POSITION PAPER:

The Need for New Charge Assessment Guidelines: HIV Non-Disclosure in British Columbia

Adopted unanimously by the Positive Living BC Board of Directors
June 11, 2014
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1. Introduction:

The need for new Charge Assessment Guidelines

New Charge Assessment Guidelines in British Columbia are required as a result of two October 2012 HIV non-disclosure decisions by the Supreme Court of Canada – R. v. Mabior and R. v. D.C. – in which the court clarified its 1998 decision, R. v. Cuerrier, by making the following determination:

A significant risk of serious bodily harm is established by a realistic possibility of transmission of HIV. On the evidence before us, a realistic possibility of transmission is negated by evidence that the accused's viral load was low at the time of intercourse and that condom protection was used. (Mabior, 2012. pp. 622-623).

As a non-profit organization whose membership includes nearly two-thirds of all persons who have been diagnosed with HIV in this province, the Positive Living Society of British Columbia is greatly concerned that these decisions by the Supreme Court may unnecessarily result in even larger numbers of criminal prosecutions arising from instances of HIV non-disclosure. Increased criminalization of HIV will serve the interests of neither justice nor public health. In order to avoid this outcome, we are calling on the Minister of Justice, through the Office of the Assistant Deputy Attorney General, to develop new charge assessment guidelines to restrain unnecessary, unjust and harmful prosecutions.

In light of these dicta, we believe that in defining “realistic possibility of transmission” for vaginal intercourse, the Supreme Court cast its net too wide. There are likely hundreds of thousands of HIV exposure events across Canada every year which might be captured by the overly cautious "realistic possibility of transmission" test, as defined in Mabior and D.C. Furthermore, persons living with HIV continue to face uncertainty about whether the same standard will apply to other sexual acts and transmission methods – such as oral sex and anal intercourse – which were not addressed in the Mabior decision. In our opinion, the Criminal Code should not be used to prosecute unintentional exposure to HIV via non-sexual activities, such as injection drug use. The Ministry of Justice cannot foster a fair, reasonable and consistent approach to the use of the criminal law to address HIV non-disclosure cases without first issuing new charge assessment – or prosecutorial – guidelines.

It is the shocking and unacceptable reality that in this, the fourth, decade of the HIV/AIDS pandemic in Canada, people living with HIV/AIDS continue to face unreasonable, uncertain, and inconsistent application of the criminal law to circumstances arising out of HIV non-disclosure. In writing the Mabior decision, Chief Justice Beverley McLachlin recognized the unfairness of situations such as this, as evidenced by the following quote:

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. [...] Condemning people for conduct that they could not have reasonably known was criminal is Kafkaesque and anathema to our notions of justice. (pp. 593-594).

Yet despite acknowledging that such situations are abhorrent, the Chief Justice then fails to acknowledge or understand that Mabior’s ‘retroactive justice’ will result in just such a situation. Some
individuals who have in good faith followed public health advice – whether by using a condom, adhering to a regimen of antiretroviral therapy, or restricting themselves to 'low-risk' sexual activities – now find themselves facing the spectre of criminal prosecution for aggravated assault or aggravated sexual assault (which requires lifetime registration as a sex offender). The Court's failure to differentiate between HIV exposure and transmission events may result in an even larger number of criminal cases for HIV non-disclosure which will further stigmatize HIV/AIDS and increase discrimination against those who are living with the disease.

The fundamental reality is that the vast majority of HIV non-disclosure events do not result in transmission, even those in which no precautions are taken. We remain of the view that it is not in the public interest to prosecute persons living with HIV who use a condom or have a low viral load. The use of the criminal law should be reserved for the worst possible acts, such as those which result in the deliberate transmission of HIV or which demonstrate an ongoing pattern of behavior indicative of reckless disregard for the health and welfare of uninfected sexual partners.

Since the introduction of highly-active antiretroviral therapy (HAART) in 1996, people living with HIV no longer face a near-certain death sentence from AIDS. HIV infection is now considered to be a chronic lifelong infection, one which can be successfully managed for decades through adherence to antiretroviral (ARV) therapy. Persons living with HIV who achieve viral suppression through adherence to HAART are expected to enjoy 'near normal' life expectancy.

Increased criminalization of HIV is inconsistent with public health campaigns designed to normalize HIV testing in this province, such as the "It's Different Now" campaign which was part of the STOP HIV/AIDS pilot project. Dr. Julio Montaner, Director of the BC Centre for Excellence in HIV/AIDS (BC-CfE) – and an outspoken critic of the criminalization of HIV non-disclosure – aptly summarizes the conundrum this creates:

> We can't have a discourse that, on one hand, says things are different now we can identify HIV, we can treat it, you can have a near-normal life and, on the other hand, says if you [do not disclose] to another person we are ready to put you in jail. (Leahy, 2012a)

This document presents our views on three Supreme Court cases which address HIV non-disclosure. We then take a look at three different ways to address HIV non-disclosure – BC's existing charge assessment guidelines, BC's public health model, and the innovative approach adopted in Scotland – before providing a series of recommendations for new charge assessment guidelines that would serve both justice and public health.

