the transmission of HIV.

The move to make PrEP available on the NHS has the power not only to transform the statistics on HIV transmission in England and Wales but also to re-shape the criminal law pertaining to HIV transmission.¹⁰ Such developments arguably have applicability for healthcare and legal systems well beyond the UK as governments and NGOs seek to utilise law to shape behaviours, manage decision-making and risk-taking.

1. The World Health Organization defines COVID-19 as ‘the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. COVID-19 is now a pandemic affecting many countries globally’. See ‘Coronavirus Disease (COVID-19)’ *Who.int* (2020) <<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses>> accessed 28 October 2020.
2. The PrEP campaign group *Prepster* describes the treatment as: ‘a way of preventing HIV infection by taking a pill on an ongoing basis before sex and continued after sex. It’s taken by someone who doesn’t have HIV, to prevent them from getting HIV. The PrEP pill is an antiretroviral drug—the same type of pill taken by someone who already has HIV to treat HIV’. See ‘Prepster’ *Prepster* (2020) <<https://prepster.info>> accessed 28 October 2020.
3. Availability was confirmed in Wales in June 2020. See Reiss Smith, ‘HIV Activists Celebrate as Wales Confirms Life-Saving HIV Drug PrEP Will Be Rolled Out on the NHS’ *PinkNews—Gay News, Reviews and Comment from the World’s Most Read Lesbian, Gay, Bisexual, and Trans News Service* (2020) <<https://www.pinknews.co.uk/2020/06/30/prep-wales-roll-out-commissioned-available-hiv-drug/>> accessed 28 October 2020.
4. Local authorities are the responsible commissioner for HIV prevention services in England under reg 6 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.
5. See ‘HIV Prevention Drug PrEP “To Be Made Available on the NHS This Year”’ *The Telegraph* (2020) <<https://www.telegraph.co.uk/news/2020/03/15/hiv-prevention-drug-made-available-nhs-year/>> accessed 28 October 2020.
6. The March announcement on PrEP was followed by some confusion about a potential step back from this position but it became clear that the rollout would be slightly delayed by Covid-19 but would still happen. See Jamie Wareham, ‘Life-Saving HIV Drug PrEP on NHS Delayed amid Coronavirus Pandemic’ *Forbes* (2020) <<https://www.forbes.com/sites/jamiewareham/2020/06/05/life-saving-hiv-drug-prep-on-nhs-indefinitely-delayed-amid-coronavirus-pandemic/#3e3080f91416>> accessed 28 October 2020.
7. On the legal battle to get to this point, see Alexander Maine, ‘Bareback Sex, PrEP, *National AIDS Trust v NHS England* and the Reality of Gay Sex’ (2020) 23(8) *Sexualities* 1362.
8. Post-exposure prophylaxis is an anti-viral treatment that can be taken after someone believes they have been exposed to a risk of HIV transmission. See ‘Is Prep Different From PEP?—Prepster’ *Prepster.info* (2020) <<https://prepster.info/ser/vices/ser-vice-2/>> accessed 28 October 2020.
9. This refers to the use of antiviral treatment by someone who is HIV positive to stay healthy and to also reduce the risk of transmitting HIV. See, generally, ‘TasP! Find Out More About Treatment as Prevention!’ *Prepster* *Prepster* (2020) <<https://prepster.info/tasp/>> accessed 28 October 2020.
10. The focus of this article is on the law in England and Wales, but the criminalisation of HIV debate is global. Problematic tropes of ‘the disease spreader’ intersect with issues of race, class and shame. See Joey L Mogul, Andrea J Ritchie, and Kay Whitlock, *Queer (In)justice: The Criminalization of LGBT People in the United States* (Beacon Press, Boston 2011) 34–36; Libby Adler, *Gay Priori: A Queer Critical Legal Studies Approach to Law Reform* (Duke University Press, Durham 2018) 68. On global legal responses to HIV more generally, see James Chalmers, *Legal Responses to HIV and AIDS* (Hart Publishing, Oxford 2008). The legal debate has not been limited to criminalisation, but also to healthcare rights, eg Alexandra Juhász and Theodore (Ted) Kerr, ‘Who Are the Stewards of the AIDS Archive? Sharing the Political Weight of the Intimate’ in Angela Jones, Joseph Nicholas DeFilippis and Michael W Yarbrough (eds), *The Unfinished Queer Agenda After Marriage Equality* (Routledge, Abingdon 2018); Maine (n 7); Matthew Weait, ‘The Healthcare Rights of People Living with HIV and AIDS’ in Chris Ashford and Alexander Maine (eds), *Research Handbook on Gender, Sexuality and the Law* (Edward Elgar, Cheltenham 2020).

The law on HIV transmission has arguably lagged behind a seismic shift in clinical practice and medical science, maintaining criminalisation under the Offences Against the Person Act 1861 (OAP).¹¹ This has contributed to moral judgments of those participating in what may be viewed as ‘high risk’ practices such as bareback¹² (condomless) sex.¹³ The interpretation of OAP as capturing HIV transmission¹⁴ has further operated to re-code such practices—from expressions of desire to enactments of violence¹⁵—supporting normative attitudes that such engagements are deviant or illegitimate.

Moreover, as Gonzalez has noted, society continues to be shaped by the original trauma of the HIV/AIDS pandemic,¹⁶ especially for queer and other marginalised communities. During the early days of that crisis there were many questions, few answers, and rumours took on a power of their own.¹⁷ In the 1980s and 1990s, AIDS found a solution—of sorts—with condoms becoming a social and medical response, and thereby a signifier for salvation, protection, and responsibility (terms which have been similarly applied to masks, social distancing, and vaccines during the current crisis). This response was, in turn, codified by the criminal law as responsibility acquired accountability. As such, the law acts as a site of trauma,¹⁸ one that is seemingly unable to move into the ‘new normal’¹⁹ of PrEP, PEP, TasP and U=U, alternatives to the condom-based discourse of ‘safe sex’.

Condomless sex is variously celebrated and condemned in Western contemporary cultures.²⁰ On the one hand, pregnancy—typically the result of condomless sexual encounters—can be reason for celebration, a triumphant result of hetero- and homonormative ideals. The child can be a symbol for reproductive instinct, the survival of humanity, our culture and our values. On the other hand, pregnancy without an identifiable father, or outside the bounds of marriage, can still be cause for moral and social concern—perhaps less prevalent but still imbued with classist and racist undertones. These tensions of normativity continue to be regulated by the operation of civil law in this sphere.²¹

By comparison, the term ‘bareback’ possesses a range of nuanced and complex meanings, each with different discursive dynamics, which have shifted over time.²² This is important for understanding how the law relating to

11. Law Commission, ‘Reform of Offences Against the Person’ (Law Com No 361 HMSO, London 2015) <https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/11/51950-LC-HC555_Web.pdf> accessed 26 October 2020.
12. See, more generally, Michael Shernoff, *Without Condoms: Unprotected Sex, Gay Men & Barebacking* (Routledge, Abingdon 2006).
13. See Chris Ashford, ‘Bareback Sex, Queer Legal Theory, and Evolving Socio-Legal Contexts’ (2015) 18(1–2) *Sexualities* 195.
14. See, generally, Matthew Weait, *Intimacy and Responsibility: The Criminalisation of HIV Transmission* (Routledge-Cavendish, Abingdon 2007).
15. See Chris Ashford, ‘Barebacking and the Cult of Violence: Queering the Criminal Law’ (2010) 74(4) *J Crim L* 339.
16. See, more generally, Paul Flynn, *Good as You* (Ebury Press, London 2017), especially ch 5. This historic trauma is not limited to gay men. Lesbians were key in the struggle. See, also, Beth E Schneider, ‘Lesbian Politics and AIDS Work’ in Ken Plummer (ed), *Modern Homosexualities: Fragments of Lesbian and Gay Experience* (Routledge, London 1992).
17. See, eg, Dennis Altman, *AIDS in the Mind of America: The Social, Political, and Psychological Impact of a New Epidemic* (Anchor Press/Doubleday, Garden City 1986); Eric Rofes, *Reviving the Tribe: Regenerating Gay Men’s Sexuality and Culture in the Ongoing Epidemic* (Harrington Park Press, New York 1996).
18. HIV/AIDS has a particular place in queer history, not only through the criminalisation of HIV transmission but a broader social agenda in which sexual health intersect with issues of homophobia and education, censorship and access to healthcare. This was particularly notable in the US context and the 1987 ‘Helms Amendment’ to what would become Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1988, and in the UK, s 28 of the Local Government Act 1988. See, respectively, Lisa Duggan and Nan D Hunter, *Sex Wars: Sexual Dissent and Political Culture* (Routledge, Abingdon 2006) 129–30, and Madeleine Colvin with Jane Hawksley, *Section 28: A Practical Guide to the Law and its Implications* (Liberty, Chennai 1989).
19. Gonzalez, ‘HIV Pre-Exposure Prophylaxis (PrEP), “The Truvada Whore,” and the New Gay Sexual Revolution’ in Ricky Varghese (ed), *Raw: PrEP, Pedagogy, and the Politics of Barebacking* (University of Regina Press, Regina 2019) 34.
20. See, more generally, Tim Dean, *Unlimited Intimacy: Reflection on the Subculture of Barebacking* (University of Chicago Press, Chicago 2009).
21. See, generally, Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, & the Limits of Law* (Duke University Press, Durham and London 2015) 50–73.
22. Adam Greteman, ‘Viral Matters: Barebacking and PrEP’ in Adam Greteman (ed), *Sexualities and Genders in Education: Towards Queer Thriving* (Palgrave Macmillan, Cham 2018).

