Criminalizing HIV Non-Disclosure: Using Public Health to Inform Criminal Law

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ABSTRACT

Canada prosecutes more people, in absolute numbers, for non-disclosure of HIV status than any other country in the world except the United States and Russia. This paper analyses the Supreme Court of Canada's decisions that, effectively, created the criminal offence of HIV non-disclosure with a particular focus on how these decisions fundamentally misunderstood the science on HIV transmission. It then considers how HIV non-disclosure prosecutions have contributed to arbitrary, unjust and stigmatized treatment of people living with HIV and have undermined public health interventions. Finally, we evaluate a recent Directive issued by the federal Justice Minister and Attorney-General of Canada to the federal Director of Public Prosecutions concerning HIV non-disclosure prosecutions against the science and public health standards.

Keywords: HIV disclosure laws; people living with HIV; prosecutorial directives; public health

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I. INTRODUCTION

Public fear of the human immunodeficiency virus (HIV), stems back to the 1980's when HIV affected mostly gay men, and the crisis was even referred to as "the gay plague."[1] In 1987, writer and cofounder of Gay Men's Health Crisis, Larry Kramer, told the *New York Times*, "You don't know what it's like to be gay and living in New York...It's like being in wartime. We don't know when the bomb is going to fall. I've had 18 friends die in the last year and a half from AIDS."[2] Now acquired immunodeficiency syndrome (AIDS) is the name given to a collection of symptoms and serious medical consequences in those affected with HIV after their immune systems have been incapacitated by the virus, but in the early days of HIV research, the terms AIDS and HIV were used interchangeably.

In the early 1980s, people living with HIV were only identifiable at the extremely advanced stages of disease: when the person's immune system had been completely destroyed.[3] When this happened, those with HIV would become ill very quickly, usually from infection by another organism, and die rapidly. United States (U.S.) Senator Jesse Helms called for a quarantine of everyone with HIV.[4] U.S. Education Secretary William Bennet said prisoners who test positive for HIV should be kept in prison beyond the end of their sentences.[5] Those with HIV were seen as evil people who might "take revenge on society" by spreading the disease to the "general population."[6]

Living with HIV is very different in 2019 than it was in 1987. Most people are diagnosed early, the medications are very effective, sexual transmission of HIV can be prevented with near total certainty, and people infected with HIV can achieve a similar life expectancy as those without.[7]

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1 Robin Marantz Henig "AIDS A New Disease's Deadly Odyssey", *The New York Times Magazine* (6 February 1983), online: <www.nytimes.com/1983/02/06/magazine/aids-a-new-disease-s-deadly-odyssey.html> [perma.cc/J6V4-RAVP].

2 *Ibid.*

3 *Ibid.*

4 United Press International "Helms Calls for AIDS Quarantine on Positive Tests", *Chicago Tribune* (16 June 1987), online: <www.chicagotribune.com/news/ct-xpm-1987-06-16-8702140384-story.html> [perma.cc/Z9TH-YW5R].

5 *Ibid.*

6 *Ibid.*

7 Francoise Barré-Sinoussi et al, "Expert consensus statement on the science of HIV in

While once a fatal infection, HIV has become a chronic condition which is manageable through antiretroviral medication (ART). Yet even now, with so much known about the virus, the stigma of having an HIV diagnosis is still significant and trusted institutions still cling to myths. Until 2013, Canadian Blood Services (CBS) refused to allow any man to donate blood if he had ever had sex with another man after 1977.[8] There was no defensible reason for the CBS policy, since all blood is automatically tested for HIV using a laboratory test that, since the late 1990s, approaches 100% sensitivity and detects infection 20 days post exposure. This means, using the normal exclusion criteria applied to everyone else, there is no realistic chance of missing an infection.[9] Even today, CBS does not allow a man to donate blood if he has had sex with another man within the last three months.[10]

Irrational fears are not confined to the health system; these fears have also deeply influenced how judges have interpreted *Criminal Code* provisions in order to criminalize HIV non-disclosure. ("HIV non-disclosure" describes criminal cases where a person, who knows they are HIV positive, does not disclose or misrepresents their HIV status prior to sexual activity, and exposes others to a realistic possibility of HIV transmission.) While the *Criminal Code* does not contain any explicit provisions on HIV status disclosures, judges have interpreted the code to support aggravated sexual assault charges against persons living with HIV who do not disclose their status on the ground that the non-disclosure is found to invalidate their partner's consent to engaging in sexual activity. Canadian authorities prosecute more HIV non-disclosure cases (in absolute numbers) than all but two other countries (Russia and the U.S.).[11] In consequence (and as will be

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the context of criminal law" (2018) 21:7 J Intl AIDS Society 1.

8 Canadian Blood Services, "Men who have sex with men" (6 December 2018), *Canadian Blood Services*, online: <blood.ca/en/blood/am-i-eligible/men-who-have-sex-men> [perma.cc/G6HG-MQDT].

9 Paul E Sax, "Screening and diagnostic testing for HIV infection" (last modified 3 July 2019), online: *UpToDate* <www.uptodate.com/contents/screening-and-diagnostic-testing-for-hiv-infection> [perma.cc/33YB-ZCBZ]; Thomas S Alexander, "Human Immunodeficiency Virus Diagnostic Testing: 30 Years of Evolution" (2016) 23:4 Clinical & Vaccine Immunology 249.

10 Canadian Blood Services, *supra* note 8.

11 Canadian Coalition to Reform HIV Criminalization, "Community Consensus Statement" (November 2017), online: <www.hivcriminalization.ca/community-consensus-statement/> [perma.cc/EBH8-GPLQ] [Canadian Coalition].

discussed), Canada's current criminal justice approach to HIV non-disclosure has been described as unscientific, arbitrary and unjust, detrimental to public health, and in need of significant reform.[12]

In this paper, we begin with a review of the science on HIV transmission. We then examine how the Supreme Court of Canada's (SCC) decisions on the criminalization of non-disclosure of HIV status demonstrate serious misunderstandings about the science of HIV transmission. The consequences stemming from the SCC's decisions have been significant for those living with HIV in Canada, so we examine some ways that the law could be brought into line with public health principles. In late 2018, Jody Wilson-Raybould (then-federal Justice Minister and Attorney-General of Canada) issued a "Directive" to the federal Director of Public Prosecutions concerning HIV non-disclosure prosecutions. In the last part of the paper we evaluate this Directive against the science and public health standards.

II. THE SCIENCE ON HIV TRANSMISSION

HIV is a virus that can be transmitted from person to person, usually in one of three ways: through sexual intercourse, exposure to infected blood, or transmission from mother to child in pregnancy (perinatal).[13] The most common forms of sexual intercourse that result in transmission are anal and vaginal intercourse.[14] Only a very small portion of the people who are exposed to the virus will become infected. The risk of transmission from sexual intercourse depends on several factors, including viral load, sexual actions and personal health status.[15] Viral load refers to the number of copies of the HIV virus in every millilitre (mL) of blood and can be thought of as the "concentration" of HIV in the blood. After a person is infected with HIV, the virus will keep producing more copies of itself (replicate) until something stops it, either the immune system or medications.[16] For all forms of transmission (sexual, blood, and perinatal) of HIV, a higher viral load in

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12 *Ibid.*

13 Paul E Sax, "The natural history and clinical features of HIV infection in adults and adolescents" (last modified 24 July 2018), online: *UpToDate* <www.uptodate.com/contents/the-natural-history-and-clinical-features-of-hiv-infection-in-adults-and-adolescents> [perma.cc/E637-LSVY] [Sax, "clinical features of HIV"].

14 *Ibid.*

15 *Ibid.*

16 *Ibid.*

the person with HIV is associated with a greater risk of transmission.[17] The viral load is measured with one of several commercially available tests. All these tests have a lower limit of detection below which they cannot count the number of copies of the virus. Anything below this lower limit is referred to as an "undetectable viral load." This lower limit has decreased over time. In 1997, the lower limit of detection was 200 copies per mL.[18] The lower limit of detection was 40 copies per mL in 2007, and today the lower limit is usually 20 copies per mL.[19] At each of these points in time, a viral load below those levels would be classified by the developers of the tests as "undetectable."