British Columbia is at the forefront of the global battle to end HIV/AIDS. We take a look at how the AIDS epidemic is being transformed in this province and consider the challenges which still remain. In our view, there is an apparent disconnect between how the justice and health systems are addressing HIV non-disclosure. We are concerned about the negative impact this may have on the efforts to bring an end to the AIDS epidemic in British Columbia. Increased criminalization of HIV non-disclosure will make further progress more difficult and bring about increased discrimination against British Columbians who are living with HIV/AIDS. Some argue that the vision of an AIDS-free generation in British Columbia is already on the horizon. Be that as it may, the war against AIDS has not yet been won. As a province, we can choose to embrace evidence-based science in order to move ahead by collectively pulling in the same direction – forward, not backward – in order to secure the vision.
2. Three Touchstones that Guide our Approach

In approaching our task, we have used the confluence of three important touchstones to guide us. First, we have embraced the core recommendations in UNAIDS Guidance on HIV Criminalization. Second, our approach is based upon the principle known as the Meaningful Involvement of People with AIDS – we believe that people living with HIV/AIDS have a fundamental right to be at the table when issues that impact us are being discussed. Third, we embrace the spirit of positive change which infuses British Columbia’s White Paper on Justice Reform.

**UNAIDS Guidance on HIV Criminalization**

In May 2013, UNAIDS released new guidelines on the use of the criminal law with respect to HIV, titled *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*. We find the guidance to be helpful and have considered it as general advice in our effort to develop a position on the use of the criminal law to address instances of HIV non-disclosure. UNAIDS urges restraint so as to “limit any application of criminal law to truly blameworthy cases where it is needed to achieve justice.” The following three principles are set forth by UNAIDS to guide all instances in which the criminal law plays a role:

1. Be guided by the best available scientific and medical evidence relating to HIV,
2. Uphold the principles of legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality and proof), and
3. Protect the human rights of those involved in criminal law cases. (HIV Justice Network, 2013)

Finally, UNAIDS recommends the importance of prosecutorial guidelines which, “clarify, limit and harmonise any application of criminal law to HIV....[by stressing] [t] he importance to ensure the effective participation of HIV experts, people living with HIV, and other key stakeholders.”

**The Meaningful Involvement of People Living with HIV (MIPA)**

We are of the view that the development of revised charge assessment guidelines on HIV non-disclosure must include meaningful consultation with people living with HIV, HIV experts, AIDS service organizations and other key stakeholders.

The principle known as the “Meaningful Involvement of People Living with HIV and Affected Communities” (MIPA) grew out of the 1994 Paris AIDS Summit Declaration which first articulated the principle of “Greater Involvement of People Living with HIV” (GIPA), in order:

- To recognize the important contribution that people living with HIV can make in response to the epidemic, and
- To create space within society for our involvement and active participation in all aspects of that response. (UNAIDS, 1999).
The White Paper on Justice Reform in British Columbia

Meaningful consultation is in keeping with The White Paper on Justice Reform which calls for a justice system which is more transparent, responsive and accountable to ordinary citizens. The White Paper argues that: “We must be inclusive in recognizing the many stakeholders in the system while focusing expertise on the most significant risks.” (Part 1).

We appreciate the sensitivities surrounding anything which may intrude upon the statutory independence of the Crown Prosecutions Branch and Crown prosecutors. Even so, D. Geoffrey Cowper, Q.C., Chair of the BC Justice Reform Initiative, has expressed the opinion that: “In my view an integrated approach to policy and administration can and should be taken, and it need not have an intrusive effect on prosecutorial discretion.” (Part 2).

The criminal justice and public health systems cannot work in separate silos in their responses to the AIDS epidemic. We support the view expressed in the White Paper which states that: “The justice system must value integrated and collaborative approaches to the way it serves citizens” (Part 2). In keeping with the White Paper and the MIPA principle, we desire to collaborate with government policy makers who are charged with the task of developing new prosecutorial guidelines.
3. Supreme Court of Canada

HIV Non-Disclosure Decisions

*R. v. Cuerrier*

In 1998, the Supreme Court of Canada ruled in *R. v. Cuerrier* that Henry Cuerrier's failure to disclose his HIV-positive status to two women with whom he had unprotected sex constituted fraud. Mr. Cuerrier was a resident of Squamish, BC when he first tested positive for HIV in 1992. The trial judge ordered a directed acquittal on the basis that both women had consented to have unprotected sex. The first court's ruling was upheld upon appeal to the BC Court of Appeal.

The Supreme Court heard the Crown's appeal, ruling that a person living with HIV has a legal duty to disclose such status prior to sexual intercourse if there is a "significant risk of serious bodily harm" (p. 436). The failure to do so amounts to fraud vitiating consent. The Supreme Court ruled that the appeal should be allowed and a new trial ordered. (Subsequently, the case was not retried in British Columbia.)

Writing for the majority (Cory, Major, Bastarache and Binnie JJ), Justice Peter Cory cautions against an overly-broad approach:

> In my view, the Crown will have to establish that the dishonest act (either falsehoods or failure to disclose) had the effect of exposing the person consenting to a "significant risk of serious bodily harm." […]

> The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud, the greater the risk of deprivation, the higher the duty of disclosure. (p. 431).

Beyond establishing the *significant risk* test, Justice Cory hints that protected sex might reduce the risk of harm below the threshold at which the requirement for disclosure is triggered, when he writes that: "Careful use of condoms might be 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" (p. 432).