HIV transmission takes on a broader power in relation to bareback sex. As Dean has noted, sex without condoms was once simply 'natural', for there was no alternative. Bareback sex was simply sex. Yet today the term can be understood in a number of forms, as the 'outcome of highly specific cultural processes of eroticization'.²³ That is to say, the fetishisation of bareback through pornographic labels and broader (sub)culture through websites, sex parties, and other interactions (sometimes intersecting with the phenomenon of chemsex)²⁴ has served to transform the act of bareback sex into one with broader cultural characteristics for many; it must be understood beyond merely the narrow normative construction of condomless sex that the criminal law has assumed.

Condomless anal sex remains a controversial subject, even in queer cultures. Mainstream and community-based media often reminds us that bareback is 'bad', and this moral policing is increasingly backed by legal interventions globally which seek to address the transmission of sexual infections, alongside regulatory regimes to control and censure visual depictions of bareback sex. This framework sees the barebacking sexual citizen²⁵ forge new visions of what it is to be a homosexual in the 21st century, challenging narratives that have often been associated with equality and normative agendas (e.g. marriage, monogamy, and military participation).²⁶ Moreover, while scholars have begun to understand this phenomenon through theoretical constructions of the homo-normative and 'good gay, bad queer' analysis,²⁷ this article seeks to theorise and discuss how scientific and social developments might produce legal shifts which re-shape our understanding(s) and construction(s) of HIV as they relate to the criminal law.

The article re-considers the law relating to HIV transmission and, in contrast with other accounts of this area, seeks to understand it within a new scientific context and people's lived experiences of sexuality. Drawing on this framework, we argue that risk and harm must be re-evaluated when considering the law pertaining to HIV.²⁸ This is particularly acute in relation to the classification of the transmission of HIV as grievous bodily harm (GBH), as we argue that HIV transmission does not meet the appropriate harm threshold.²⁹ This article develops over three parts. Firstly, we explore recent scientific research about the effectiveness of TasP and the use of PrEP for preventing the transmission of HIV. Secondly, we explore the relevant law, to understand how and why the transmission of HIV has been criminalised. In doing this, we offer reflections on why some HIV charities and other groups have endorsed the criminalisation of transmission. Lastly, we explore how harm has been conceptualised in legal, medical, and societal terms. By analysing these different notions of 'harm', we argue that HIV no longer attains the severity required to constitute GBH, and that—by being unaware of the harms which criminalisation itself perpetuates, through stigma and trauma—the criminal law (as it stands) undermines core aspects of the liberal case in favour of legally regulating consenting sexual behaviours.

Part One: HIV Treatment and Prevention

Before the development of 'highly effective' antiretroviral therapies (ART) in 1996 an HIV test signalled serious health implications for almost anyone who tested positive.³⁰ The effects of the virus on a person's

23. Tim Dean, 'Afterword: The Raw and the Fucked', in Ricky Varghese (ed), *Raw: PrEP, Pedagogy, and the Politics of Barebacking* (University of Regina Press, Regina 2019) 259.

24. This broader context can be understood within a broader 'sluttiness' or sleaze, also known as 'pig' behaviour. See, eg, João Florêncio, *Bareback Porn, Porous Masculinities, Queer Futures: The Ethics of Becoming-Pig* (Routledge, Abingdon 2020). Again, this also needs to be understood in the broader context of shame. See David M Halperin and Valerie Traub, *Gay Shame* (University of Chicago Press, Chicago 2009).

25. See, generally, David Bell and Jon Binnie, *The Sexual Citizen: Queer Politics and Beyond* (Polity Press, Cambridge 2000).

26. See, eg, Michelangelo Signorile, *It's Not Over: Getting Beyond Tolerance, Defeating Homophobia, and Winning True Equality* (Houghton Mifflin Harcourt, Boston/New York 2015); Jeffrey Weeks, *The World We Have Won* (Routledge, Oxon 2007).

27. See, eg, Chris Ashford, '(Homo)normative Legal Discourses and the Queer Challenge' (2011) 1(1) *Durham L Rev* 77; Lisa Duggan, *The Twilight of Equality? Neoliberalism, Cultural Politics, and the Attack on Democracy* (Beacon Press, Boston 2003); Gayle S Rubin, *Deviations* (Duke University Press, Durham/London 2011) ch 5.

28. And, we would argue, the transmission of disease more generally.

29. A similar argument has begun to be advocated in the Australian context, see, eg, Thomas Poberezy-Lynch, 'Criminalising Infection: Questioning the Assumption that Transmitting HIV Constitutes Grievous Bodily Harm' (2019) 44(2) *Alt LJ* 138.

30. 'Why Can't Current Drugs Cure HIV Infection?' *Tufts Now* (2016) <<https://now.tufts.edu/articles/why-can-t-current-drugs-cure-hiv-infection>> accessed 28 October 2020.

immune system contributed to a constellation of opportunistic infections, cancers (Kaposi's sarcoma), and other life-threatening conditions collectively referred to as 'AIDS' (Acquired Immunodeficiency Syndrome). However, as the efficacy and variety of medications available to treat HIV has increased, the virus has been transformed 'from an inexorably fatal disease to a chronic, manageable condition' with few—if any—long term physiological consequences.³¹ In countries such as England, where access to ART is available to most through the NHS, research suggests that people living with HIV will have a 'normal life expectancy'.³² If diagnosed and treated early, some health organisations have even suggested that HIV positive people may live longer than average due to the detailed and regular health checks they receive.³³ In short, access to ART means that those who test positive for HIV can expect long and healthy lives.³⁴

Alongside improved health outcomes for positive people, a series of major studies have proved that being on ART lowers the risk of HIV transmission so much that it has been described as 'scientifically equivalent to zero'.³⁵ For example, the *PARTNER* study evidenced the preventative effectiveness of treatment by documenting over 58,000 acts of condomless sex between 888 serodiscordant couples—where one partner was positive and the other was negative³⁶—across 14 European countries between September 2010 and May 2014.³⁷ Focusing exclusively on 'gay couples', the *PARTNER2* study replicated these results, documenting over 77,000 acts of bareback sex between 783 couples between May 2014 and April 2018. These studies followed a series of research projects with smaller samples³⁸ including the *Opposites Attract* study (2017), which also focused on men who have sex with men (MSM), and documented 12,000 acts of bareback sex between 358 couples in Australia, Brazil and Thailand.³⁹ To date, there has never been a recorded case of someone transmitting HIV when their viral load is 'undetectable'.

The term undetectable refers to the number of copies of the virus found in 1 millilitre of an HIV positive person's blood being below the threshold for detection (fewer than 20 copies in the most sensitive tests available). Given the overwhelming body of medical evidence now available, health organisations around the world—including the US Centers for Disease Control and Prevention, National Institutes of Health, and World Health Organization—have embraced the tagline 'Undetectable equals Untransmittable' (U=U). In 2018, an 'Expert Consensus Statement' was published by leading HIV scientists, who further argued that 'criminal law is sometimes applied in a manner inconsistent with contemporary medical and scientific evidence: including overstating both the risk of HIV transmission and also the potential for harm to a person's health and wellbeing'.⁴⁰ This new understanding of HIV 'harm' and 'risk'—or lack thereof—has become a

31. Mauro Guarinieri and Lital Hollander, 'From Denver to Dublin: The Role of Civil Society in HIV Treatment and Control' in Srđan Matic, Jeffery Lazarus and Martin Donoghoe (eds), *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management* (World Health Organization, Copenhagen 2006) 98.

32. Antiretroviral Therapy Cohort Collaboration, 'Survival of HIV-Positive Patients Starting Antiretroviral Therapy between 1996 and 2013: A Collaborative Analysis of Cohort Studies' (2017) 4(8) *The Lancet HIV* 349.

33. Simon Collins, *ART in Pictures: HIV Treatment Explained* (HIV I-Base, London 2017) 3.

34. Wei Xu and others, 'Advancements in Developing Strategies for Sterilizing and Functional HIV Cures' (2017) 2017 *Biomed Res Intl* 1.

35. Gus Cairns, 'Zero Transmissions Means Zero Risk—PARTNER 2 Study Results Announced' *aidsmap.com* (2018) <<http://www.aidsmap.com/Zero-transmissions-mean-zero-risk-PARTNER-2-study-results-announced/page/3311249/>> accessed 28 October 2020.

36. The idea of serodiscordant couples is another aspect of HIV discourse which has been rooted in narratives of shame and risk. PrEP and TasP means that the risk of HIV transmission in serodiscordant couples is virtually non-existent. See Dion Kagan, *Positive Images: Gay Men & HIV/AIDS in the Culture of 'Post-Crisis'* (IB Taurus, London 2018) 114–21.

37. Alison Rodger and others, 'Risk of HIV Transmission through Condomless Sex in Serodifferent Gay Couples with the HIV-Positive Partner Taking Suppressive Antiretroviral Therapy (PARTNER): Final Results of a Multicentre, Prospective, Observational Study' (2019) 393(10189) *The Lancet* 2428.