Different sexual actions also pose different risks for sexual transmission of HIV. Assuming that one's partner has HIV, is not using a form of barrier protection such as a condom (so-called "unprotected sex"), does not have a concurrent sexually transmitted infection (STI) or immune system impairment, and is not on treatment, the average risk of transmission of HIV for each sex act is as follows[20]:

Sexual act	Risk of transmission
Receptive anal intercourse	1 in 72
Insertive anal intercourse	1 in 900
Receptive penile-vaginal intercourse	1 in 1,250
Receptive or insertive penile-oral sex	0 to 4 in 10,000

Transmission risk can be lowered by the use of male condoms. A review in 1997 of all the studies published up to that date suggested that consistent

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17 *Ibid.*

18 Michael D Hughes et al, "Monitoring Plasma HIV-1 RNA Levels in Addition to CD4+ Lymphocyte Count Improves Assessment of Antiretroviral Therapeutic Response" (1997) 126:12 Annals Internal Medicine 929 at 931.

19 Kimberly A Sollis et al, "Systematic Review of the Performance of HIV Viral Load Technologies on Plasma Samples" (2014) 9:2 PLoS One 1.

20 Myron S Cohen, "HIV infection: Risk factors and prevention strategies" (last modified 13 May 2018) online: *UpToDate* <www.uptodate.com/contents/hiv-infection-risk-factors-and-prevention-strategies/print> [perma.cc/3AVK-TU59] [Cohen, "Risk factors"].

condom use can reduce the risk of HIV transmission by 90-95%.[21] However, a similar review conducted in 2002 suggested that consistent condom use only reduced the risk by 80%.[22] Note that the authors of these reviews could not assess if the condoms were used correctly.[23] Therefore, the reduction in risk presented in each review would represent average condom use, including those who applied the condom incorrectly. Proper condom use would likely lead to a greater reduction in risk.

The risk of transmission of HIV is also affected by the personal health status of both the person without HIV and the person with HIV. If either partner has another STI, the risk of HIV transmission is increased approximately 3-4 times.[24] The risk of transmission would also increase if the person without HIV was taking any medication or had any medical condition that impaired his or her immune system.

The most effective way of preventing sexual transmission of HIV is by decreasing the viral load of the person with HIV. Viral load is the most important risk factor for transmission of HIV.[25] For each 10-fold decrease in the viral load, the risk of transmission is lowered 2.5-fold.[26] A person's viral load is decreased when on ART treatment for HIV. Without treatment, the viral load at the early stage of infection can often be greater than 1 million copies per mL.[27] However, with ART the viral load should decrease by 10-fold after one to two weeks, 100-fold after four weeks, and be undetectable (less than 50 copies per mL in this study) after 8 to 24 weeks.[28] So if a person is on ART and able to decrease his viral load from 1 million copies per mL to 10 copies per mL over 8 to 24 weeks, this would decrease the risk of infection 100 times. However, even this may

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21 *Ibid.*

22 *Ibid.*

23 Steven D Pinkerton & Paul R Abramson, "Effectiveness of Condoms in Preventing HIV Transmission" (1997) 44:9 Soc Science & Medicine 1303; S Weller & K Davis, "Condom effectiveness in reducing heterosexual HIV transmission" (2002) 1:CD003255 Cochrane Database Systematic Reviews 1.

24 Cohen, "Risk factors", *supra* note 20.

25 *Ibid.*

26 *Ibid.*

27 Sax, "Clinical features of HIV", *supra* note 13.

28 Paul E Sax, "Patient monitoring during HIV antiretroviral therapy" (last modified 7 May 2018), online: *UpToDate* <www.uptodate.com/contents/patient-monitoring-during-hiv-antiretroviral-therapy> [perma.cc/NT2D-BDDN].

underestimate the risk reduction from ART; there is evidence that below a certain viral load threshold HIV may not even be transmissible.

Studies often estimate risk of HIV transmission by following HIV-serodiscordant couples; that is, relationships where one person is infected with HIV and the other person is not infected with HIV. There are no confirmed cases of sexually transmitted HIV to an HIV-negative partner when the HIV-positive partner was continuously on ART with sustained viral suppression. In one study with 415 heterosexual HIV-serodiscordant couples in Uganda, followed for an average of two years, despite 89% of them never wearing condoms, no transmissions of HIV occurred when the viral load was less than 1,500 copies per mL.[29] In the HPTN 052 trial, involving 1,763 HIV-serodiscordant couples, 97% of which were heterosexual, randomized to receive early or delayed treatment, and with 95-96% of them always using condoms, there were no transmissions of HIV when the viral load was less than 400 copies per mL.[30] In the PARTNER study of 888 HIV-serodiscordant couples (548 heterosexual and 340 same-sex male couples) who chose not to use condoms, there was no documented HIV transmission when the partner with HIV was virally suppressed on ART (less than 200 copies per mL in this study), after an average of 1.5 years of follow-up.[31] Finally, in the PARTNER2 study, 779 HIV-serodiscordant, same-sex, male couples were followed for an average of 1.6 years, and after 74,567 sex acts without a condom, again there was no documented HIV transmission when the partner with HIV was virally suppressed on ART (less than 200 copies per mL). It is also important to note that the threshold at which there was no HIV transmissions may have been higher than 400 and 200 copies per mL, but those were the pre-determined levels at which the viral load was considered "suppressed."

Taken together, these studies show that with a viral load of less than 200 copies per mL, the risk of transmission of HIV, even without a condom, is less than 1 in 100,000, and may not even be possible. This risk is in the same realm as the average yearly risk of being injured by a lightning strike

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29 TC Quinn et al, "Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1" (2000) 342:13 New England J Medicine 921.

30 Myron S Cohen et al, "Antiretroviral Therapy for the Prevention of HIV-1 Transmission" (2016) 375:9 New England J Medicine 830.

31 AJ Rodger et al, "Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy" (2016) 316:2 J American Medical Assoc 171.

in Canada (1 in 300,000), and lower than the average yearly risk of death from a motor vehicle collision in Canada (1 in 19,000 in 2015).[32] Most of this evidence was known by the early 2000s, although some has been published in the last few years. These findings were confirmed with another systematic review published in late 2018 in the *Canadian Medical Association Journal*.[33] The authors concluded that "there is a negligible risk of sexually transmitting HIV when an HIV-positive sex partner adheres to antiretroviral therapy and maintains a suppressed viral load of less than 200 copies/mL on consecutive measurements every 4 to 6 months."[34] But as we will now discuss, the case law on non-disclosure of HIV status has misunderstood or not kept up with the science.

III. HIV SCIENCE AND THE SUPREME COURT OF CANADA

A. *Cuerrier:* Fraud and "Significant Risk"

In September 1998, the SCC released its decision in the case of *R v Cuerrier* and criminalized the non-disclosure of HIV status prior to sexual activity by modifying the interpretation of fraud as it related to consent to sexual intercourse.[35] Henry Cuerrier, who had been diagnosed with HIV, was charged with two counts of aggravated assault for having unprotected (no condom) vaginal intercourse (UVI) with two women without disclosing his HIV status before those sexual interactions.[36] He had sex with the first woman approximately 100 times, and sex with the second woman approximately 10 times.[37] Neither woman contracted HIV.[38] The SCC did not note whether the defendant was on any treatment for HIV; a telling

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32 Government of Canada, "Lightning in Canada: frequently asked questions" (last modified 13 August 2018), online: <www.canada.ca/en/environment-climate-change/services/lightning/frequently-asked-questions.html> [perma.cc/ZW6G-EF2Z] [*Lightning*]; Government of Canada, "Canadian Motor Vehicle Traffic Collision Statistics: 2015" (last modified 26 May 2017), online: <www.tc.gc.ca/eng/motorvehiclesafety/tp-tp3322-2015-1487.html> [perma.cc/T6A4-ZWM5] [MVC].

33 Jennifer LeMessurier et al, "Risk of sexual transmission of human immunodeficiency virus with antiretroviral therapy, suppressed viral load and condom use: a systematic review" (2018) 190:46 Can Medical Assoc J E1350 at E1358.

34 *Ibid.*

35 *R v Cuerrier*, [1998] 2 SCR 371, [1998] SCJ No 64 [*Cuerrier* cited to SCJ].

36 *Ibid.*

37 *Ibid* at paras 79, 82.