It is worth noting that the *significant risk* test is deemed to be "sufficient to encompass not only the risk of HIV infection but also other sexually transmitted diseases..." (p.435). Six out of the seven judges thus indicated that careful condom use might provide sufficient protection to avoid being captured by the "significant risk test," but since the case concerned *unprotected* sex there was no decision in that regard (CHALN, 2012. p. 2).

Writing for the minority (per Gonthier and McLachlin JJ.), Justice Beverley McLachlin (as she then was) summarizes the current law:

> Since the 1888 decision in *Clarence*, the law has been settled: fraud does not vitiate consent to assault unless the mistake goes to the nature of the act of 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. (p. 375).
It seems that Justice McLachlin had a bone to pick with Clarence's take on Victorian morality and sees the opportunity to correct an injustice by returning the common law of fraud vitiating consent to its pre-Clarence perspective, when she writes that:

In this case, the current state of the law does not reflect the values of Canadian society. It is unrealistic to think that consent given to sex on the basis that one's partner is HIV-free stands unaffected by blatant deception on that matter. (p. 410).

McLachlin J states that practising safer sex would reduce the risk of harm to below the significant risk threshold, by “catching only deceit as to venereal disease where it is established, beyond a reasonable doubt, that there was a high risk of infection (emphasis added) and that the defendant knew or ought to have known that the fraud actually induced consent to unprotected sex” (p. 414). Later in the decision, she confirms this view, by stating: “Again, protected sex would not be caught...” (emphasis added). Justice McLachlin makes statements that appear to indicate she is sympathetic towards persons living with HIV and the challenges they face.

Justice McLachlin criticizes the majority judgement for its failure to draw a “bright line” that separates criminal behaviour from that which is non-criminal:

The criminal law must be certain. If it is uncertain, it cannot deter inappropriate conduct and loses its raison d’être. Equally serious, it becomes unfair. People who believe they are acting within the law may find themselves prosecuted, convicted, imprisoned and branded as criminals. Consequences as serious as these should not turn on the interpretation of vague terms like “significant” and “serious.” (p. 401).

Justice McLachlin speaks out against over-criminalization which might result in greater stigmatization of, and discrimination against, persons living with HIV. Evidently, she even appreciates that unexpected things can happen when people are having sex:

The equation of non-disclosure with lack of consent oversimplifies the complex and diverse nature of consent. People can and do cast caution to the winds in sexual situations. [...] Yet the proposed test would criminalize non-disclosure nonetheless. This effectively writes out consent as a defence to sexual assault in such cases. The offence of sexual assault is replaced by a new offence – the offence of a failure to disclose a serious risk. (pp. 401-402).

The public health arguments for limiting the use of the criminal law are presented by Justice McLachlin as if she had adopted them as her own:

Broad criminal sanctions are unlikely to be effective. In fact criminal measures may act as a deterrent, since criminalizing a broad range of HIV related conduct will only impair such efforts. Moreover, because homosexuals, intravenous drug users, sex trade workers, prisoners, and people with disabilities are those most at risk of contracting HIV, the burden of criminal sanctions will impact most heavily on members of these already marginalized groups. (p. 405).

Although the majority of the Court were of the view that the criminal law does have a legitimate role to play, Justice Cory characterizes it as being limited to the following type of situations:

Where public health endeavours fail to provide adequate protection to individuals like the complainants, the criminal law can be effective. The criminal law has a role to play both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities. (p. 437).

As such, the role Justice Cory ascribes to the criminal law is secondary to the public health role.
Later in the decision, Cory J justifies the use of the criminal law because public health measures have failed to curb the growth of the AIDS epidemic:

First, it is significant that the percentage of persons using condoms in the U.S. and Canada, despite the threat of HIV/AIDS, remains alarmingly low. [...] Perhaps most distressing is the fact that the rate of new HIV infections in Canada continues to rise steadily. In 1996 there were between 3,000 and 5,000 estimated new infections up from 2,500 to 3,000 per year in the period 1989 to 1994. This appears to indicate that public education alone has not been successful in modifying the behavior of individuals at risk of contracting AIDS. (emphasis added) It follows that if the deterrence of criminal law is applicable it may well assist in the protection of individuals and it should be utilized. (p. 439).

What immediately jumps out when reading the decision is the fact that Justice Cory proposes to use the criminal law to protect those uninfected individuals who refuse to modify their own behavior by using condoms, roughly 75 percent of all young adults (p. 439). He takes this fact as evidence that public health HIV prevention measures have been unsuccessful.

Justice Cory characterizes the AIDS epidemic as one which has continued to grow unabated between 1989 and 1996, based upon annual estimates of the number of incident cases during that period. In retrospect, we can now see that those estimates were inaccurate. The Public Health Agency of Canada subsequently released revised estimates which indicate that the annual number of new HIV infections in Canada peaked in 1985 (at 4,649 persons). Between 1985 and 1996, the estimated number of new HIV infections fell by 50 percent (to 2,276 persons) (PHAC, 2012. Figure 2). It appears that the Supreme Court may have in part based its decision in R. v. Cuerrier on inaccurate statistics. (Subsequently, the estimated number of incident cases did increase gradually to 3,300 cases in 2008, before declining to 3,175 cases in 2011 – still well below the 1985 peak. In 2012, PHAC reported that the number of new HIV diagnoses recorded across Canada was the lowest since 1985; this despite significant population growth – up by roughly 20 percent – and the recent inclusion of new immigrants living with HIV.)