38. See, further, Simon Collins, 'The Evidence for U=U (Undetectable = Untransmittable): Why Negligible Risk Is Zero Risk | HTB | HIV I-Base' *I-base.info* (2017) <<https://i-base.info/htb/32308/>> accessed 27 October 2020.

39. 'Effective HIV Treatment Halts HIV Transmission among Homosexual Couples, Study Finds | UNSW—The Kirby Institute for Infection and Immunity in Society' *Kirby.unsw.edu.au* (2017) <<https://kirby.unsw.edu.au/news/effective-hiv-treatment-halts-hiv-transmission-among-homosexual-couples-study-finds/>> accessed 27 October 2020.

40. Françoise Barre-Sinoussi and others, 'Expert Consensus Statement on the Science of HIV in the Context of Criminal Law' (2018) 21 *J AIDS Soc* 1, 2.

powerful tool for reframing discussions of HIV among activists, academics, and policymakers.⁴¹ Therefore, in this article, we suggest that the manner in which HIV is framed by UK criminal law is flawed, principally because it overstates the harm that this virus causes in contexts where ART is accessible.

The Significance of PrEP

Given the efficacy of ART in making onward transmission of HIV an impossibility for positive people who get tested and treated, another area of medical research has expanded to explore whether the same medications can be used by negative people to prevent seroconversion. Much like Post-Exposure Prophylaxis (PEP)—treatment which has been available to healthcare workers since 1997 and the general public since 2005⁴²—Pre-Exposure Prophylaxis (PrEP) refers to HIV medications taken as a precautionary or preventative measure. While PEP is recommended for use immediately after exposure (within 72 hours),⁴³ PrEP can be taken as a daily regimen in case of possible exposure to HIV. Both preventative treatments use medications which are the same as, and sometimes identical to, those taken by positive people to suppress the virus. The first HIV medication approved for use as PrEP was trademarked under the name Truvada, a combination of the drugs emtricitabine and tenofovir, although generic versions are now also available.⁴⁴

To date, there has only been one documented case of someone on PrEP acquiring a strain of HIV which was *not* drug-resistant, where regular adherence has been adequately measured.⁴⁵ Both the *PROUD* trial of PrEP use among 544 MSM in England,⁴⁶ and the *IPERGAY* trial of ‘on-demand’ or ‘event-based’ PrEP use among 353 MSM in Canada and France, found treatment to be 86% effective.⁴⁷ Halving the number of pills taken on average, participants in the latter study were asked to take PrEP immediately (2 to 24 hours) before bareback sex, and for the following two days, rather than daily.⁴⁸ These studies demonstrated the efficacy of PrEP when self-prescribed or taken on an irregular basis.

Although there is now clear evidence of ART as treatment/prevention reducing rates of HIV transmission, it is difficult to discern the comparative success of each method. For example, the largest sexual health clinic in London saw a 42% decrease in new HIV diagnoses between 2015 and 2016 (from 679 to 393), with little difference in diagnoses of other sexually transmitted infections (STIs).⁴⁹ However, it remains unknown whether positive people taking ART or negative people taking PrEP contributed more to this unprecedented decline, especially as the clinic was involved in both the *PROUD* study and had recently stepped up efforts to provide HIV treatment immediately following diagnoses. Similarly, following an 18% decrease in new diagnoses the year before, San Francisco saw a 17% decrease in new HIV diagnoses between 2014 and 2015 (from 309 to 255)—shortly after Truvada was approved for use as PrEP, but before it had been widely adopted.⁵⁰ One explanation for

41. ‘ZERO: No Linked HIV Transmissions in PARTNER Study after Couples Had Sex 58,000 Times without Condoms | HTB | HIV I-Base’ *I-base.info* (2017) <<http://i-base.info/htb/30108>> accessed 5 July 2017.

42. Department of Health, *Guidelines on Post-Exposure Prophylaxis for Health Care Workers Occupationally Exposed to HIV* (Department of Health, London 1997).

43. ‘Can Post-Exposure Prophylaxis (PEP) Stop Me Getting HIV?—Health Questions—NHS Choices’ *Nhs.uk* (2017) <<http://www.nhs.uk/ckq/Pages/1840.aspx?CategoryID=73>> accessed 5 July 2017.

44. ‘PrEP—Love May Have Another Protector’ *Men.PrEPfacts.org* (2017) <<http://men.PrEPfacts.org/the-basics/>> accessed 5 July 2017.

45. Elske Hoornenborg and others, ‘Acquisition of Wild-Type HIV-1 Infection in a Patient on Pre-Exposure Prophylaxis with High Intracellular Concentrations of Tenofovir Diphosphate: A Case Report’ (2017) 4 (11) *The Lancet HIV* e522.

46. Sheena McCormack and others, ‘Pre-Exposure Prophylaxis to Prevent the Acquisition of HIV-1 Infection (PROUD): Effectiveness Results from the Pilot Phase of a Pragmatic Open-Label Randomised Trial’ (2016) 387(10013) *The Lancet* 53.

47. Jean-Michel Molina and others, ‘Efficacy, Safety, and Effect on Sexual Behaviour of On-Demand Pre-Exposure Prophylaxis for HIV in Men Who Have Sex with Men: An Observational Cohort Study’ (2017) 4(9) *The Lancet HIV* e402.

48. Jean-Michel Molina and others, ‘On-Demand Pre-Exposure Prophylaxis in Men at High Risk for HIV-1 Infection’ (2015) 373 *N Engl J Med* 2237.

49. ‘42% Drop in New HIV Diagnoses at 56 Dean Street in Just 12 Months—Chelsea and Westminster Hospital NHS Foundation Trust’ *Chelwest.nhs.uk* (2017) <<http://www.chelwest.nhs.uk/about-us/news/40-drop-in-new-hiv-diagnoses-at-56-dean-street-in-just-12-months>> accessed 26 October 2020.

50. San Francisco Department of Public Health, *HIV Epidemiology Annual Report 2015* (HIV Epidemiology Section, 2016) <<https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp>> accessed 28 October 2020.

this decline in transmission may be that a significant number of MSM began purchasing generic versions of Truvada online—using websites such as *iwantprepnw.com*—before these medications had been approved officially. Whichever prevention method has been most responsible for reducing the rate of transmission, HIV medications common to both explain this trend, given that there is no evidence of a decline in bareback sex following their availability. Furthermore, the increased availability of PrEP in these studies found either no change or more diagnoses of other STIs:

Incidence rate ratios showed that MSM using PrEP were 25.3 times more likely to acquire a *Neisseria gonorrhoeae* infection, 11.2 times more likely to acquire a *Chlamydia trachomatis* infection, and 44.6 times more likely to acquire a syphilis infection versus MSM not using PrEP.⁵¹

At face value, these numbers may appear concerning, but if the principle of testing as prevention is applied (i.e. those who become aware of an infection can take additional measures, including treatment, to prevent its onward transmission) then the distribution of PrEP combined with routine sexual health screening has been modelled to suggested lower rates of transmission across the board.⁵²

The research outlined in Part One demonstrates that HIV has changed considerably over the past decade, even if there is a lag in cultural attitudes shaped by dominant discourses of law and medicine (see below). As this suggests, a core component of successful public health strategies involves allowing people to routinely monitor their sexual health and access ART. Furthermore, combining testing and treatment is more likely to be achieved by the distribution of PrEP through official healthcare systems (such as the NHS), where information and resources can be shared across the population. With a basic understanding of the epidemiological evidence about HIV, it is clear that such medications have been effective at preventing or eliminating transmission, making a health problem once perceived as an existential threat into something manageable and survivable. In the following sections, we describe the social and legal implications these developments may have as they become more widely known.

Part Two: HIV and the Criminal Law

Criminal statute in England and Wales does not explicitly address the subject of HIV transmission. Nonetheless, the criminalisation of HIV transmission has become the subject of growing academic and policy debate.⁵³ Falling under the rubric of the Offences Against the Person Act 1861, the criminal law has established that HIV transmission can constitute an offence of GBH.⁵⁴ The effect of this has been that, while some instances of condomless sex are valorised (as noted above) others are legally and socially re-coded as acts of violence.⁵⁵

51. Noah Kojima, Joseph Davey Dvora and D Klausner Jeffrey, 'Pre-Exposure Prophylaxis for HIV Infection and New Sexually Transmitted Infections among Men Who Have Sex with Men' (2016) 30(14) *AIDS* 2251, 2252.

52. See Jean-Michel Molina and others, 'Post-Exposure Prophylaxis with Doxycycline to Prevent Sexually Transmitted Infections in Men Who Have Sex with Men: An Open-Label Randomised Substudy of the ANRS IPERGAY Trial' (2018) 18(3) *The Lancet: Infectious Diseases* 308.