38 *Ibid* at para 83.

omission given the correlation between viral load and risk of transmission cannot be understated. Other risks related to transmission, such as concurrent STIs, and other medical conditions of the defendant or the partners were also not mentioned in the decision. Before *Cuerrier*, the SCC used a narrow interpretation for actions that would vitiate consent to sexual intercourse. As Justice McLachlin stated, the law had been settled for more than a century that:

> [F]raud does not vitiate consent to assault unless the mistake goes to the nature of the act or the identity of the partner. Fraud as to collateral aspects of a consensual encounter, like the possibility of contracting serious venereal disease, does not vitiate consent.[39]

However, Justice Cory, delivering the decision for the majority, expanded the definition of fraud for consent to sexual intercourse. Fraud for those living with HIV now included not disclosing one's HIV status.[40] More specifically, fraud included any action, or inaction, that was considered "deceptive" and resulted in "deprivation."[41] For the criterion of deception, theoretically the Crown still needed to prove that the sexual partner would not have consented to sexual intercourse if the defendant had disclosed his HIV status before sexual intercourse.[42] However, Justice Cory considered this basically a given, at least in the case of UVI, as he said that it is unlikely anyone would agree to this.[43] Deprivation, as Justice Cory defined it, is "a significant risk of serious bodily harm."[44] Unfortunately, the Court did not define either "significant risk" or "serious bodily harm." Justice Cory did go on to say:

> The standard is sufficient to encompass not only the risk of HIV infection but also other sexually transmitted diseases which constitute a significant risk of serious harm.[45]

He also qualified "significant risk" by saying:

> To have intercourse with a person who is HIV-positive will <u>always</u> present risks. Absolutely safe sex may be impossible. Yet the careful use of condoms might be

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39 *Ibid* at para 25.
40 *Ibid* at para 127.
41 *Ibid* at paras 126-128.
42 *Ibid* at para 130.
43 *Ibid*.
44 *Ibid* at para 128.
45 *Ibid* at para 137.

> found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation.[46]

"Significant risk" and "serious bodily harm" stood as the legal definition of risk and harm for HIV non-disclosure until 2012, the year the SCC decided the case of *R v Mabior*.

The SCC made two other important determinations in *Cuerrier*. First, the defendant was not charged with simple assault, or sexual assault, but instead with aggravated assault and the SCC suggested that their analysis also applied to aggravated sexual assault.[47] Aggravated assault and aggravated sexual assault are reserved for the most severe acts of assault. They apply to someone "who wounds, maims, disfigures or endangers the life of the complainant."[48] Aggravated assault carries a maximum penalty of 14 years in prison,[49] and aggravated sexual assault carries a maximum penalty of life in prison,[50] the same sentence as for someone convicted of murder.[51] Since the SCC believed that HIV infection could result in death, it decided that the defendant endangered the life of his sexual partners. The SCC failed to consider the effectiveness of HIV treatment or any modifying factors other than condom use. There had already been significant advancements in treatment for HIV by 1998, the year *Cuerrier* was decided. ART was used to treat people with HIV, and between 1995 and 1997, the life expectancy lost for the average gay or bisexual man living with HIV in Vancouver's West End was 10 years.[52] To put this into perspective, the life expectancy lost for the average 40-year-old, non-smoking man is three years if he is overweight, and 6 years if he is obese (compared to someone of ideal bodyweight).[53] Second, the Court decided that there was no requirement of actual harm to the sexual partners, as in this case neither of the defendant's sexual partners acquired HIV.[54] Simply exposing someone to the risk of acquiring HIV was enough to establish the charge of aggravated sexual assault.

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46 *Ibid* at para 129 [emphasis added].

47 *Ibid* at para 14.

48 *Criminal Code*, RSC 1985, c C-46, s 268(1).

49 *Ibid*, s 268(2).

50 *Ibid*, s 273(2).

51 *Ibid*, s 235(1).

52 Evan Wood et al, "Modern Antiretroviral Therapy Improves Life Expectancy of Gay and Bisexual Males in Vancouver's West End" (2000) 91:2 Can J Public Health 125.

53 A Peeters et al, "Obesity in adulthood and its consequences for life expectancy: a life-table analysis" (2003) 138:1 Annals Internal Medicine 24.

54 *Cuerrier*, *supra* note 35 at para 95.

B. *Mabior:* "Realistic Possibility"

Criminalization of HIV in Canada was supposed to be clarified in 2012 by the SCC in *R v Mabior*.[55] Clato Mabior was charged with six counts of aggravated sexual assault for having vaginal intercourse (VI) with six women without disclosing his HIV diagnosis.[56] He engaged in both unprotected (no condom) vaginal intercourse (UVI) and protected (with a condom) vaginal intercourse (PVI). During sexual encounters with some of the women, he was on ART, including times when his viral load was undetectable (less than 40 copies per mL using the tests at that time).[57] Chief Justice (CJ) McLachlin stated for the SCC that, after *Cuerrier,* the circumstances where non-disclosure of HIV vitiated consent and converted sexual activity into aggravated sexual assault were unclear.[58] The SCC tried to clarify the circumstances by saying that one only need disclose that one is living with HIV if there is a "realistic possibility that HIV will be transmitted."[59] The SCC went on to say that there would not be a requirement to disclose if two criteria were met: "the HIV-positive person has a low viral count as a result of treatment and there is condom protection."[60] The term low viral load is used by the SCC to define less than 1,500 copies per mL. This is not a commonly used medical or scientific threshold and it is unclear why it was used by the SCC.

When it considered the *Mabior* case, the Manitoba Court of Appeal (MBCA) had unanimously decided that the threshold of less than "a realistic possibility" of transmission is met with one of: undetectable viral load (below 40 copies per millilitre (mL); the threshold given to the MBCA for detection at the time) or careful and consistent condom use.[61] The SCC rejected this definition of "a realistic possibility" asserted by the MBCA. Unfortunately, McLachlin CJ did not go further to clarify what "a realistic possibility" of transmission means. This failure to clarify is inexplicable given her earlier comments in the decision:

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55 *R v Mabior,* 2012 SCC 47 [*Mabior* SCC].

56 *R v Mabior*, 2010 MBCA 93 [*Mabior* CA].

57 *Ibid* at paras 119-137.

58 *Mabior* SCC, *supra* note 55 at para 3.

59 *Ibid* at para 4.

60 *Ibid* [emphasis added].

61 *Ibid* at paras 93-103; *Mabior* CA, *supra* note 56 at para 103.

> About "significant risk", some people say that virtually any risk of serious bodily harm is significant. Others argue that to be significant, the risk must rise to a higher level. These debates centre on statistical percentages. Is a 1% risk "significant"? Or should it be 10% or 51% or, indeed, .01%? How is a prosecutor to know or a judge decide? And if prosecutors, defence counsel and judges debate the point, how – one may ask – is the ordinary Canadian citizen to know?[62]

C. Where the SCC Got the Science Wrong

In contrast to the SCC, the MBCA went through a very detailed scientific analysis for risk of HIV transmission based on expert witness testimony provided by Dr. Richard Smith, an expert in the area of HIV and AIDS who testified for the Crown in the original trial. The MBCA decided that either an undetectable viral load or careful and consistent condom use would remove the obligation to disclose that one is living with HIV.[63] The MBCA determined that without ART and without using a condom, the average risk of HIV transmission from a single event of receptive vaginal intercourse (RVI) was 1 in 1,250, and that it was significant enough to require disclosure.[64] The MBCA accepted that condom use in general decreased the risk of transmission of HIV by 80%, though careful and consistent condom use would likely be even more effective.[65] It therefore determined that the risk of transmission for RVI with condom use, but without being on ART, would be approximately 1 in 10,000.[66] This level of risk, the MBCA said, was low enough that there was not a significant risk of transmission.[67] However, the MBCA did go on to say that if the condom broke, this would be equivalent to UVI, so the person living with HIV would have to disclose his status so the partner could obtain post-exposure prophylaxis for HIV.[68] With this decision, the MBCA established a risk threshold of somewhere between 1 in 1,250 to 1 in 10,000 as the point at which disclosure of HIV status would be required.

The MBCA applied the same type of logic when it considered the issue of viral load and ART for HIV. According to the evidence considered by the MBCA, the risk of transmission of HIV for RVI with an undetectable

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62 *Mabior* SCC, *supra* note 55 at para 16.

63 *Mabior* CA, *supra* note 566.

64 *Ibid* at para 77.

65 *Ibid* at para 86; Cohen, "Risk factors", *supra* note 20.

66 *Mabior* CA, *supra* note 566 at para 86.

67 *Ibid* at para 89.

68 *Ibid* at para 97.

viral load (below 40 copies per mL) was somewhere between 1 in 100,000 and 1 in 1,000,000.[69] Therefore, a single event of RVI would be low enough to not pose a "significant risk" of transmission.[70]

Using this risk threshold of somewhere between 1 in 1,250 to 1 in 10,000, consent would not be vitiated without disclosure from one sexual encounter if a condom was used, but it may be vitiated if there were several sexual encounters, even with a condom. As well, consent would not be vitiated if the viral load was less than 40 copies per mL, regardless of the number of sexual encounters, but higher viral loads could vitiate consent if the risk of transmission of HIV was greater than 1 in 10,000. While it is difficult to be precise when estimating these types of risks, especially since there are other factors that can affect HIV transmission, this framework could have informed concrete legal information for people living with HIV.