After Cuerrier

Nearly fifteen years separate Cuerrier from R. v. Mabior, when the Supreme Court of Canada next considered the issue of HIV non-disclosure. During the intervening years, criminalization of HIV non-disclosure grew tremendously in Canada. This and several other issues that gained prominence following Cuerrier are discussed briefly in the following section.

Criminalization of HIV Non-Disclosure: Canada from the Global Perspective

In the fifteen years between the 1998 Supreme Court decision in R. v. Cuerrier and the 2012 decisions in R. v. Mabior and R. v. D.C., there was a very significant increase in the number of criminal HIV non-disclosure cases in Canada. In fact, Canada has become a ‘world leader’ when it comes to the criminal prosecutions of such cases. The following sobering quote is taken from a 2011 working paper prepared for the Global Commission on HIV and the Law:

Canada and the US have, in absolute terms, convicted more people (a disproportionate number from minority and ethnic, especially African and Afro-Caribbean, communities) for HIV exposure and transmission offences than all the other countries of the world combined. (Wealt, 2011, p. 13).
Writing in an expanded version of an article originally appearing in *JAMA (The Journal of the American Medical Association)*, Scott Burris, Edwin Cameron and Michaela Clayton conclude that: “No discernible connection can be found between criminalization and a jurisdiction’s prevalence of HIV” (2008, p. 7). (It merits mention that Justice Cameron is appointed to South Africa’s highest court, the Constitutional Court, and formerly served on the Supreme Court of Appeal of South Africa. He is the only senior South African official to state publicly that he is living with HIV/AIDS.)

Comparing the number of HIV-related criminal prosecutions between Canada and other common-law jurisdictions, UBC law professor and legal expert Isabel Grant observes:

> Perhaps most notable is the high number of prosecutions in Canada compared to the other jurisdictions. Over 100 prosecutions have been documented in Canada compared to 17 in England and Wales, 7 in New Zealand, and between 22 and 28 in Australia. (2011, p. 41).

There is no evidence that there is a positive correlation between the high number of HIV-related criminal prosecutions in Canada and our country’s performance in the fight against HIV/AIDS taken from an international perspective, as measured by recent global rankings of HIV/AIDS disability-adjusted life years (DALY) by country. A 2013 report on the results of the 2010 Global Burden of Disease Study, which assessed the impact of disease burden resulting from 291 diseases and injuries in 187 countries between 1990 and 2010, found that for each country, the individual diseases and injuries are ranked from the highest burden (i.e., #1) to the lowest burden (i.e., #291).

South Africa (#1) had the poorest performance, since HIV/AIDS is the disease which contributed the highest rate of DALYs in that country. In the US, HIV/AIDS was ranked #34; in Canada it was ranked #49. These are comparatively poor rankings, indicating relatively high disease burden from HIV/AIDS in both countries. By comparison, the rate of DALYs lost to HIV/AIDS in Australia (#84), the UK (#91) and New Zealand (#99) was far lower than those for Canada and the US. (Ortblad et al, 2013).

**Overcriminalization of HIV Non-Disclosure: The view from within**

The total number of HIV-related criminal prosecutions in Canada is currently estimated at approximately 155 cases, with major increases in prosecutions taking place following the *Cuerrier* decision in 1998 and then again after the *Williams* decision in 2003. According to “Global Criminalization Scan,” a web site operated by GNP+ (Global Network for People Living with HIV), as of July 2012 there had been 11 prosecutions and seven convictions for HIV non-disclosure in British Columbia.

Although we were unable to locate comparable data for British Columbia, the “Ontario Burden of Infectious Disease Study Summary (ONBOIDS) December 2010” identifies and ranks the ten infectious diseases which have the highest health burden in Ontario. Three of the top ten infectious diseases are blood-borne pathogens which rank higher than HIV, as follows:

- Hepatitis C Virus (#1)
- Human papillomavirus (#3)
- Hepatitis B virus (#4), and
Prosecutions centering on HIV seem, in the context of all STDs, strangely disproportionate and even discriminatory. As discussed above, the number of annual deaths from AIDS in Canada has declined from 1,501 in 1995 to less than 100 in recent years (PHAC, 2009). Using the broader category of 'deaths from HIV disease,' Statistics Canada mortality data shows that, from 2006 onwards, there have been more annual deaths from viral hepatitis in Canada (e.g., 460 in 2011) than from HIV (e.g., 303 in 2011) (Table 102-0552, pp. 1-3). This suggests that HIV has been and continues to be singled out on the basis of nothing more substantial than prejudice.

“HIV non-disclosure and the criminal law: Establishing policy options for Ontario” is a research study prepared by E. Mykhalovskiy, G. Betteridge and D. McLay in 2010. The authors identify the following problem which has arisen from the Supreme Court decision in R. v. Cuerrier:

PHAs [People living with HIV/AIDS] have a legal obligation to disclose their HIV status to sex partners before engaging in sexual activities that pose a “significant risk” of transmitting HIV. In spite of over 100 prosecutions, Canadian courts have yet to clearly define what sex acts, under what circumstances, carry a legally “significant risk” of HIV transmission. This has led to the overarching problem posed by the criminalization of HIV non-disclosure in Canada and Ontario – that PHAs are unable to determine, with any certainty, what their legal obligations are under the Criminal Code. (p. 10).