53. See, eg, Matthew Weait, 'Criminal Law and the Sexual Transmission of HIV' (2005) 68(1) *MLR* 121–34; Simon Cooper and Alan Reed, 'Informed Consent and the Transmission of Sexual Disease: Dadson Revivified' (2007) 71(5) *J Crim L* 461; Udo Schuklenk, 'Should We Use the Criminal Law to Punish HIV Transmission' (2008) 4(3) *International Journal of Law in Context* 277; Law Commission, 'Reform of Offences Against the Person: A Scoping Consultation Paper' (Law Commission 2014); David Hughes, 'Condom Use, Viral Load and the Type of Sexual Activity as Defences to Sexual Transmission of HIV' (2013) 72(2) *J Crim L* 136; George Mawhinney, 'To Be Ill or to Kill: The Criminality of Contagion' (2013) 77(3) *J Crim L* 202; John Francis and Leslie Francis, 'HIV Treatment as Prevention: Not an Argument for Continuing Criminalisation of HIV Transmission' (2013) 9(4) *Int JLC* 520; Samantha Ryan, 'Disclosure and HIV Transmission' (2015) 79(6) *J Crim L* 395; Samantha Ryan, '“Active Deception” v Non-Disclosure: HIV Transmission, Non-Fatal Offences and Criminal Responsibility' (2019) *Crim LR* 4.

54. It should be noted that other offences may be possible in certain circumstances. See, generally, Law Commission, 'Reform of Offences Against the Person' (n 53).

55. Rubin (n 27).

The placement of HIV transmission within the remit of GBH—or more generally Offences Against the Person (OAP)—is telling of the law's desire to disown its cultural and social effects; to deny its regulation of what it regards as the pre-eminently personal sphere.⁵⁶ Specifically, all cases of HIV transmission which have been successfully prosecuted fell under either s 20⁵⁷ or s 18⁵⁸ of the Offences Against the Person Act 1861, rather than under an offence created by the Sexual Offences Act 2003 or its predecessors.⁵⁹ In this sense, the criminal law ignores the sexual nature of STIs, instead coding them simply as bodily harm.

The offence of GBH is the most serious non-fatal offence which can be charged under the laws of England and Wales. GBH requires that the defendant 'inflict grievous bodily harm' either intentionally (s 18) or while being subjectively reckless as to the risk of causing harm (s 20). *Wilson* has established that GBH does not require an assault or battery to have been committed.⁶⁰ Rather, it requires that the:

Accused has directly or violently inflicted it [the harm] by assaulting the victim or . . . [that] the accused has 'inflicted' it by doing something intentionally which though it is not in itself a direct application of force to the body of the victim does result in some force being applied violently to the body of the victim so that he suffers grievous bodily harm.⁶¹

Following the judgment in *Burstow*, 'inflicting' is synonymous with 'causing', meaning that all that is required is for the defendant to have caused harm.⁶² It then requires that the victim suffer harm arising to the level of GBH. Pivotaly, the 2004 case of *R v Dica*⁶³ decided that previous authority in the form of *R v Clarence*⁶⁴ should not prevent:

The successful prosecution of those who, knowing that they are suffering from HIV or some other serious sexual disease, recklessly transmit it through consensual sexual intercourse, and inflict grievous bodily harm on a person from whom the risk is concealed and who is not consenting to it.⁶⁵

The result of this decision was that, since 2004, HIV transmission through consensual sex has been a ground for criminal sanction. Finally, for GBH, it must be shown that the defendant intended harm (s 18)⁶⁶ or was reckless as to the risk of some harm (s 20), although this need not be the level of harm that in fact occurred.⁶⁷ Indeed, it is only a requirement that the defendant was reckless to *any level of harm* occurring (see below for further discussion of how 'harm' is defined). Consequently, a defendant who did not know their HIV status but anticipated the possibility of harm (such as abrasions or bruises during sexual interaction) and unintentionally transmitted HIV to their partner(s) could be liable under s 20.

56. It should be noted n stating this that English Common Law has traditionally recognised no distinct right to private life. See, generally, *R v Khan* [1996] UKHL 14, [1997] AC 558. However, a right to privacy is provided under art 8 of the European Convention on Human Rights and Fundamental Freedoms. See Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8. Following the passing of the Human Rights Act 1998, this right to privacy should be considered both when interpreting statutes and developing the common law.

57. *R v Dica* [2004] QB 1257 (CA); *R v Konzani* [2005] 2 Cr App R 14 (CA).

58. *R v Rowe (Daryll)* [2018] EWCA Crim 2688, [2019] 1 Cr App R (S) 38.

59. Indeed, in *EB* it was found that non-disclosure of HIV positive status did not undermine effective consent as defined by s 74 of the Offences against the Sexual Offences Act 2003. See *EB* [2006] EWCA Crim 2945, [2007] 1 Cr App R 29.

60. *R v Wilson* [1984] AC 242 (HOL).

61. *Ibid* 260.

62. *R v Ireland and Burstow* [1998] AC 147 (CA).

63. *R v Dica* (n 57).

64. *R v Clarence* (1888) 22 QBD 23 (CA).

65. *R v Dica* (n 57).

66. In line with the standard criminal law approach to intention this requires that D intended harm or that they foresaw that harm was virtually certain to occur because of their action. See *Wollin* [1999] AC 82 (HOL).

67. *R v Savage; R v Parmenter* [1992] 1 AC 699 (CA).

Confusions Between Consent, Violence and Sexuality

As can be seen from this overview of the relevant criminal law, the absence of consent is not a part of the offence of GBH. Despite this, both *Dica*⁶⁸ and *Konzani*⁶⁹—the leading cases on the transmission of HIV—focused on consent as a central issue. In the context of non-fatal OAP, such as GBH, consent is regarded as a defence instead of its absence being a core part of the offence. However, consent is available as a defence only within a limited number of categories of accepted and lawful activity.⁷⁰ Thus, in almost every case where an HIV positive person (who knows their status) engages in bareback sex, in circumstances where they do transmit the virus, there is a prima facie offence. By contrast, placing the absence of consent as a central aspect of the offence, the Sexual Offences Act 2003 has more carefully avoided criminalising consensual sexual activities.

Indeed, law's placement of HIV transmission under OAP represents a disclamation of the sexual dimensions of transmission, constructing the offence as one of causing harm or committing violence.⁷¹ This ignores the fact that most incidents of HIV transmission occur during consensual sex.⁷² This re-coding of HIV transmission as a result of interpersonal violence, rather than an outcome of mutually desired interactions, undermines elements of UK public health messaging and places the burden for preventing HIV transmission exclusively on positive people.⁷³ Further, criminalisation obscures the ability of the 'victim' (as constructed by law) to consent to such activity.

It should be noted that within his dissenting judgment in *R v Brown*, Lord Mustill attempted to challenge the categorisation of any sexual conduct under the OAP Act.⁷⁴ As his argument suggested, capturing consenting sexual activity represented an intrusion of law into what had historically been considered a pre-eminently private domain, stating that the court should not be swayed by 'repugnance and moral objection... neither of which are, in my opinion, grounds upon which the court could properly create a new crime'.⁷⁵ In other words, the language of criminal law, in its treatment of HIV transmission as an abstracted form of violence, is a kind of obfuscation. Drawing on legal concepts, and a legal language which was never intended to be applied to sexual interactions, law thus constructs and moderates complex inequalities and power dynamics between sexual partners. Through the reframing of HIV transmission as an act of harm, criminalisation also implicates the positive partner as a 'vector of disease'.⁷⁶ In doing so, we argue that the language of law diminishes the humanity of HIV positive people by re-constituting them as a 'danger' or 'threat' to ('innocent') HIV negative people. Not only does this dichotomous discursive framing perpetuate an unfair status quo, which fundamentally undermines the internal coherence of law in relation to OAP,⁷⁷ it also undermines the efforts of public health campaigns (see below). The problem with such language in this context is that the transmission of STIs is analysed through the same lens as any other form of harm accruing because of violent conduct, such as a non-lethal stabbing. Thus, an HIV positive person who has bareback sex without informing their partner of their status is deemed 'reckless', despite the possibility of transmission now being low or non-existent, as outlined in Part One.

68. *R v Dica* (n 57).

69. *R v Konzani* (n 57).

70. *R v Brown* [1993] UKHL 19, [1994] 1 AC 212.

71. The previous law under *R v Clarence* had held that consensual sexual intercourse did not constitute a battery and therefore no liability could arise under the Offences Against the Person Act 1861 when consensual sexual intercourse led to a sexual infection. See *R v Clarence* (n 64).

72. As established in the previous section where either the positive partner is on effective treatment or the negative partner is on PrEP, the 'potential' nature of transmission is scientifically negligible.

73. Matthew Weait, 'Knowledge, Autonomy and Consent: *R v Konzani*' (2005) Crim LR 763, 765–67.

74. *R v Brown* (n 70) 256–75.

75. Ibid 274.

76. Peter Davies and Paul Simpson, 'On Male Prostitution and HIV' in Peter Aggleton, Peter Davies and Graham Hart (eds), *AIDS: Individual, Cultural and Policy Dimensions* (Routledge, London/New York 1990) 117.