The SCC did not analyse the evidence on transmission as carefully as the MBCA, and even misquoted and misunderstood parts of the MBCA decision. First, the SCC said that the MBCA used a threshold of "high risk" of transmission of HIV before the MBCA considered the risk significant enough to vitiate consent.[71] This is incorrect. The MBCA used the ambiguous "significant risk" threshold provided by the SCC in *Cuerrier* and decided that 1 in 10,000 was below that threshold. Second, the SCC insinuated that when Dr. Smith stated "it is highly advisable that persons even with an undetectable viral load who are having sex with more than one partner unfailingly and correctly use a condom" in the original trial, he was referring to the risk of transmission of HIV to the person without HIV.[72] However, as noted by the MBCA:

> [Dr. Smith's] reason was not because it affected the risk of transmission to other people, but rather because it affected the accused's own risk. If he did not wear a condom and had multiple partners, even though he was on antiretroviral therapy, he was at risk of getting STDs and would be opening himself to the possibility of exacerbating the course of his own disease by infecting himself with a strain of uncontrolled HIV from another person.[73]

Third, the SCC made a serious error in misquoting a study on ART effectiveness, also showing a lack of understanding of the scientific

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69 *Ibid* at para 106.

70 *Ibid* at para 155.

71 *Mabior* SCC, *supra* note 55 at para 84.

72 *Ibid* at para 101.

73 *Mabior* CA, *supra* note 56 at para 110 [emphasis added].

information. Referencing research done by M. S. Cohen and others,[74] McLachlin CJ stated that:

> The most recent wide-scale study on this issue, relied on by a number of interveners, concludes that the risk of HIV transmission is reduced by 89 to 96% when the HIV-positive partner is treated with antiretrovirals, irrespective of whether the viral load is low or undetectable.[75]

However, the authors of that study actually said:

> [There] was a relative reduction of 96% in the number of linked HIV-1 transmissions resulting from the early initiation of antiretroviral therapy, as compared with delayed therapy. There was a relative reduction of 89% in the total number of HIV-1 transmissions resulting from the early initiation of antiretroviral therapy, regardless of viral linkage with the infected partner.[76]

This is a serious error by the SCC. Viral load is the most important risk factor for transmission of HIV.[77] Every reference to risk of transmission of HIV includes viral load. For the SCC to say that the risk of transmission of HIV is reduced, irrespective of whether the viral load is low or undetectable, means that the SCC did not understand what that article said and that the SCC had a fundamental misunderstanding of the scientific evidence in this case. Viral linkage is the process of confirming that the HIV virus in the partner who was initially infected is the same as the HIV virus in the other partner. The HIV virus can mutate over time, so different people can have slightly different strains of the HIV virus. Using viral linkage is a way of confirming that the newly infected person received the virus from her partner rather than from someone else. It has nothing to do with viral load.

As well, the SCC did not seem to understand how to interpret another key piece of scientific evidence: the combination of two factors that reduce risk. The SCC found that even though a low viral load would reduce the risk of transmission of HIV by 89 to 96% from the baseline risk of transmission from RVI, this reduction was not enough to justify non-disclosure.[78] If a man living with HIV has RVI with a woman, the average risk of transmission is 1 in 1,250, without a condom and without being on ART.[79] Therefore, combining these two statistics, a risk reduction of 92.5%

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74 Myron S Cohen et al, "Prevention of HIV-1 Infection with Early Antiretroviral Therapy" (2011) 365:6 New England J Medicine 493 [Cohen, "Prevention of HIV"].

75 *Mabior* SCC, *supra* note 55 at para 101 [emphasis added].

76 Cohen, "Prevention of HIV", *supra* note 744 at 503 [emphasis added].

77 Cohen, "Risk factors", *supra* note 20.

78 *Mabior* SCC, *supra* note 55 at paras 100-101.

79 Cohen, "Risk factors", *supra* note 20.

(halfway between the 89 to 96% range the SCC accepted) after starting ART to achieve a low viral load (less than 1,500 copies per mL) means the average risk of RVI in this case falls to 1 in 16,667, without using a condom.[80] If we add the 80% risk reduction from condom use discussed above, the average risk from RVI in this situation drops to 1 in 83,333. The SCC did not perform these calculations or demonstrate any understanding of multiplication of risk, a standard method for assessing risk. McLachlin CJ simply states that the standard for vitiating consent without disclosure is "a realistic possibility of transmission of HIV," and that this is negated by the combination of a low viral load (less than 1,500 copies per mL) and condom use, but not by an undetectable viral load alone.[81] There is no comment on why 1 in 83,333 (RVI on ART with a condom) is not "a realistic possibility of transmission" but 1 in 16,667 (RVI on ART with no condom) falls above this threshold. Again, for comparison, the average yearly risk of death from a motor vehicle collision each year in Canada is approximately 1 in 19,000.[82]

So, despite the SCC stating that its decision in *Mabior* would clarify the law surrounding non-disclosure of HIV, it simply went from the standard of "significant risk" in *Cuerrier* to "a realistic possibility of transmission of HIV" without any explanation of what a "realistic possibility" actually means. The standard is arguably even more confusing after *Mabior* than after *Cuerrier* since the SCC said the risk of transmission from an undetectable viral load was too high, but the risk from a low viral load with condom use was acceptable. This is incomprehensible since an undetectable viral load likely poses a lower risk than the combination of a viral load of 1,500 copies per mL (the SCC threshold for a low viral load) and condom use.[83]

The SCC also made one other important decision in *Mabior*. It stated that if the Crown establishes that a defendant living with HIV did not disclose his status to his partner, and engaged in sexual intercourse without a condom, there was a *prima facia* case of deception and deprivation.[84] Then,

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80 Note: A 92.5% risk reduction means that the new risk is only 7.5% that of the original risk (or 7.5/100). Therefore, a 92.5% reduction in risk for RVI from condom use can be calculated by multiplying the original risk, 1 in 1,250, by 7.5%, or 7.5/100, which equals 1 in 16,667.

81 *Mabior* SCC, *supra* note 55 at paras 100, 104.

82 *MVC*, *supra* note 32.

83 Cohen, "Risk factors", *supra* note 20.

84 *Mabior* SCC, *supra* note 55 at para 105; Canada, Department of Justice, *Criminal Justice System's Response to Non-Disclosure of HIV*, (Ottawa: DOJ, 2017) at 12, online (pdf):

it was up to the defence to show that there was no realistic possibility of transmission, which the SCC referred to as a "tactical burden."[85] Due to the SCC's misapplication of the scientific evidence, and not understanding that a viral load of less than 200 copies per mL results in a risk of HIV transmission, even without a condom, of less than 1 in 100,000,[86] this essentially shifts the burden of proof to the defence. The defendant must call evidence of his medical record and expert witnesses to establish the actual risk of transmission of HIV. However, the Crown is allowed to establish a *prima facia* case without actually proving that there was any risk. This is a fundamental flaw in the decision and, probably (although it is beyond the scope of this paper to permit further exploration) a breach of one of the core principles of the Canadian justice system: the presumption of innocence.

In *Mabior*, the Court was given the opportunity to clarify the ambiguous definition of "significant risk" of HIV transmission that the justice system was left with after *Cuerrier*. The MBCA went through a careful and rigorous appraisal of the scientific evidence presented at the original trial, most of which the SCC ignored, misrepresented, or misinterpreted. After the SCC *Mabior* decision, lawyers, judges, and the public across Canada are left with contradictory and ambiguous messaging regarding when a person with HIV may be charged for HIV non-disclosure.

D. HIV Non-disclosure post-Cuerrier and Mabior: Case Law and Prosecutorial Directives

The *Cuerrier* decision had significant consequences for those living with HIV in Canada. Between 1998 and 2012, more than 130 people living with HIV were charged for allegedly not disclosing their HIV status to a sexual partner.[87] In a 2017 review by the Department of Justice Canada (DOJC), of 59 criminal cases between 1998 and 2017 with HIV non-disclosure charges that did not involve any forced sexual contact, 45 (or 76%) resulted in findings of guilt.[88] Twenty-three of those findings of guilt were from

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<www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/hivnd-vihnd.pdf> [perma.cc/Y586-BSHE] [*DOJC*].

85 *Ibid.*

86 Cohen, "Risk factors", *supra* note 20.

87 *R v Mabior*, 2012 SCC 47, (Factum of the Interveners at para 6).