Between 1989 and 2009, there were 104 criminal cases related to HIV non-disclosure in Canada. The provincial distribution of criminal cases for each of the largest three provinces compared to their individual share of reported HIV cases is as follows:

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<th>Province</th>
<th>Percentage of Criminal Cases</th>
<th>Percentage of HIV Cases</th>
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<tr>
<td>Ontario</td>
<td>47%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Quebec</td>
<td>14%</td>
<td>22.6%</td>
</tr>
<tr>
<td>BC</td>
<td>11%</td>
<td>19.8%</td>
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In over 90% of the criminal cases in Canada charges have been laid against men, including 72% which were against heterosexual men. Men who have sex with men (MSM) and women have been underrepresented overall, although there has been a recent trend towards increasing numbers of prosecutions against members of these groups. Between 2004 and 2009, racialized men accounted for 50% of all heterosexual cases, whereas caucasian men accounted for 41.7% (pp. 12-13).

The report is critical of the fact that “mainstream media coverage has drawn on court proceedings in criminal cases in ways that exaggerate the risk of HIV transmission and that represent PHAs as irresponsible, dishonest and criminally dangerous” (p. 14). In Ontario, such reports often have racial overtones. The resulting stigma and discrimination experienced by populations which are over-represented in both the HIV/AIDS epidemic and in the HIV-related criminal cases which have been prosecuted also prevents some individuals from being tested and seeking ARV treatment.

For example, in Ontario large numbers of HIV-positive people come from countries which have large endemic, heterosexual HIV populations. Yet, according to Remis, Swantee and Liu, a large percentage of persons living with HIV remain undiagnosed in Ontario:

Overall, we estimated that 65% of HIV-infected persons knew they were infected as of 2009. However, only 54% of persons infected by heterosexual transmission and persons from HIV-endemic countries have been diagnosed.” (2012, Exec. Summary).

Remis et al. also point to a US study which determined that the estimated transmission rate of HIV among those unaware of their status was more than 3.5 times the rate of those who are aware.
Rather than containing the size of the HIV epidemic, the overcriminalization of HIV non-disclosure has the opposite effect, in that a high percentage of persons living with HIV remain undiagnosed, choosing not knowing as an absolute defense against criminal prosecution.

During the twenty-year period studied by Mykhalovskiy et al., 63% of HIV-related criminal cases in Canada resulted in convictions, evenly split between convictions at trial and those resulting from guilty pleas. Ten percent were acquitted. There was a very high rate of incarceration (83%) for those who were convicted, in part due to sentencing reforms which came into effect in December 2007 which discontinued the possibility of optional sentences for “serious personal injury offences” (p. 15).

In addition to uncertainty about the criminal law as it applies to HIV non-disclosure, Mykhalovskiy et al. also discovered the following three main types of inconsistencies were characteristic of HIV non-disclosure cases from the period following the Cuerrier decision:

- in evidence used to establish whether sexual relations involved significant risk of HIV transmission;
- in how courts have interpreted the “significant risk” legal test; and
- with respect to the actual decision. (pp. 19-22).

**What works best – Disclosure or Safer Sex?**

Should the emphasis be on disclosure of HIV status or on practicing safer sex? The Supreme Court of Canada decided in *R. v. Cuerrier* that a person living with HIV has a duty to disclose his/her HIV status prior to engaging in sexual relations when there is a significant risk of serious bodily harm. As organizations representing and working with people living with HIV/AIDS, we recommend disclosure if possible, even though it does not necessarily protect the HIV-negative partner from becoming infected with the HIV virus. However, for certain groups and individuals – especially those who have experienced stigma and discrimination – disclosure is very difficult or may even seem impossible. Even in the event of non-disclosure of HIV status, the vast majority of people living with HIV/AIDS are believed to practice safer sex to reduce or eliminate the risk of transmission to their sexual partners.

Practicing disclosure or safer sex is not an “either/or” proposition. Even so, what do we know about the effectiveness of both strategies? Jane Simoni and David Pantalone investigated this topic in an article, titled “Secrets and safety in the age of AIDS: Does HIV disclosure lead to safer sex?”, published in 2004 by the IAS – USA in *Topics in HIV Medicine*. The researchers conducted a literature review of 23 empirical studies on disclosure of HIV-status and sexual safety which determined that, “disclosure alone does not automatically lead to safer sex in the way one might presume” (p. 115). In fact, their conclusion is that: “Deceptively simply HIV prevention interventions such as encouraging disclosure will probably never succeed on their own” (p. 117).

In comparing the use of the criminal law in Canada – which emphasizes HIV disclosure – with New Zealand – which focuses on condom use to prevent transmission – Isabel Grant provides the following assessment:

Reliance on disclosure is not an effective means of curbing transmission. The legal system should encourage the public health message rather than undermine it. (2011, p. 20).
She concludes by noting that:

The law should encourage behavior that reduces the risk of HIV transmission, such as the use of condoms and low-risk sexual practices. Over-reliance on disclosure shifts the focus away from the consequences we are trying to avoid. [...] The consistent use of condoms and maintenance of an undetectable viral load are more effective means of curbing sexual transmission than relying on disclosure and a subsequent denial of consent. (p. 59).