77. See, generally, Weait, 'Criminal Law and the Sexual Transmission' (n 53).

The law recognises consent as continuing to function as an effective defence in certain circumstances. Prior to *R v Dica*, the longstanding authority of *R v Clarence*⁷⁸ held sway. This decision affirmed that there had been lawful consent to sexual intercourse and, thus, no battery had occurred. As such, the pre-*Dica* legal position was that where there had been consent to sexual intercourse, there had also been consent to any results of that intercourse. In other words, an individual could not be liable for transmitting an STI—regardless of the level of harm this entailed—if there had been valid consent to sexual intercourse. The question of consent—or the ability of the ‘victim’ to consent to an act amounting to GBH—is problematised by the decision of the House of Lords in *R v Brown*.⁷⁹ In *Brown*, the court held that consent to bodily harm of a severity amounting to GBH or actual bodily harm (ABH) is not a consent recognised by law.⁸⁰ Rather, consent to the risk of such harm will only be valid in the context of certain socially accepted activities, or categories of activities, which are themselves lawful. For example, play fighting⁸¹ or surgery.⁸² Bareback sex is not considered to be among these categories, while sexual gratification is explicitly outlawed as a category.⁸³

As this suggests, *R v Brown* has effectively stifled the ability of someone to consent to HIV transmission itself, meaning that within *Dica*—in order to leave open a possibility of an effective defence to s 20, where HIV transmission has occurred and some harm was foreseen—there was a need to distinguish between transmission itself and the risk of transmission.⁸⁴ As Judge LJ put it:

These authorities [Brown] demonstrate that violent conduct involving the deliberate and intentional infliction of bodily harm is and remains unlawful notwithstanding that its purpose is the sexual gratification of one or both participants. Notwithstanding their sexual overtones, these cases were concerned with violent crime, and the sexual overtones did not alter the fact that both parties were consenting to the deliberate infliction of serious harm or bodily injury on one participant by the other. To date, as a matter of public policy, it has not been thought appropriate for such violent conduct to be excused merely because there is a private consensual sexual element to it. The same public policy reason would prohibit the deliberate spreading of disease, including sexual disease.⁸⁵

This created a context where one is able to consent to the risk of a harm—such as the transmission of HIV—but not the harm itself.⁸⁶ As Weait argued, ‘to criminalise the taking of such risks...[is] not only... impracticable in enforcement terms, but... involve[s] unwarranted intrusion into the pre-eminently private sphere of adult sexual relations’.⁸⁷

Further confusing the issue of consent in the context of OAP is the decision of the court in *R v Wilson*.⁸⁸ In *Wilson*, a man branded his wife with his name, using a heated bread knife. Here, the court held that his wife had offered valid consent, categorising the activity as bodily adomment. Academics have made much of the gap between *Wilson* and *Brown*, even arguing that the heteronormative standards of the court were at play in

78. *R v Clarence* (n 64).

79. *R v Brown* (n 70).

80. *Ibid.*

81. *Jones* [1986] 83 Cr App R 375 (CA).

82. *R v Brown* (n 70) 266 Per Lord Mustill.

83. *Ibid.*

84. This in itself being objectionable because it leaves the difference between a lengthy prison sentence and an acquittal to the behaviour of a virus, rather than the behaviour of the defendant.

85. *R v Dica* (n 57) [46].

86. Of course, to consent to a risk of harm the victim must first be aware of the risk. The result of this is that the law as it stands requires HIV positive people to disclose their status in order to later rely on a defence of consent. This has been problematised by Cherkassky. See Lisa Cherkassky, ‘Being Informed: The Complexities of Knowledge, Deception, and Consent When Transmitting HIV’ (2010) 74(3) J Crim L 242.

87. Matthew Weait, ‘Criminal Law and the Transmission of HIV: *R v Dica*’ (2005) 68(1) MLR 121, 124.

88. *R v Wilson* (1996) 2 Cr App R 241 (CA).

both decisions.⁸⁹ Indeed, we agree with Weait's argument that the diverging treatment of *Brown* and *Wilson* demonstrates the extent to which 'the right to respect for private life in law is contingent on conformity to established gender roles, traditional relationship types and heterosexual orientation'.⁹⁰ As this suggests, the difference between a *Wilson* scenario and a *Brown* scenario can lie in the ability of the judge to interpret the conduct through a normative lens.

Weait has drawn attention to how, 'in cases of HIV transmission, there appears to be an implicit assumption that the magnitude of the risk makes no difference. Either a person consents to the risk of transmission or they do not'.⁹¹ Given recent developments in the science of HIV, as described in Part One, this legal position seems even less justifiable. There is a need for law to recognise that the risk of harm has been dramatically reduced or even eliminated—where the positive partner is on TasP or the negative partner is on PrEP—and that even if transmission does occur, ART should be accounted for within the harm threshold, to the extent that continuing to classify a manageable chronic condition with few long-term health consequences as 'grievous' (meaning 'very serious' in lay terms) is flawed. In stating this, we accept that a broken arm is also treatable. However, a key point of differentiation here is in *how* the harm is caused. A broken arm is the immediate result of a direct action by the defendant, so treatment works as treatment. In the case of HIV acquisition, however, the harm is the result of a virus over time. In most cases, the initial HIV infection is asymptomatic. Indeed, fast application of treatment (in the form of PEP) can prevent any demonstrable harm. Therefore, in many cases of transmission, treatment functions as a mode of prevention, stopping the virus from replicating prior to the onset of harm. In this sense, it can be argued that, with modern treatment, most cases of HIV transmission do not result in a harm in the traditional sense of the term, certainly not a harm meeting the threshold of GBH.

Discourses of HIV and LGBT Organisations

Despite the reduced risks and harms surrounding HIV, some activist groups and charities appear to support the criminalisation of transmission, as part of a trade-off for other benefits.⁹² This represents an inversion of traditional priorities, with groups—lesbians, gays, bisexuals and trans people (LGBT)—who have been discriminated against by the legal system historically now turning to become its beneficiaries, adherents, and advocates. In doing so, these organisations may simultaneously endorse the law's victimisation of other marginalised groups.⁹³ This turn has occurred concurrently with the arrival of a homonormative culture within mainstream LGBT activism,⁹⁴ which has seen an increasing number of groups and individuals invested in methods of punishment⁹⁵ and rights-based frameworks which operate around a version of negative legal equality (e.g. marriage and non-discrimination norms). This shift can be explained by examining a phenomenon which Adler has termed 'LGBT equal rights discourse'. Specifically, this discourse is defined as a series of now familiar narratives around equality and inclusion advocacy which 'comprises a cluster of constituent strands that depict, characterise and represent LGBT people'.⁹⁶ LGBT equal rights discourse has, in recent years, adopted an increasingly normative thrust, targeting agendas such as marriage equality or tougher

89. See, further, Ben Ramanauskas, 'BDSM, Body Modification, Transhumanism, and the Limits of Liberalism' (2020) 40(1) *Ec Aff* 85.

90. Matthew Weait, 'Harm, Consent and the Limits of Privacy' (2005) 13 *Fem LS* 97, 98.

91. Weait, 'Criminal Law and the Transmission of HIV' (n 87) 121, 125.

92. Dean Spade and Craig Willis, 'Confronting the Limits of Gay Hate Crimes Activism: A Radical Critique' (2000) 21 *Chicano-Latino L Rev* 38, 38–52; Adler (n 10) 56–57, 105–107.

93. See Sarah Lamble, 'Queer Necropolitics and the Expanding Carceral State: Interrogating Sexual Investments in Punishment' (2013) 24(3) *Law & Crit* 229.

94. Homonormative describes a condition where LGBT constituencies increasingly adopt—rather than oppose normative social and political frameworks. In particular, it sees a discursive movement which stresses similarities over differences. See, generally, L Duggan, 'The New Homonormativity: The Sexual Politics of Neoliberalism' in Russ Castronovo and Dana Nelson (eds), *Materialising Democracy: Toward a Revitalized Cultural Politics* (Duke University Press, Durham 2002) 175–94.

95. Mariana Valverde and Miomir Cirak, 'Governing Bodies, Creating Gay Spaces: Policing Security Issues in "Gay" Downtown Toronto' (2003) 43(1) *Brit J Criminol* 102.

96. Adler (n 10) 3.

sentences for those accused of hate crime.⁹⁷ Often, the framing of arguments by LGBT organisations aligns with an assimilationist politics which seeks to secure rights and tolerance by accentuating similarities between homosexual and the heterosexual norms.

The normative thrust of LGBT equal rights discourse can be seen in the push for hate crime legislation. For example, Lamble has strongly critiqued contemporary LGBT endorsement of the carceral state along these lines.⁹⁸ Many of the arguments in favour of carceral responses to hate crime are justified on the basis that it targets a specific characteristic which marks the individual—and the group to which they ‘belong’—out as different.⁹⁹ Therefore, the discursive function of hate crime and anti-discrimination legislation is often to disclaim differences by arguing that everyone has a right to be treated the same. While these arguments are well meaning, they can obfuscate the ways in which queer people are different. Among these differences, for example, are preferences for alternative forms of relationship, interests in alternative lifestyles, and non-normative sexual desires.

Something often elided in the progress narrative around LGBT rights is a consideration of how discursive and tactical decisions can be detrimental to those less able—or less willing—to adhere to somatic or behavioural norms. As Adler argues, drawing on Foucault, ‘norm production is a useful mechanism for understanding the process by which the western progress narrative of gay rights imposes costs on groups that are out of step with that narrative’.¹⁰⁰ Two such groups include HIV positive people and those who desire bareback sex.

Although we acknowledge that there can be tactical, short term, incentives for HIV and LGBT organisations to embrace a normative ‘equal rights discourse’, there is also a contradiction between this approach and public health outcomes which have also been stated as central concerns of such organisations.¹⁰¹ As Dodds et al. have argued, ‘criminalisation has a limited capacity to support HIV precautionary behaviour, such as enabling people to use condoms or disclose their HIV status to a sexual partner, and on balance is likely to have a negative impact on public health goals’.¹⁰² Their research—comprising of a series of focus groups with HIV service providers—found ‘most participants arguing that allocation of responsibility was not uniform and that it needed to be understood within specific circumstances that can constrain precautionary behaviour’.¹⁰³ In uncritically or implicitly defending the criminalisation of HIV transmission, such organisations may inadvertently be harming the service users they claim to support, by placing responsibility on HIV positive people themselves. In the next section, we explore different legal, medical, and social definitions of harm, putting forward a case that HIV transmission is no longer sufficiently harmful to constitute GBH.