88 *DOJC*, *supra* note 84 at 14.

trial.[89] In 26 of those 45 cases (58%), there was no transmission of HIV to any partners.[90] Aggravated sexual assault or aggravated assault accounted for 85% of the charges laid for those 45 findings of guilt.[91] The other 15% involved a range of charges, from attempted murder to common nuisance.[92] Sentencing information was available for 43 of the 45 cases. In 20 of those cases, the defendant was sentenced to imprisonment for 5 years or longer: 6 people were sentenced to 10-15 years, 2 people were sentenced to 18 years, and 1 person was sentenced to life imprisonment.[93]

Lower courts have responded differently to the uncertainty of "significant risk" and "realistic possibility of transmission of HIV." As summarized by the DOJC, the 2013 *Felix* decision by the Ontario Court of Appeal upheld the defendant's conviction for aggravated sexual assault where the defendant did not use a condom and no evidence of transmission risk or viral load was introduced.[94] It stated that the defendant's viral load and the degree of risk were not relevant since there was sexual intercourse without a condom.[95] Following *Felix*, in the 2013 *Murphy* decision, the Ontario Superior Court of Justice found that engaging in sexual intercourse once without a condom where HIV was not transmitted and viral load was less than 50 copies per mL was enough to convict the defendant of aggravated sexual assault.[96] Again, there is no documented evidence that it is even possible to transmit the virus with a viral load of less than 200 copies per mL. In the 2017 *Schenkels* decision, the MBCA upheld a conviction of aggravated sexual assault for three acts of sexual intercourse without a condom, despite no evidence being introduced of the defendant's viral load or specific risk of transmission.[97]

Courts in other provinces have interpreted *Mabior* differently. Nova Scotia courts, starting in 2013 with the *JTC* decision, have found that the realistic possibility of transmission test is not met when there is sex without

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89 *Ibid.*
90 *Ibid* at 15.
91 *Ibid.*
92 *Ibid.*
93 *Ibid.*
94 *Ibid* at 12.
95 *Ibid* at 12-13.
96 *Ibid* at 13.
97 *R v Schenkels*, 2017 MBCA 62.

a condom and a viral load of less than 500 copies per mL.[98] Ontario courts have also changed their standard since 2017, following the lead of Nova Scotia, saying that a viral load of less than 60 copies per mL was low enough to remove a realistic possibility of transmission.[99] Only two provinces, Ontario and British Columbia (BC), have established prosecutorial directives for HIV non-disclosure. These two directives are not consistent with each other. Ontario's directive states that:

> [If] a person living with HIV is on antiretroviral therapy and has maintained a suppressed viral load for six months, there is also no realistic possibility of transmission. In these circumstances a failure to disclose does not result in criminal liability for exposure to HIV.[100]

The BC Directive takes a very different approach.[101] According to a submission made by the Canadian HIV/AIDS Legal Network, it suffers from various deficiencies including: no guidance on limiting prosecutions, a bias toward prosecuting widely, lack of guidance on the meaning of "realistic possibility of transmission," and a limited understanding of the "public interest."[102]

The Canadian HIV/AIDS Legal Network and others[103] have been calling for reform of Canada's criminal HIV disclosure law for years. More recently, out of concern that "Canada's approach to HIV criminalization is unscientific, unjust and undermines public health,"[104] experts in medicine and law formed the Canadian Coalition to Reform HIV Criminalization

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98 *DOJC*, *supra* note 84 at 13.

99 *Ibid* at 13.

100 Ontario, Ministry of the Attorney General, *Crown Prosecution Manual*, (Toronto: MAG, 2017) at "Sexually Transmitted Infections and HIV Exposure Cases", online (pdf): <files.ontario.ca/books/crown_prosecution_manual_english_1.pdf> [perma.cc/H48T-GRJU].

101 BC Prosecution Service, "Sexual Transmission, or Realistic Possibility of Transmission, of HIV" in *Crown Counsel Policy Manual*, online (pdf): <www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/prosecution-service/crown-counsel-policy-manual/sex-2.pdf> [perma.cc/7AFN-RSYB].

102 Canadian HIV/AIDS Legal Network, "Ending Unjust HIV Prosecutions in British Columbia: Modernizing prosecutorial policy" (January 2019), online at <www.aidslaw.ca/site/ending-unjust-hiv-prosecutions-in-british-columbia/?lang=en> [perma.cc/HA35-LR6C].

103 Among others, HIV & AIDS Legal Clinic Ontario (HALCO), Positive Living Society of British Columbia, Canadian Positive Peoples Network (CPPN), Ontario Working Group on Criminal Law + HIV Exposure (CLHE), and, more recently, the Canadian Coalition to Reform HIV Criminalization.

104 Canadian Coalition, *supra* note 11 at 2.

(CCRHC). While we have focused so far in this paper on the problems with misunderstandings about HIV science, there are other problems with the law especially from a public health perspective. We turn now to a brief examination of some of these problems.

IV. How HIV Non-Disclosure Laws Undermine Public Health

A. Arbitrariness, Discrimination and Stigmatization in HIV Prosecutions

People who have HIV are still stigmatized in Canada.[105] HIV is treated in criminal law in a fundamentally different way than other STIs or any other risk associated with sexual activity. When someone agrees to sexual activity, they agree to risk associated with transmission of chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C, oral and genital herpes, and pregnancy. Depending on the sexual activity, they may also be agreeing to the risk associated with transmission of hepatitis A, hepatitis E, and other infectious organisms. Hepatitis C may be fatal, and until very recently was not consistently curable. However, in the 2002 *Jones* case, the New Brunswick Court of Queen's Bench decided that someone with hepatitis C does not need to disclose his condition to a sexual partner, even for anal sex without a condom.[106] In *Jones*, the risk of transmission considered by the Court for anal sex without a condom, 1-2.5% (which equated to a risk of 1 in 40 to 1 in 100), was low enough not to pose a significant risk of serious bodily harm.[107] Compare this risk threshold to the threshold of 1 in 83,333 that the SCC seemed to be saying was necessary for those with HIV to not pose a significant risk of serious bodily harm. Oral and genital herpes are not curable and can cause serious health risks in childbirth. Hepatitis B is

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105 See e.g. MA Kesler et al, "Prosecution of non-disclosure of HIV status: Potential impact on HIV testing and transmission among HIV-negative men who have sex with men" (2018) 13:2 *PLOS ONE* 1; Sophie E Patterson et al, "The Impact of Criminalization of HIV Non-Disclosure on the Healthcare Engagement of Women Living with HIV in Canada: a Comprehensive Review of the Evidence" (2015) 18 J Intl AIDS Society 1; Akim Adé Larcher & Alison Symington, *Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario*, (African and Caribbean Council on HIV/AIDS in Ontario, November 2017).

106 *R v Jones*, 2002 NBQB 340.

107 *Ibid* at 26.

not curable, can lead to liver cancer, and can be transmitted in pregnancy. Hepatitis A and E can be fatal. Syphilis can be transmitted in pregnancy and cause significant health consequences for newborns. Gonorrhea can cause septic arthritis and lead to joint destruction. Both chlamydia and gonorrhea can lead to pelvic inflammatory disease, which can cause infertility and can be life threatening. Yet prosecutions for non-disclosure of these other STI's are unheard of in Canada.[108]

HIV may be treated differently from every other STI because it originally appeared to be uniformly fatal, but also perhaps because of its initial association with gay men. Canada has a significant history of discrimination against homosexuality, and gay men in particular. It is still illegal to have anal sex in Canada, unless you are "husband and wife," or over 18 years old and no more than two people are involved.[109] This provision is still contained in the *Criminal Code* and still applied.

> Even after Ontario struck down the law in 1995, police continued to charge people with anal intercourse. Between 2008 and 2014 in Ontario, 22 people were charged with anal intercourse under Section 159. Two of those were youth. More than half of those charged in Quebec were youth.[110]

As already noted, even Canadian Blood Services still uses policies that discriminate against gay men donating blood, with no basis in science.[111] Police and prosecutors also seem to pursue charges more often when the couples are heterosexual. Eighty-nine percent of the 45 cases the DOJC reviewed that resulted in a conviction involved heterosexual partners.[112] However, in Canada 59% of those with HIV who were exposed through sexual contact are gay men.[113] Speculating about the reason for this large discrepancy, perhaps the justice system feels more obligated to "protect" heterosexual "victims" from HIV than gay men.

Another explanation may be the higher prevalence of HIV among men of colour. Canada also has a significant history of discrimination against men of colour. The DOJC reported that in 2015, 18.7% of diagnoses of

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108 *DOJC*, *supra* note 84 at 17.