In our view, Professor Grant's conclusion makes perfectly good sense.

**Serious Consequence Charges and the “Cuerrier Paradox”**

In the years following Cuerrier, Professor Grant wrote several articles in which she considers the criminalization of HIV non-disclosure in Canada. In “The Prosecution of Non-Disclosure of HIV in Canada,” Professor Grant identifies several important facts and trends which merited consideration. The first of these she refers to as playing “the numbers game”: “Courts have increasingly relied on expert evidence...with numerical assessments of the risk of transmission associated with specific conduct” (2011, p. 27).

The second point Professor Grant raised in the Canadian context was the fact that when the criminal law is engaged in response to one-or-more HIV non-disclosure events, inevitably serious consequence charges are filed: “Yet once the Crown proves sexual assault, it automatically proves aggravated sexual assault as well. This is because the test for endangerment of life is virtually identical to the test for establishing fraud.” She continued by arguing that, “A serious consequences crime is not appropriate where the virus is not transmitted.” In her opinion, “Aggravated assault offences should be reserved for cases where the virus has been transmitted.” This would reduce the number of criminal prosecutions by 40%; the cost-savings could be redirected to other justice priorities (p. 56).

In “The Boundaries of the Criminal Law: The Criminalization of the Non-Disclosure of HIV,” Professor Grant identifies a peculiar phenomenon which she calls the “Cuerrier paradox,” which “refers to the fact that it was often easier to charge people under Cuerrier when the complainant did not contract HIV than when they did (Rathwell, 2012a). The case which is used to demonstrate this paradox is R. v. Williams, 2003 SCC 41. After his diagnosis in late 1991, Harold Williams failed to disclose his HIV-positive status to his girlfriend nor did he use condom protection as directed by two doctors and a nurse. Although found guilty at trial for aggravated assault in 2000, Williams appealed to the Newfoundland and Labrador Court of Appeal which substituted a conviction for attempted aggravated assault because it could not be proven that he had infected his partner who may already have been HIV-positive at the time. The Crown appealed the decision to the Supreme Court of Canada which dismissed the appeal when it ruled in September 2008, upholding Williams' conviction on the lesser charge of attempted aggravated assault.

**R. v. Mabior**

Cluato Mabior tested positive for HIV in 2004 while living in Winnipeg. He was advised by a public health nurse to inform his sexual partners and to always use a condom. He began ARV therapy
shortly thereafter and between October 2004 and 2005 his viral load was undetectable. McLachlin CJ provides this background concerning Mr. Mabior:

His house was a party house. People came in and out, including a variety of young women [Some were Indigenous; one was fourteen years old]. Alcohol and drugs were freely dispensed. From time to time, Mr. Mabior had sex with women who came to his house, including the nine complainants in this case. Mr. Mabior did not tell the complainants that he was HIV-positive before having sex with them; indeed, he told one of them that he had no STDs. On some occasions he wore condoms, on others he did not. Sometimes the condoms broke or were removed.... (Mabior, 2012, p. 590).

In common parlance, Mr. Mabior was a 'creep.' In a 2009 McGill Law Journal article published prior to the appeal being heard at the Supreme Court, Professor Isabel Grant comments:

It is clear that Mabior is a particularly troubling case and one that understandably evoked outrage in the trial judge. An HIV-positive man preying on vulnerable teenage girls and refusing to disclose his HIV-positive status makes a compelling case for prosecution. (p. 403).

Unfortunately, as Judge Robert Rolfe noted famously in Winterbottom v. Wright (1842): “Hard cases, it has often been observed, are apt to introduce bad law.”

McLachlin CJ 'salvages' the “significant risk of serious bodily harm” test from Cuerrier, by interpreting it to hinge on “the realistic possibility of transmission.” Using this interpretation, the Chief Justice rules in Mabior that:

This leads to the conclusion that on the evidence before us, the combined effect of condom use and low viral load precludes a realistic possibility of transmission of HIV. [...] However, the general proposition...does not preclude the common law from adapting to future advances in treatment where risk factors other than those considered in the present case are at play. (pp. 622-623).

In the decision, the Chief Justice explains the hardline approach to HIV non-disclosure taken by various courts in Canada by making reference to the Constitution:

In keeping with the Charter values of equality and autonomy, we now see sexual assault not only as a crime associated with emotional and physical harm to the victim, but as the wrongful exploitation of another human being. To engage in sexual acts without the consent of another person is to treat him or her as an object and negate his or her human dignity. (p. 605).

McLachlin CJ writes that the courts in Canada treat HIV non-disclosure differently than in other common law jurisdictions because: “Deception that exposes a partner to a risk of transmission – but that does not ultimately result in transmission – is not criminalized in many jurisdictions” (pp. 605-606). She quotes the expert opinion provided by Isabel Grant,(2011), as follows:

In Canada, the same charge of aggravated (sexual) assault is typically used regardless of the nature of the deception, whether the virus is transmitted, or whether there is an isolated incident of non-disclosure or an ongoing course of non-disclosure. In all other jurisdictions
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[canvassed in this study], the offence is characterized as the infliction of bodily harm, and not as non-consensual sexual contact. (pp. 606-607).