Part Three: Conceptualising Harm

Definitions of harm are central to understanding liberal legal systems. Noting the *volenti non fit injuria* maxim, Feinberg distinguished between normative and non-normative harms as either ‘wrong’ or a ‘setback to interests’, arguing that Mill’s Harm Principle captures ‘both the risks it generates for the other person and the setbacks it causes to that person’s interests either intentionally or negligently’.¹⁰⁴ Strictly speaking, no harm is required for most non-fatal offences against the person. For example, a defendant taking hold of a victim’s arm when they had made it clear they objected to such contact can constitute a battery.¹⁰⁵ However,

97. Ibid 105–107.

98. See Lamble (n 93).

99. See, generally, Spade (n 21) ESP 1–21. See, also, Spade and Willis (n 92).

100. Adler (n 10) 83.

101. See, generally, UNAIDS, ‘Criminal Law, Public Health and HIV Transmission: A Policy Options Paper (UNAIDS 2002) <<https://www.hivlawandpolicy.org/resources/criminal-law-public-health-and-hiv-transmission-policy-options-paper-unaids>> accessed 26 October 2020.

102. Catherine Dodds and others, ‘Keeping Confidence: HIV and the Criminal Law from HIV Service Providers Perspectives’ (2015) 25 *Critical Public Health* 410, 411.

103. Ibid 417.

104. Joel Feinberg, *Harm to Others: The Moral Limits of the Criminal Law* (OUP, Oxford/New York 1984) ch 4.

105. *Collins v Wilcock* [1984] 3 All ER 374 (CA).

when approaching more serious non-fatal offences against the person, such as GBH, the law has applied thresholds for harm which must be met, in order for the *actus reus* of the offence to be made out. In this sense, the legal definition of harm features as a central aspect of offences such as GBH. This is relevant to our discussion of HIV transmission because, as argued above, questions must be raised about whether acquiring the virus meets the level of harm required.

In cases where harm has occurred which does not meet the threshold for GBH, an offence of ABH may be found to have occurred. The requirements for ABH are similar to those required for GBH,¹⁰⁶ except a lower harm threshold is set; specifically, 'any hurt or injury calculated to interfere with the health of comfort of [V]'.¹⁰⁷ In this sense, an offence of ABH can be made out with any harm which is not determined to be 'transient and trifling'.¹⁰⁸ As this suggests, the law has traditionally taken the enactment of harm against another person to be a 'serious' matter, with serious criminal sanctions applied to even 'moderate' inflictions of harm.¹⁰⁹

The caselaw shows that minor injuries such as bruising can be sufficient to meet the harm threshold for ABH.¹¹⁰ However, recognising this, prosecutorial discretion is often employed so that *prima facie* cases of ABH rarely come to be criminally charged. As stated by the 2020 Crown Prosecution Service Charging standards, while it is for prosecutors to decide whether to charge (after considering all the circumstances), it will also be relevant to consider whether the injuries are 'serious or less serious':

Serious injuries include damaged teeth or bones, extensive and severe bruising, cuts that require suturing... the appropriate charge will usually be contrary to section 39 (Battery) where injuries amount to no more than the following: grazes; scratches; abrasions; minor bruising; swellings; reddening of the skin; superficial cuts.¹¹¹

Therefore, while the legal harm threshold for ABH is set relatively low, lesser forms of harm can be charged as battery or allowed to pass without charge. This is generally in service to matters of practicality and the effective use of legal resources.

Excluding fatal offences such as murder, GBH and wounding are the most serious offences against the person recognised under the criminal laws of England and Wales. Following *DPP v Smith*, the term GBH simply refers to 'really serious' harm.¹¹² However, in recent caselaw, *Golding* has indicated that this harm need not be permanent or dangerous to be considered really serious.¹¹³ Following *Golding*, the question of whether the harm threshold has been met is ultimately a matter for the Jury, applying 'contemporary social standards'.¹¹⁴ It is in order to discern these 'contemporary social standards' that we turn to medical and sociological conceptualisations of harm below.

Further insight into the criminal law's approach to constructing and defining harm can be taken from *Bollom*, which outlined that an analysis of harm should be done with an awareness of the particular characteristics of a complainant. Specifically, the court stated:

these injuries on a six foot adult in the fullness of health would be less serious than on, for instance, an elderly or unwell person... in deciding whether injuries are grievous, an assessment has to be made of, amongst other things, the effect of the harm on the particular individual.¹¹⁵

106. Although, unlike GBH, ABH continues to require a base offence of assault or battery to have been committed before ABH can be found to have taken place.

107. *Donovan* [1934] 2 KB 498 (CCA).

108. *Ibid.*

109. ABH carries a maximum of five years' imprisonment. See *Offences Against the Person Act 1861*, s 47.

110. *T v DPP* [2003] EWHC 266 (Admin).

111. 'Offences Against the Person, Incorporating the Charging Standard | The Crown Prosecution Service' *Cps.gov.uk* (2020) <<https://www.cps.gov.uk/legal-guidance/offences-against-person-incorporating-charging-standard>> accessed 24 June 2020.

112. *DPP v Smith* [1960] 3 WLR 546 (HOL).

113. *Golding* [2014] EWCA Crim 889.

114. *Ibid.*

115. *Ibid.*

As with ABH, the 2020 charging standards provide guidance as to when a charge of GBH may be appropriate. Again, these standards depart from, yet remain intrinsic to, the strict terms of the law. For example, they inform prosecutors that: 'Life changing injuries should be charged as GBH . . . significant or sustained medical treatment . . . may indicate GBH injuries even if a full or relative recovery follows'.¹¹⁶

This could be viewed in terms of a *sliding scale of severity*, accounting for the form of interaction between, and characteristics of, the individuals involved. At the lower end of that scale are trifling or minor injuries such as a graze. If charged as an offence at all, this would be treated as a battery, with the criminalisation tending to relate more to the conduct of the defendant than the harm caused. More serious harms such as bruising, which cannot be considered very serious, will generally be treated as attaining the threshold of ABH. However, it should be recognised that, following the CPS charging standards, harms of this level may not be charged or appear in court unless they are towards the more severe end of the spectrum, such as a chipped tooth resulting from the defendant's actions. Finally, GBH is intended to be reserved for the most serious forms of harm. However, as argued above, the latest science should raise questions over whether HIV infection continues to be among these most severe harms. The legal definitions of harm are multiple and complex, conceivable in terms of an overlapping scale, but—at least in respect of GBH—are ultimately for a jury to determine.

Following *Golding* and *Bollom*, and applying the medical developments described in Part One, we suggest that the criminal law relating to HIV transmission as a form of harm needs to be reconsidered and reconceptualised, taking contemporary social standards and the characteristics of victims into account. In general terms, with the availability of new treatments (which prevent harm accruing), we suggest that cases of HIV transmission will rarely amount to the level of seriousness required to constitute GBH.

Medical and Mental Harm

Medicine has also provided influential definitions of harm which both inform and exist alongside the criminal law. From Hippocrates' principle of 'first, do no harm' to modern medicine's focus on the diagnosis, treatment and prevention of disease, harm reduction strategies have been important to health practitioners and policy-makers. However, medically informed perspectives have also been drawn on to critique the criminal justice system's emphasis on moralising punishment as a form of disincentive, on issues ranging from drug consumption¹¹⁷ to sex work.¹¹⁸ For example, the World Health Organization opposes the criminalisation of sex work on the basis of harm reduction, where 'studies indicate that decriminalising sex work could lead to a 46% reduction in new HIV infections in sex workers over 10 years'.¹¹⁹ Alongside reducing sexual violence, reducing HIV transmission is used here synonymously with reducing harm. As Amnesty International further suggests, social stigma 'discourages many sex workers from obtaining sexual and reproductive health information and services including on HIV/AIDS'.¹²⁰ Relatedly, drug decriminalisation has been endorsed as a strategy to reduce rates of addiction, problematic consumption and HIV transmission.¹²¹ The harm reduction approach has also been championed by 'legal scholars, clinicians, virologists, and epidemiologists, along with

116. 'Offences Against the Person, Incorporating the Charging Standard' (n 111).

117. See, further, Fiona Mesham, 'Drug Safety Testing, Disposals and Dealing in an English Field: Exploring the Operational and Behavioural Outcomes of the UK's First Onsite 'Drug Checking' Service' (2019) 67 *International Journal of Drug Policy* 102.

118. See, further, Teela Sanders and Rosie Campbell, 'Criminalization, Protection and Rights: Global Tensions in the Governance of Commercial Sex' (2014) 14(5) *Criminology & Criminal Justice* 535.

119. 'Sex Workers' *World Health Organization* (2020) <https://www.who.int/hiv/topics/sex_work/en/> accessed 28 October 2020.

120. 'Amnesty International Publishes Policy and Research on Protection of Sex Workers' Rights' *Amnesty.org* (2016) <<https://www.amnesty.org/en/latest/news/2016/05/amnesty-international-publishes-policy-and-research-on-protection-of-sex-workers-rights/>> accessed 28 October 2020.