109 *Criminal Code*, *supra* note 48, s 159.

110 Egale Canada Human Rights Trust, *The Just Society Report: Confronting the Legacy of LGBTQ2SI Discrimination in Canada*, (Toronto: Egale, 2016) at 40, online: <www.academia.edu/26229209/The_Just_Society_Report_Confronting_the_Legacy_of_LGBTQ2SI_Discrimination_in_Canada> [].

111 Canadian Blood Services, *supra* note 8.

112 *DOJC*, *supra* note 84 at 15.

113 *Ibid* at 4.

HIV were among "black" individuals.[114] However, of the 121 people who were charged between 1989 and 2016 and whose ethnicity was known, 36% were identified as "black";[115] and since *Mabior* in 2012, 48% of people who have faced charges and whose ethnicity is known were "black."[116] There could be more reasonable explanations for the discrepancies noted for gay men and individuals identified as "black," but without reviewing all the case files and interviewing all of those involved, it is impossible to say for certain.

The SCC has also chosen to use a practical public health approach rather than criminalizing non-disclosure of prior high-risk behaviour, like unprotected sex with sex workers or injection drugs, that likely pose a larger risk than many of the cases involving HIV non-disclosure. Manitoba sees approximately eight new infections of HIV for every 100,000 people in the province each year.[117] Certain populations have a higher rate of new infections than the average. In 2010-2011, a study testing for new HIV infections in the emergency room at Winnipeg's Health Sciences Centre, the largest tertiary-care hospital in the province, found seven new infections from 501 people tested.[118] This translates to a rate of 1,400 new infections per 100,000 people per year, though with such small numbers the reliability of this rate is diminished. Individuals who inject drugs and those who participate in sex work are at a higher than average risk of acquiring HIV.[119] An estimated 65,040 people were living with HIV in Canada in 2014, but approximately 20% of those people have yet to be diagnosed.[120] Those with undiagnosed HIV pose the highest risk of transmission and account for a

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[114] Ibid.

[115] Canadian HIV/AIDS Legal Network, "HIV Criminalization in Canada: Key Trends and Patterns" by Colin Hastings, Cécile Kazatchkine & Eric Mykhalovskiy (March 2017), online at <www.aidslaw.ca/site/hiv-criminalization-in-canada-key-trends-and-patterns/?lang=en> [perma.cc/PBY9-LBNT].

[116] *Ibid.*

[117] Manitoba, Department of Health, Seniors and Active Living, *2016 Annual Statistical Update: HIV and AIDS* (Winnipeg: DHSAL, 2018) at 17.

[118] Marissa L Becker et al, "Feasibility and Success of HIV Point-of-Care Testing in an Emergency Department in an Urban Canadian Setting" (2013) 24:1 Can J Infectious Diseases & Medical Microbiology 27.

[119] Manitoba, Communicable Disease Control, *Communicable Disease Management Protocol: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)* (Winnipeg: CDC, 2010).

[120] *DOJC*, *supra* note 84 at 3.

disproportionate number of HIV transmission cases.[121] Therefore, choosing to engage in sexual intercourse without a condom, especially with someone who engages in sex work or uses injection drugs, poses a risk of acquiring HIV. However, someone who has not been tested for STIs can engage in unprotected sex with sex workers without telling their partner, thus exposing the partner to all STIs, without facing the risk of criminal charges from vitiating consent. The way the law has been applied in Canada incentivises not getting tested for HIV by providing real legal consequences to testing. The criminalization of non-disclosure adds to the already significant stigma surrounding HIV testing, and does real harm to efforts to identify and treat those living with undiagnosed HIV.

B. Advising Clients

McLachlin CJ stated in *Mabior*:

> It is a fundamental requirement of the rule of law that a person should be able to predict whether a particular act constitutes a crime at the time he commits the act. The rule of law requires that laws provide in advance what can and cannot be done. Condemning people for conduct that they could not have reasonably known was criminal is Kafkaesque and anathema to our notions of justice. After-the-fact condemnation violates the concept of liberty in s. 7 of the *Canadian Charter of Rights and Freedoms* and has no place in the Canadian legal system.[122]

The tests of "significant risk" and "realistic possibility of transmission of HIV" have created uncertainty for those counselling people with HIV about their disclosure obligations. For example, the Centre for Human Rights Research and Sex Workers of Winnipeg Action Coalition, in a pamphlet designed for sex workers, simply stated that "the law on HIV disclosure is unclear" but noted that one risked a conviction for failure to disclose unless viral load was low and a condom was used.[123] In its 2016 document, *Indigenous Communities and HIV Disclosure to Sexual Partners,* the Canadian HIV/AIDS Legal Network observes that it is uncertain if one needs to disclose if only oral sex is involved, or if there is anal sex with a condom and a low or undetectable viral load.[124]

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121 *Ibid* at 5.

122 *Mabior* SCC, *supra* note 55 at para 14 [citation omitted].

123 Centre for Human Rights Research & Sex Workers of Winnipeg Action Coalition, "Canada's New Sex Work Laws: Know the Law and Stay Safe" pamphlet (January 2018), online (pdf): <chrr.cc.umanitoba.ca/chrr/wp-content/uploads/sites/5/2018/04/sex-worker-pamphlet-170793.pdf> [perma.cc/A9VR-S4CG].

124 Canadian HIV/AIDS Legal Network, "Indigenous Communities and HIV Disclosure

C. Last Resort: Intent to Transmit and Actual Transmission

In the 2017 DOJC review, stakeholders recommended that "the criminal law should only be used in limited circumstances for the most blameworthy conduct, where public health measures have been exhausted and have failed to change the behaviour of persons who engage in a pattern of non-disclosure that exposes others to risk."[125] The CCRHC also asserts that the criminal law should be limited in its scope and application and only be used as a last resort in cases where there is no other option.[126] Otherwise people will avoid testing and treatment. They assert that the charges should only be laid in cases of intentional and actual transmission of HIV.[127] Specifically, it proposes any prosecution should require proof that the person intended to transmit HIV and engaged in sexual activity that was likely to transmit the virus, and that HIV was actually transmitted.[128] The CCRHC also listed circumstances where a conviction should not be possible, including where a person living with HIV:

- did not understand how the virus is transmitted;
- disclosed their status to their sexual partner or reasonably believed their sexual partner was aware of their status through some other means;
- did not disclose their status because they feared violence or other serious negative consequences would result from such disclosure;
- was forced or coerced into sex; or
- engaged in activities that, according to the best available scientific evidence, posed no significant risk of transmission, including oral sex; anal or vaginal sex with a condom; anal or vaginal sex without a condom while having a low viral load; and spitting and biting.[129]

These reforms would create an environment that incentivizes safer sex practices of condom use, and testing and treatment of HIV. This approach is the most effective way of reducing the spread of HIV and eventually eliminating this public health threat.

The issue of intent is important and should be elaborated on. Does it mean intent according to the *Criminal Code*? If it does mean criminal intent,

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to Sexual Partners" (April 2016) at 9, online: <www.aidslaw.ca/site/indigenous-communities-and-hiv-disclosure-to-sexual-partners-questions-and-answers/?lang=en> [perma.cc/EC9A-JGWL].

125 *DOJC*, *supra* note 84 at 17.

126 Canadian Coalition, *supra* note 11.

127 *Ibid*.

128 *Ibid*.

129 *Ibid*.

is it general subjective intent, with a minimum standard of recklessness? Or does it have to be planned and deliberate, a much higher standard? For example, the *mens rea* standard for criminal negligence is: "wanton or reckless disregard for the lives or safety of other persons."[130] For an action to be criminally reckless, it would generally mean that the negative outcome would need to be "likely." Determining if an outcome is "likely" is again complex when it comes to transmission of HIV. Is UVI between a woman living with HIV who is not on treatment and a man without HIV reckless? There is an average risk of transmission of 1 in 2,500. How about anal intercourse where the person without HIV is the receiving partner and the partner living with HIV just started treatment and used a condom? If the viral load has come down 10-fold during the time on treatment, the average risk of transmission is approximately 1 in 900. Based on previous decisions, the Court would likely say that the woman from the first case was reckless, but the man in the second case was not reckless. However, this would not be logical based on the estimated risk of transmission. The Court does not seem equipped to interpret the scientific evidence on HIV and apply a consistent rational standard. As stated above, it is a fundamental requirement of the rule of law that a person should be able to predict what does and what does not constitute a crime. And this decision should be rational. For this process to be fair, the definition of intent would need to be very clear, and communicated in advance to the general public, before any HIV-related charges were considered.