The Chief Justice replies indirectly to Professor Grant's analysis, when she writes: “In sum, while the experience of other jurisdictions is not conclusive, it sounds a note of caution against extending the criminal law beyond its appropriate reach in this complex and emerging area of law.” However, the Chief Justice returns shortly to dismiss this “note of caution,” when she writes: “While Cuerrier takes the criminal law further than courts in other common law jurisdictions have, it can be argued other courts have not gone far enough” (p. 608).

Arguments against Criminalization are Dismissed

The various arguments for and against criminalization of HIV non-disclosure are generally well known at present, having been discussed at length in both cases. There has been little discussion, however, about the extent to which the Chief Justice’s views have changed since Cuerrier. In Mabior, the Court is far less sympathetic to the argument that criminalization has a negative impact on public health efforts to control the spread of HIV. McLachlin CJ curtly dismisses the supporting materials from some interveners (including the Canadian HIV/AIDS Legal Network and Positive Living BC), with this comment:

The conclusions in these studies are tentative, and the studies were not placed in evidence and not tested by cross-examination. They fail to provide an adequate basis to justify judicial reversal of the accepted place of the criminal law in this domain. (p. 608).

Thus, arguments which appear to have resonated with McLachlin J in Cuerrier are apparently viewed with considerable skepticism by McLachlin CJ in Mabior. It seems, too, that the Chief Justice is growing tired of the “numbers game” and the continuous availability of new research findings supported by complex statistical analyses to bolster the arguments of the anti-criminalization camp.

Nevertheless it is possible that the Supreme Court’s refusal to look at these “tentative conclusions” may complicate the streamlined approach the Chief Justice envisions for future HIV non-disclosure trials, which is supposed to replace the “onerous burden” of the case-by-case approach. In all likelihood, there will be plenty enough new arguments, research studies, statistical calculations and expert opinions to be considered at future trials (where they can be entered into evidence and subject to cross-examination), thereby upsetting the efficiency targets of ‘cookie cutter’ justice.

Possible Approaches

Refusing to jettison Cuerrier, the Chief Justice attempts to solve the problem of uncertainty and reach arising from applying the significant risk test by considering briefly (before rejecting), a number of possible solutions in quick succession:

- **Active Misrepresentation**: Dismissed because there is no distinction between active and passive deception. “Should the trusting wife who does not ask a question as to HIV status of her partner be placed in a worse position than the casual date who does?”

- **Absolute Disclosure**: Dismissed as “unfair and stigmatizing to people with HIV, an already vulnerable group.”
• **Case-by-Case Fact-Based**: Dismissed since it would be onerous and untimely, just like the mess in which the Court finds itself. Requires expert medical evidence. Any doubt must be resolved in favor of the accused. [Is there a problem with 'reasonable doubt'?] The risk of conflicting judgments would make the process systemically unfair.

• **Judicial Notice on Condom Use**: Dismissed as not being available "in the absence of indisputable consensus."

• **Relationship-Based Distinctions**: Dismissed with a rhetorical question – "Is there a good reason for compelling disclosure to one's wife but not to a casual date?" [Certain relationship-based distinctions are a factor in determining whether the public interest test has been satisfied prior to the possible filing of other criminal charges.]

• **Reasonable Partner**: Dismissed, even though it would be based on the expectations of the parties in each case. "In this sense, it is fairer than a test that is based on a general norm presumed to apply in all cases." Unfortunately, it "does not lay down a clear test for fraud" [which could result in] "unfairness to the accused." […] "In the heat and anticipation of the sexual moment, assessments of what a reasonable partner would expect might be mistaken. Is the person then to be criminalized and sent to prison for perhaps years, for what is at its base the result of misjudgment?" (emphasis added) (pp. 609-615).

**An Evolving Common Law Approach**

Given that McLachlin J had supported the incremental use of the common law in *Cuerrier*, it comes as no surprise that the Chief Justice quickly selects an "evolving common law approach" in *Mabior*. She explores how to clarify the *Cuerrier* test of "significant risk of serious bodily harm" and settles somewhere in the middle "between the extremes of 'no risk' (the trial judge's test) and 'high risk' (the Court of Appeal's test)" -- "a standard of realistic possibility of transmission of HIV...." (emphasis added) (p. 616).

Writing the majority opinion in *Cuerrier*, Justice Cory had captured the inverse relationship between risk and harm in a single sentence: "The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse" (*Cuerrier*, 1998. p. 431).

In writing the unanimous decision in *Mabior*, Chief Justice McLachlin suggests that there is a more complex relationship between factors. The Chief Justice discusses the "complex calculus" which must be used to determine whether the circumstances of a particular HIV non-disclosure case meet the "significant risk" threshold, as follows:

The uncertainty inherent in the concepts of "significant risk" and "serious bodily harm" is compounded by the fact that they are interrelated. The more serious the nature of the harm, the lower the probability of transmission needs to be to amount to a significant risk of serious bodily harm, it is argued. So it is not simply a matter of percentage of risk and seriousness of the potential disease. It is a matter of the two as they relate to each other.

What emerges is a complex calculus that makes it impossible, in many cases, to predict in advance whether a particular act is criminal under s.265 (3)(c) or not. (pp. 594-595).
Does the Court’s “complex calculus” add up?