121. Paula Vale de Andrade and Ludmila Carapinha, 'Drug Decriminalisation in Portugal' (2010) 341 *British Medical Journal* c4554.

civil society and international organisations' who oppose the criminalisation of HIV.¹²² Therefore, it is important to explore how harm is conceptualised by health and medical professionals.

For many, medical experts will be considered the final authority on the harms associated with HIV. It is doctors and nurses, alongside lab technicians and mental health practitioners, who test and treat people for HIV. However, the political dimensions of healthcare cannot be easily ignored. For example, the Department of Health was central to communicating the 'harms' and 'risks' of the UK's HIV epidemic to the public.¹²³ In 1987, the 'Don't Die of Ignorance' television broadcasts had a lasting impact on people's knowledge of HIV/AIDS, with John Hurt's dystopian voiceover announcing: 'There is now a danger, which has become a threat to us all. It is a deadly disease and there is no known cure'. This campaign also raised awareness through a leaflet sent to almost every household:

AIDS is caused by a virus. This can attack the body's defence system which normally helps fight off diseases and infections. And if this happens people then develop AIDS—the disease itself. They become ill and die from illnesses they cannot fight off.

The campaign became deeply ingrained in the national consciousness and continues to shape people's responses to HIV. In this sense, it may have contributed to the 'contemporary social standards' by which harm falls to be determined in court. Yet there has been no state-funded information campaign to update the public about new methods of prevention and treatment, as we have described. The Department for Health did announce that PrEP would become routinely commissioned on the NHS starting in 2020, even if this was delayed until later this year by the emergence of Covid-19.¹²⁴ However, queer theorists have highlighted how information about HIV prevention, both in the 1980s and more recently, have tended to be led by LGBT people, publications, and venues, without the assistance of state bodies.¹²⁵

Another dimension of harm which has been given greater political attention over recent years is mental health, with successive governments pledging 'parity of esteem between mental and physical health services'.¹²⁶ This was enshrined in law by the Health and Social Care Act 2012, following publication of the Government's *No Health without Mental Health* report. Around this time, the British Psychological Society, British HIV Association and Medical Foundation for AIDS & Sexual Health published a report which noted that 'despite significant medical advances in HIV treatment, people living with HIV experience significantly higher rates of psychological difficulties than the general population', including anxiety, depression, and post-traumatic stress disorder.¹²⁷ It further noted an 'array of concerns about quality of daily life and other personal, social and medical issues, with widespread reports of discrimination and social isolation' which can have a detrimental effect on overall health and wellbeing. Highlighting how criminalisation can exacerbate harm, Ramanauskas has further argued, in the context of BDSM:

If a person were to sustain an injury which required medical treatment, they might be reluctant to seek medical assistance. This is because they might be worried about the legal implications for themselves or their

122. Matthew Weait, 'Limit Cases: How and Why We Can and Should Decriminalise HIV Transmission, Exposure, and Non-Disclosure' (2019) 27(4) *Med L Rev* 576, 578.

123. Sharif Mowlabocus, *Gaydar Culture: Gay Men, Technology and Embodiment in the Digital Age* (Routledge, Abingdon 2016).

124. Julia Robinson, 'Prep to be Phased into Routine Commissioning During 2020/2021' *Pharmaceutical Journal* (2020) <<https://www.pharmaceutical-journal.com/news-and-analysis/news/prep-to-be-phased-into-routine-commissioning-during-2020/2021/20208000.article?firstPass=false>> accessed 28 October 2020.

125. Mowlabocus (n 123); Rubin (n 27) 236–40.

126. HM Government, *No Health without Mental Health Report* (HM Government, London 2011) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf> accessed 28 October 2020.

127. British Psychological Society, British HIV Association and Medical Foundation for AIDS & Sexual Health, *Standards for Psychological Support for Adults Living with HIV* (Medfash, London 2011) <https://www.bhiva.org/file/BbShtfyMFNKCz/Standards_for_psychological_support_for_adults_living_with_HIV.pdf> accessed 28 October 2020.

partner. Moreover, given the stigma attached to criminal activities, there might again be a reluctance on the part of patients to be open with their doctor about the nature of their injuries.¹²⁸

Relatedly, someone showing the symptoms of seroconversion may fear consequences for their partner under the law if they were to seek medical assistance. Reviews of the international literature in psychology suggest that people living with HIV experience elevated rates of anxiety, depression, and suicidality, due in part to the social stigma which criminalisation fuels.¹²⁹

Stigma is one of the main reasons for health inequalities between HIV negative and positive people identified by the research literature. In a survey of 1,777 people living with HIV in the UK, Weatherburn et al. found that the most common problem experienced by respondents in the past year was 'anxiety and depression' (72%), followed closely by 'self-confidence' (71%), 'sleep' (70%) and 'sex' (68%), where 'HIV stigma and discrimination were also common causes of problems, as were difficulties with status disclosure, which led to isolation, loneliness and fear of never finding someone to love'.¹³⁰ Respondents identified that the 'sources of such problems were often neighbours, work colleagues and those in wider social networks. Comments were variously rooted in homophobia, racism and HIV-related stigma'.¹³¹ The role of the criminal justice system in contributing to social exclusion has also been noted, where structural stigma is 'problematic because it often intersects with structural homophobia and racism'.¹³² Interviewing HIV service providers, Dodds et al. found that 'no one, when directly asked what they thought prosecutions accomplished in public health terms, was able to describe a beneficial public health outcome'. This brings us back to a central question of this article: what is the purpose of criminalising the transmission of HIV? If the answer is to protect public health, in the opinion of those working with HIV positive people directly, it is failing.

Because pandemics are necessarily *social* phenomena, they cannot be adequately prevented or understood at an *individual* level, a fact which demonstrates the criminal law's limitations in helping to control or make sense of public health matters. The focus of liberal legal systems on rational, choice-making at the individual-level will always be found wanting when the harms under consideration operate at a population-level. Indeed, the feasibility of attributing individual blame may be another reason that the transmission of HIV has been criminalised while coronavirus has not been. Therefore, a public health approach to HIV transmission is at odds with the punitive approach adopted by current law. The result of these two approaches being contradictory is that the law fails to prevent the harms it claims to address and that it compounds stigma, resulting in more harm to the health of HIV positive people.

Social Harm and Stigma

The study of social harms—*zemiology*—proposes that the individualism of criminal law is flawed as it cannot accurately account for, or fairly respond to, collective wrongdoing (e.g. corporate crimes). Drawing on postmodern and social constructivist ideas, zemiology has been championed by critical criminologists seeking to deconstruct performative categories such as 'criminal'. This label is performative in the sense that it has no ontological basis beyond the lawmakers who communicate it to regulate, and thus construct, specific behaviours and identities. In short, the label 'criminal' can be applied to any act or person associated with a 'crime'.¹³³ The labelling of HIV transmission as a crime can therefore be complicated through a social harm perspective, which can also be used to highlight how the criminal justice system might itself perpetuate 'more

128. Ramanauskas (n 89) 85, 89.

129. Lorraine Sherr and others, 'HIV and Depression—A Systematic Review of Interventions' (2011) 16(5) *Psychology, Health & Medicine* 493.

130. Peter Weatherburn and others, *What Do You Need? 2007–2008: Findings from a National Survey of People Diagnosed with HIV* (Sigma Research, Chennai 2009) 61.

131. *Ibid* 97.

132. Marilo Gagnon and Christine Vézina, 'HIV Criminalization as "Risk Management": On the Importance of Structural Stigma' in Suzanne Hindmarch, Michael Orsini and Marilo Gagnon (eds), *Seeing Red: HIV/AIDS and Public Policy in Canada* (University of Toronto Press, Toronto 2018) 55–78.

133. Dennis Baker, *The Right Not to be Criminalized: Demarcating Criminal Law's Authority* (Ashgate, Farnham 1988) 2.

damaging and pervasive forms of harm'.¹³⁴ Queer theory similarly observes that labels such as 'homosexual', as constructed by medicine and law, occur within an ever-shifting social landscape.¹³⁵

Drawing a distinction between *personal* criminalisation and *regulatory* criminalisation, Baker notes that while the criminal law can punish an individual's 'culpable choice to bring about bad consequences for others', it is unable to punish collective entities (such as corporations or governments) for comparably harmful consequences, which can be significantly *more harmful* by qualitative or quantitative measures.¹³⁶ When collective entities are held to account by regulatory criminalisation, through the levying of fines or revoking of licences, it 'does not censure or blame an individual as opposed to a collective of individuals in a very indirect way, since it is the fictitious entity' despite, in both cases, the criminal law being justified on grounds of harm prevention.¹³⁷

The social harm approach also allows for a 'focus upon harms caused by chronic conditions or states of affairs' beyond individual actions, including 'institutionalised racism and homophobia'.¹³⁸ However, national governments are unlikely to endorse this conceptual framework as 'their activities (or inactivities) are likely to be highlighted as *sources* of harm'.¹³⁹ Critical criminologists have further drawn attention to the role of the criminal law in constructing certain behaviours as 'harmful' and people as 'criminal', without recognising the harms such forms of labelling can perpetuate. As Hillyard and Tombs note:

Defining an event as a 'crime' either sets in motion, or is the product of, a process of criminalisation. The state—via the criminal justice system—appropriates the conflict and imposes punishment, of which the prison sentence is the ultimate option.¹⁴⁰

They add that 'these very processes create wider social harms which may bear little relationship to the original offence and pain caused', including social inequality, ostracism, and stigma.¹⁴¹ Alongside physical harm, a social harm perspective considers economic, emotional, and sexual harms as alternatives to the 'overly-individualistic' approach of traditional law.¹⁴² As with medical definitions of harm provided above, zemiology considers the mental health consequences of stigma, as created by criminalisation. It highlights that 'crime is not just a question of who *breaks the law*, but also about who *makes the law*',¹⁴³ and that this cannot be considered separate from the wider socio-political context in which laws are made. Focusing on examples such as BDSM and body modification, Ramanauskas has argued that—rather than rational conceptions of consent or harm reduction—feelings of disgust have influenced decisions such as *Brown and Wilson*, to the extent that 'the law has had an unacceptably disproportionate impact on marginalised groups in society',¹⁴⁴ including those who use illicit drugs, sex workers, and people living with HIV, among others.¹⁴⁵ A social harm approach moves beyond the individualism of law and medicine to consider humans as a social being, including the complexity of our desires and interactions, alongside the mechanisms of power which construct and constrain them.