Should those who engage in sexual activity likely to transmit the virus, but who do not end up transmitting it, face charges? After all, we charge people for driving under the influence of alcohol, even when no harm has occurred. And knowingly putting someone at risk of acquiring HIV does carry some moral blameworthiness. However, we do not criminalize all morally blameworthy actions. Lying to someone about your marital status, or your feelings for another person, in order to have sexual intercourse with that person, are both morally blameworthy actions. Courts and legislators have chosen not to criminalize those actions. Charging someone for risky sexual activity would not be consistent with the way the justice system has dealt with other STIs. As mentioned above, non-disclosure of hepatitis C and hepatitis B have not been criminalized despite higher risks of sexual transmission than with HIV and serious health effects should transmission

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130 *Criminal Code*, *supra* note 48, s 219(1).

occur. Hepatitis B and C are dealt with as public health issues rather than criminal justice issues. With the success and life expectancy associated with ART today, it does not make sense to treat non-disclosure of HIV status, especially when risk of transmission is very low, differently from other STI-status disclosures

D. Proof of Reciprocity

Finally, we would suggest Canada should consider one more requirement prior to prosecution: proof of reciprocity. The most common ethics framework used in public health for determining when to use legislation for coercive action is the 2002 Upshur framework.[131] It contains four principles: the harm principle, least restrictive means, reciprocity, and transparency. The harm principle refers to the need for there to be a real risk of harm to another person before using coercive measures. Least restrictive means refers to the requirement to examine if a less restrictive measure can be used to accomplish the same goal. Reciprocity refers to the requirement of the state to help the individual fulfill any duties placed on him by the state, and compensate the individual if appropriate. Transparency is the requirement for state actors to be open about their decision-making processes, so their actions are clear and accountable.[132]

If the state is going to continue to criminalize HIV non-disclosure to any degree, there should be proof that the person living with HIV was provided every support possible to reduce the risk of transmission. This support includes covering medication costs for those unable to afford them, providing immediate free addictions treatment for those suffering with addiction, covering transportation costs for those having difficulty accessing care, supplying free condoms, and providing immediate access to free counselling services to help adjust to living with HIV. This idea is neither radical nor novel; it is the same standard of care used by public health officials in Manitoba for other communicable diseases, like tuberculosis, before any coercive measures are used. If someone is diagnosed with tuberculosis in Manitoba, all tuberculosis medications are provided to that individual free of charge; a health professional will deliver the medications to the individual for every dose over the six to nine months required for

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131 REG Upshur, "Principles for the Justification of Public Health Intervention" (2002) 93:2 Can J Public Health 101.

132 *Ibid.*

treatment; bus passes or other transportation expenses for attending medical appointments will be covered if necessary; and public health professionals will help address any other barriers to care.[133] Only after all options are exhausted, members of the public are at significant risk of being infected with tuberculosis, and the individual continues to refuse treatment for tuberculosis, are coercive legal powers considered.

In Manitoba, some of these services are currently unavailable for those diagnosed with HIV. Some people, especially the working poor, cannot afford the medications and do not qualify for government assistance.[134] Many people with addictions, especially those addicted to substances other than alcohol or opioids, are unable to access timely addictions treatment.[135] Free counselling services have long wait lists, especially in rural Manitoba. And some have difficulty taking time away from work and paying for transportation to attend the many medical appointments required to effectively manage their HIV. If the state is going to place the burden of possible criminal charges on someone, essentially for not medically managing their HIV, these barriers to treatment need to be addressed first, as they have been for other communicable diseases.

The Canadian justice system has treated HIV in a fundamentally different way than other serious and incurable STIs. It has incentivized avoiding testing for HIV, but it used a practical public health approach toward other sexual activities that may pose a high risk of transmission of all STIs. Canada needs to adopt a public health approach to those living with HIV and only consider using the criminal law as a last resort. Federal and provincial governments should use directives for prosecution, such as those suggested by the CCRHC, but further clarity needs to be added to these directives for the standard of intent required for criminal charges. The public health ethics principle of reciprocity should also be incorporated into any criminal justice approach to those living with HIV as it has for other communicable diseases like tuberculosis.

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133 Manitoba, Communicable Disease Control, *Communicable Disease Management Protocol: Manitoba Tuberculosis Protocol* (Winnipeg: CDC, 2014) at 4, online: <www.gov.mb.ca/health/publichealth/cdc/protocol/> [perma.cc/FJ8L-YT8C].

134 Pierre Plourde, "HIV/AIDS, Harm Reduction and Criminalization", (21 November 2018) at 00h:31m:30s, online (podcast): <chrr.cc.umanitoba.ca/chrr/wp-content/uploads/sites/5/2018/11/Dr-P-part-one-.mp3>.

135 *Ibid.*

V. The 2018 Federal Directive On HIV Non-Disclosure Laws

In late 2016, Jody Wilson-Raybould (then-federal Justice Minister and Attorney-General of Canada) recognized that, "the over-criminalization of HIV non-disclosure discourages many individuals from being tested and seeking treatment, and further stigmatizes those living with HIV."[136] A year later, the DOJC published its report, *Criminal Justice System's Response to Non-Disclosure of HIV*, reviewing the *Cuerrier* and *Mabior* decisions, discussing the current state of the criminalization of HIV in Canada, and containing stakeholder recommendations for a new approach to criminal HIV disclosure laws in Canada.[137]

In late 2018, Wilson-Raybould issued a Directive to the Director of Public Prosecutions.[138] The Directive's preamble recognizes that "HIV is first and foremost a public health issue" and that "any future developments in the relevant medical science, should be considered before pursuing a criminal prosecution in HIV non-disclosure cases."[139] It also acknowledges that the:

> most recent medical science shows that the risk of HIV transmission through sexual activity is significantly reduced where: the person living with HIV is on treatment; condoms are used; only oral sex is engaged in; the sexual activity is limited to an isolated act; or, the person exposed to HIV, for example as a result of a broken condom, receives post-exposure prophylaxis.[140]

The preamble also goes on to state that "the Supreme Court of Canada has stated that the criminal law has a role to play in cases involving sexual activity and non-disclosure of HIV where public health interventions have failed and the sexual activity at issue poses a risk of serious harm."[141]

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136 Canada, Department of Justice, Press Release, "Minister Wilson-Raybould Issues Statement on World AIDS Day" (1 December 2016), online: <www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/p10.html> [perma.cc/P5V2-9N8Q]

137 *DOJC*, *supra* note 84.

138 Directive (Office of the Director of Public Prosecutions), (2018) C Gaz I, 4322, online (pdf): <www.gazette.gc.ca/rp-pr/p1/2018/2018-12-08/pdf/g1-15249.pdf> [perma.cc/FYN5-KCU7] [Directive].

139 *Ibid* at 4322-4323.

140 *Ibid.*

141 *Ibid* at 4322.

After the preamble, the Directive sets out four principles that should govern prosecutorial decision-making in criminal HIV non-disclosure cases:

> (a) The Director shall not prosecute HIV non-disclosure cases where the person living with HIV has maintained a suppressed viral load, i.e., under 200 copies per ml of blood, because there is no realistic possibility of transmission.
>
> (b) The Director shall generally not prosecute HIV nondisclosure cases where the person has not maintained a suppressed viral load but used condoms or engaged only in oral sex or was taking treatment as prescribed, unless other risk factors are present, because there is likely no realistic possibility of transmission.
>
> (c) The Director shall prosecute HIV non-disclosure cases using non-sexual offences, instead of sexual offences, where non-sexual offences more appropriately reflect the wrongdoing committed, such as cases involving lower levels of blameworthiness.
>
> (d) The Director shall consider whether public health authorities have provided services to a person living with HIV who has not disclosed their HIV status prior to sexual activity when determining whether it is in the public interest to pursue a prosecution against that person.[142]

We will now consider whether this Directive is responsive to the concerns we have raised about criminal HIV non-disclosure laws.

A. The Need for Federal Legislative Reform

Advocacy groups have been calling for clear prosecutorial directives to be developed in every province and territory in Canada to address the risk of over-criminalization,[143] curb arbitrary laying of charges, and achieve improved interaction between public health, criminal law and community-based organizations.[144] As prosecutorial decision-making is, for the most

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142 *Ibid* at 4323.

143 See e.g. Positive Living Society of British Columbia, "The Need for New Charge Assessment Guidelines: HIV Non-Disclosure in British Columbia" (11 June 2014), online (pdf): <positivelivingbc.org/wp-content/uploads/2015/03/new_charge_guidelines_-_position_paper_-_final_-_2014-06-111.pdf> [perma.cc/M3Z6-3EP4]; HIV & AIDS Legal Clinic Ontario (HALCO) & Canadian HIV/AIDS Legal Network, "The criminalization of HIV non-disclosure: Recommendations for police" (February 2013), online <www.aidslaw.ca/site/the-criminalization-of-hiv-non-disclosure-recommendations-for-police/?lang=en> [perma.cc/3QBR-BPN7].