134. Paddy Hillyard and Steve Tombs, 'Beyond Criminology?' in Danny Dorling and others (eds), *Criminal Obsessions: Why Harm Matters More Than Crime* (2nd edn Centre for Crime and Justice Studies, London 2008) 7.

135. See, generally, Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, New York 1990); Adler (n 10).

136. Baker (n 133) 23.

137. *Ibid.*

138. Hillyard and Tombs (n 134) 17.

139. *Ibid.*

140. *Ibid.* 11.

141. *Ibid.*

142. See, further, Frank Pearce and Steve Tombs, 'Foucault, Governmentality, Marxism' (1998) 7(4) *S & LS* 567.

143. 'Questioning Crime: Social Harms and Global Issues' *OpenLearn* (2020) <<https://www.open.edu/openlearn/society-politics-law/questioning-crime-social-harms-and-global-issues/content-section-1>> accessed 28 October 2020.

144. Ramanauskas (n 89) 85, 88.

145. Max Morris, 'Incidental Sex Work: Casual and Commercial Encounters in Queer Digital Spaces' (Doctoral thesis, Durham University 2018).

Conclusion

Sexual risk, and sex more generally, has long preoccupied legislators and others engaged in debates over criminal justice.¹⁴⁶ The ability of individual citizens to interact sexually with others throws a series of criminal law concepts, such as consent,¹⁴⁷ risk, recklessness, and harm into a kaleidoscope, in which they might be examined and contested. Yet, our framing of criminal law is often underpinned by transient moral and normative understandings which reflect the shifting attitudes of society. This is not to say that these concepts are necessarily understood or integrated into the law itself. Rather, as Brooks has, we draw attention to the fact that research in the broader field of sexuality ‘suffers from distance from a sexual life’,¹⁴⁸ and the challenge for the criminal law is to understand and take account of the lived experience of sex and risk.

The criminal law, and its focus upon a doctrinal dissection of sex, can lose sight of the human, the erotic, and the complex performance of bodies and their fluids, which tend to be silenced within legal discourse.¹⁴⁹ By understanding these lived experiences, we can re-introduce the human into the criminal law and prompt a re-evaluation of how the law operates. Key concepts—notably in the area of HIV transmission—relating to risk and harm need to be understood not merely in historical doctrinal terms, but as elements of people’s sexual lives in the present moment. As we elaborated in Part One, in this moment, the science has transformed the meaning of an HIV diagnosis while providing new (and outstandingly effective) tools to prevent transmission.

Halperin has noted that HIV prevention requires ‘a miracle every day’ and that ‘repetition is where miracle and history meet, and it is where, if anywhere, safe sex becomes habitual’.¹⁵⁰ That repetition has arguably arrived in the form of PrEP and it has miraculous properties for transforming legal, medical, and social understandings of risk and sex. Together with TasP, the medical landscape through which risk can be pharmaceutically controlled is significantly different from that of even just five years ago. The science and healthcare provision relating to HIV is evolving rapidly. Our understanding of HIV is transformed through a reappraisal of the significance of medications (ART) which can be used as treatment and/or prevention. While doctrinal law has failed to appreciate this shift, thus far, broader legal and activist narratives also lag in their conception of themes including consent and violence.

The effects of PrEP and TasP on social attitudes towards sexuality arguably amount to a sexual revolution. As Gonzalez noted, ‘the new sexual revolution may not appear revolutionary, in the wider public sphere, but it is slowly changing the queer cultural landscape’.¹⁵¹ This is a cultural and health revolution that underlines the anachronistic nature of the law relating to HIV transmission. Moreover, by maintaining a site of historic trauma, the criminal law is serving as a force that prevents a cultural healing that mirrors the health transformation that we have seen in recent years and, in doing so, sustains discourses of fear and stigma that are incongruous with contemporary understandings of HIV/AIDS in the sphere of law in England and Wales. Put simply, the science has changed, but the law has not kept pace.

Hunter has previously observed the paradox that, with partial decriminalisation of homosexuality, there was also heightened scrutiny and regulation of ‘deviant’ sex.¹⁵² This informs the sex that men seek and engage in, and HIV transmission has been a powerful part of this narrative, amidst a broader context of equal rights discourse in which a new, normative framework has been applied.¹⁵³ The positioning of bareback sex as

146. As such, it can be arguably seen as a tool in the ‘war on sex’. Halperin has described this as a war that ‘has gone unnoticed, for the most part, except by those who have been affected by it, directly or indirectly’. The classic account on the sex wars can be found in Duggan and Hunter (n 18) 1.

147. For a broader queer critique of consent, see Joseph J Fischel, *Screw Consent: A Better Politics of Sexual Justice* (University of California Press, Oakland 2019).

148. Victoria Brooks, *Fucking Law* (Zero Books, Alresford 2019) 48.

149. This can be understood within the broader legal struggle of LGBTQ activism and the shift in emphasis that accompanied a move from liberation to equality.

150. David M Halperin, *What Do Gay Men Want? An Essay on Sex, Risk, and Subjectivity* (University of Michigan Press, Ann Arbor 2007) 109.

151. Gonzalez (n 19) 45.

152. Nan D Hunter, ‘Sexual Orientation and the Paradox of Heightened Scrutiny’ (2004) 102(7) Mich L Rev 1528.

153. See Adler (n 10); Ashford (n 27).

‘risky’ or ‘slutty’ situates it as behaviour that can attract stigma¹⁵⁴ because—as noted above—of the continued attitudes perpetuated by doctrinal criminal law towards HIV, and STI transmission more broadly. However, as Fischel has argued, to resist law is not the same as resisting responsibility,¹⁵⁵ and the changed medical landscape means that resistance to law is arguably the assertion of a new—medically and culturally informed—responsibility to each other.

In this article, we have attempted to bring critical criminology, cultural theory, and health sociology into conversation with the criminal law as it pertains to HIV transmission. In contrast to the normative cascade that dominates discourse relating to the criminalisation of HIV and other STIs, a queering of this narrative that acknowledges non-monogamous relationships, reframes ‘slutdom’, and understands these relationship dynamics in a framework that is science-informed and culturally-aware would re-shape the criminal law in this area. Paradoxically, contemporary law finds itself acting perversely and against its own interests. The use of criminal law in cases of HIV transmission serves to punish the ‘responsible’ behaviour of testing, treatment, and openness, while it privileges *not knowing* your status. As Sedgwick argued, ‘ignorance is as potent and as multiple a thing there as is knowledge’.¹⁵⁶ Yet it is precisely this ignorance, sustained and supported by stigmatising criminalisation, that serves as the greatest risk for further HIV transmission.

Alongside arguing that HIV transmission does not accrue the necessary harmfulness threshold to constitute GBH, we have drawn on this perspective to raise questions about whether criminalisation could be considered an additional harm; one which is unprincipled in legal terms, unnecessary in public health terms, and unjust in sociological terms. The social harm perspective is also critical of the notion of ‘risk society’ described by Beck, Giddens, and others, where ‘the control of dangerous populations is now a central concern of the penal system, and an actuarial criminology has replaced a rehabilitative criminology’.¹⁵⁷ The dichotomy between criminal justice and medical intervention is also open to critique from postmodern or queer theory, which has drawn attention to the ways in which both legal and medical discourses contribute to the othering, victimising, and stigmatising of HIV positive people and marginalised others. We are arguably at a point where a re-appraisal of doctrinal criminal law relating to HIV transmission is not merely overdue but also urgent.

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154. See, more generally, Ashford (n 13); Florêncio (n 24). See on stigma associated with PrEP: Josh Grimm and Joseph Schwartz, “It’s Like Birth Control for HIV”: Communication and Stigma for Gay Men on PrEP’ (2019) 66(9) *Journal of Homosexuality* 1179.

155. Joseph J Fischel, *Sex and Harm in the Age of Consent* (University of Minnesota Press, Minneapolis 2016) 211.

156. Eve K Sedgwick, *Epistemology of the Closet* (University of California Press, Berkeley/Los Angeles 1990) 4.

157. Hillyard and Tombs (n 134) 21.