144 Isabel Grant, "The Boundaries of the Criminal Law: the Criminalization of the Non-disclosure of HIV" (2008) 31:1 Dal LJ 123; See also Isabel Grant, "The Prosecution of Non-disclosure of HIV in Canada: Time to Rethink Cuerrier" (2011) 5:1 McGill JL & Health 7; Isabel Grant, "The Over-Criminalization of Persons with HIV" (2013) 63:3

part, within provincial jurisdiction, the Directive only applies directly in the territories (Yukon. Northwest Territories and Nunavut). However as only two provinces have published prosecutorial directives addressing at least some of these concerns, the federal initiative is welcome especially if it encourages the development of policies that bring clarity and reflect public health concerns at the provincial level.

The federal government has the power to make criminal law which is applicable across the country and, as most criticisms made in this paper about the current law relate to the offence itself, it is disappointing not to see any movement on legislative reform. Without legislative reform, it may be difficult to displace the "realistic possibility of transmission" test developed by the SCC or to prosecute non-disclosure through a charge for an offense other than aggravated sexual assault. Legislative reform is also the most effective way to introduce the requirement of intention to transmit or actual transmission. Similarly, while defences to a non-disclosure charge, such as those advocated for by the CCHRC, (including for example, non-disclosure because the person feared violence would result from the disclosure) could be developed incrementally by courts, legislative reform would provide welcome clarity. Similarly, while the Directive states that "the Director shall prosecute HIV non-disclosure cases using non-sexual offences, instead of sexual offences, where non-sexual offences more appropriately reflect the wrongdoing committed, such as cases involving lower levels of blameworthiness," there are no precedents supporting such charges. The federal failure, at least to date, to deal legislatively with the "realistic possibility" test, charge type, defences, intention to transmit and actual transmission or blameworthiness is disappointing.

B. Curbing Over-Criminalization

The Directive has some clear strengths. It repeatedly uses the *Mabior* language of "realistic possibility of transmission of HIV." In the absence of legislative reform, this usage is not surprising because, despite repeated criticism, the *Mabior* decision is still the authoritative decision. However, unlike the SCC decisions, the Directive makes some important qualifying remarks about determining if a "realistic possibility" exists. The Directive states that "the most recent medical science" should be used and notes that transmission is "significantly reduced" where the "person living with HIV is

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on treatment; condoms are used; only oral sex is engaged in; the sexual activity is limited to an isolated act; or, the person exposed to HIV, for example as a result of a broken condom, receives post-exposure prophylaxis."[145] It also clearly sets out situations where no charges should be laid; More specifically, it directs against prosecution "where the person living with HIV has maintained a suppressed viral load, i.e., under 200 copies per ml of blood, because there is no realistic possibility of transmission."[146] Specification of a clear viral load provides is welcomed and is in line with current medical evidence. However, it is unfortunate that the language of "significantly reduced" is used in some places rather than "realistic possibility" as it is not clear if these standards are the same.

C. Avoiding Arbitrariness, Discrimination and Stigmatization

Does the Directive make it clear for those advising their patients, clients or the general public about the disclosure obligations for those living with HIV? Mabior indicated that both a "low viral load" and condom use were necessary to decrease the risk of transmission below the threshold of a "realistic possibility." The Directive makes it clear that a viral load less than 200 copies per mL reduces the risk threshold to below a realistic possibility, but leaves a significant degree of ambiguity in most other circumstances as to whether an individual may be prosecuted. What factors change the circumstances from those which the Crown will "generally not prosecute HIV non-disclosure cases" to circumstances where they will prosecute? Even though the Directive indicates that the most recent medical science will be used to determine if a realistic possibility of transmission existed, the Directive does not state a general risk threshold by which to judge that science. Is a risk of 1 in 1000 low enough, or 1 in 10,000, or 1 in 100,000? As indicated above in section IV (c), the actual risk posed by sexual activity is not always intuitive. Vaginal intercourse without a condom may pose a lower risk of transmission of HIV than anal intercourse with a condom, depending on other circumstances. Unfortunately, Canadian courts do not have a good track record of interpreting this medical science in a consistent and logical way. Therefore, very clear risk thresholds need to be stated by the federal government to, as McLachlin stated in Mabior, meet the

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145 Directive, *supra* note 138 at 4323.

146 *Ibid.*

"fundamental requirement of the rule of law that a person should be able to predict whether a particular act constitutes a crime at the time he commits the act."[147] This Directive fails to meet that fundamental requirement.

The Directive also fails in include any safeguards against discrimination of gay men or ethnic minorities. We see continuing discrimination toward gay men in official government policies, such as those of the Canadian Blood Services, as noted in the Introduction. We also note the discrepancy between the proportion of diagnoses of HIV among "black" individuals and the proportion of charges "black" individuals have faced. As former Associate Chief Judge of the Manitoba Provincial Court, Murray Sinclair, and former Associate Chief Justice of the Manitoba of Court of Queen's Bench, Alvin Hamilton, wrote in the *Report of the Aboriginal Justice Inquiry of Manitoba* when discussing the over-representation of Indigenous People in Manitoba's justice system:

> A significant part of the problem is the inherent biases of those with decision-making or discretionary authority in the justice system. Unconscious attitudes and perceptions are applied when making decisions. Many opportunities for subjective decision making exist within the justice system and there are few checks on the subjective criteria being used to make those decisions. We believe that part of the problem is that while Aboriginal people are the objects of such discretion within the justice system, they do not "benefit" from discretionary decision making, and that even the well-intentioned exercise of discretion can lead to inappropriate results because of cultural or value differences.[148]

Without safeguards to protect against discrimination, even a system full of well-intentioned people can lead to a disproportionate burden being placed on stigmatized or minority populations.

D. Does the Directive Improve Interaction with Public Health?

The Directive recognizes that "HIV is first and foremost a public health issue" and that "criminal law has a role to play…where public health interventions have failed."[149] As already noted, the Directive is silent and no legislative action seems to be in the works respecting most of the steps

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147 *Mabior* SCC, *supra* note 55 at para 14.

148 Manitoba, *Report of the Aboriginal Justice Inquiry of Manitoba*, vol 1 (Winnipeg: AJIM, 1991) at chapter 4 "Systemic Discrimination", online: <www.ajic.mb.ca/volumel/chapter4.html> [perma.cc/HUN8-38CN].

149 Directive, *supra* note 138 at 4322.

towards improving interaction with public health systems and principles, such as a more detailed list of situations where charges should not be laid, and restriction of criminal charges to cases where intent to transmit can be established.

The Directive does provide that "the Director shall consider whether public health authorities have provided services to a person living with HIV who has not disclosed their HIV status prior to sexual activity when determining whether it is in the public interest to pursue a prosecution against that person."[150] If this is an attempt to follow the principle of reciprocity discussed above, it is a severely impoverished attempt. The Directive does not specifically consider an individual's ability to obtain HIV medication, or timely access to counselling, addictions, and public health services. It does not mention that these services are unavailable to many Canadians, especially marginalized populations, or provide any way forward for provinces to improve these services. When considered with the ambiguous language of the directive noted above, it is not clear that the Canadian government does recognize "HIV is first and foremost a public health issue,"[151] or recognize the challenges facing a public health approach to HIV in Canada.

VI. CONCLUSION

Canada relies on a system of checks and balances to ensure that justice prevails. Unfortunately, the criminal justice systems across Canada have failed those living with HIV in Canada. It has misunderstood and ignored the science of HIV transmission, and pursued the prosecution of HIV non-disclosure in an arbitrary, discriminatory and stigmatizing manner. Canada's Ministers of Health and Justice have both publicly acknowledged this failure; and while Minister Wilson-Raybould issued a Directive to address some ambiguities in the criminal law approach to non-disclosure created by the SCC, the federal response to HIV criminalization is, at best, a partial response. Canada should adopt a legislative response, which follows the four public health principles guiding use of coercive legislative powers: the harm principle, least restrictive means, reciprocity and transparency. Existing recommendations from organizations such as the CCRHC can be used for guidance, and thresholds for intent and risk, if

150 *Ibid* at 4323.

151 *Ibid* at 4322.

they are used, should be very clear and evidence based. Wilson-Raybould has acknowledged that HIV is first and foremost a public health issue; now is the time to act like it.