Nevertheless there is more than enough evidence to support the argument that the court’s “complex calculus” doesn’t add up. Furthermore, it can lead to outcomes that may not be justified. The contemporary Court’s determination in Mabior to correct the historical problems arising from Clarence by asserting the Charter values of autonomy and equality may simply have replaced one injustice with another.

So what is one to make of this “complex calculus”? Let’s begin by looking at the “harm” which can result from HIV/AIDS in 2012 as opposed to 1998. In Cuerrier, Justice Cory quoted the expert opinion of Professor Holland at trial:

   The consequences of transmission [of HIV] are grave: at the moment there is no “cure”, a person infected with HIV is considered to be infected for life. The most pessimistic view is that without a cure all people infected with the virus will eventually develop AIDS and die prematurely. (p. 432).

However, looking at the significant decline in new AIDS cases (> 90%) and AIDS-related mortality (97%) since the advent of HAART in 1996 (McLay, 2013), most observers are likely to conclude that HIV in 2012 is a mere shadow of its former self. Yes, “it’s different now” (and certainly less deadly). The descriptions of HIV/AIDS on public health web sites today are far less frightening than those from the pre-HAART era. It is only the Chief Justice and her fellow justices who are evidently willing to take the position that AIDS today is still deadly, just as it was in the early days of the epidemic.

Given the inverse relationship that is supposed to characterize the two factors in the “significant risk” test – as harm increases, the possibility of transmission required to trigger the duty to disclose decreases – one would expect that the threshold for triggering the duty to disclose in 2012 would be much higher than it was in 1998, given the fact that HIV is now considered to be a chronic (versus deadly) disease with a near-normal life-expectancy. In 1998, the full extent of HAART’s effectiveness in treating HIV was not thoroughly understood. In writing the reasons for the unanimous judgment, the Chief Justice failed to acknowledge that the two factors involved in the “complex calculus” did not vary inversely. The Court also failed to apply sufficient rigor in justifying its decision that only “the combined effect of condom use and low viral load precludes a realistic possibility of transmission” (p. 622).

In her reasons, (McLachlin CJ did not establish definitively what is meant by “low” viral load, although she uses 1500 cells/ml in serum blood in discussion. This provides yet another example of how the Court in Mabior fails to provide the necessary certainty required of the law, resulting in a Kafkaesque situation which the Chief Justice herself had indicated earlier in the decision would be intolerable.

“Realistic possibility of transmission”

How did the Court arrive at its decision in Mabior? This is a matter of particular interest since McLachlin J in Cuerrier states that her proposed application of the “significant risk” test would only capture unprotected sex. The Mabior decision interprets Cuerrier’s “significant risk of serious bodily harm” as requiring “a realistic possibility of transmission.” Condom use and “low viral load” are required to escape the duty to disclose. Since either condom use or low viral load provides a high-degree of protection against HIV transmission, the Mabior standard represents a major reduction in risk tolerance. Let us recall Justice McLachlin’s own words in Cuerrier:
A return to the pre-Clarence view of the common law that deception as to venereal disease may vitiate consent would catch the conduct here at issue.... This proposed extension of the law is relatively narrow, catching only deceit... [where] there was a high risk of infection and that the defendant knew or ought to have known that the fraud actually induced consent to unprotected sex. (1998, p. 414).

To the lay person, Mabior’s “complex calculus” –the tolerable possibility of transmission being inversely related to how serious the bodily harm would be – has generated a “perverse outcome”. The reasons for judgment in Mabior fail to acknowledge this apparent contradiction, with nary a wink.

The Chief Justice claims that the Court selected a “low level” of risk, between the “high risk” of the appeal court and the “no risk” approach used by the trial judge. (The “no risk” approach required both “condom use and undetectable viral load.”) The “low risk” approach requires “condom use and low viral load.” The difference between the two is insignificant, since the risk involved in the “condom use and low viral load” approach “is so low that the risk is reduced to a speculative possibility rather than a realistic possibility.” (p. 621). In effect it is virtually identical to the “no risk” option.

McLachlin CJ chooses “low risk” over “no risk”, since: “This avoids the evidentiary difficulties associated with establishing an undetectable viral load...” The “low” viral load option can accommodate ‘so-called ’spikes’ or ‘blips’...” (pp. 621-622). In our view, the Court’s chosen approach contradicts it own views, as quoted below:

First, “significant risk of serious bodily harm” cannot mean any risk, however small. That would come down to adopting the absolute disclosure approach, with its numerous shortcomings, and would effectively read the word “significant” out of the Cuerrier test. (pp. 621-622).

Finally, since the law already prosecutes both HIV exposure and transmission events as serious consequence crimes, convicting a defendant when the facts establish a “significant risk of serious bodily harm,” it is especially distressing to read the Chief Justice’s afterthought when she states that: “Of course, actual transmission of HIV constitutes serious bodily harm” (p. 615). This seems to suggest that a defendant may face a form of double jeopardy.

**Two cases cited for using a “realistic possibility” test**

In Mabior, McLachlin CJ makes brief reference to two other cases which have interpreted Cuerrier’s “significant risk of serious bodily harm” to mean a “realistic possibility of transmission”: R. v. Jones and R. v. J.A.T.

In the first case, R. v. Jones, the risk of sexual transmission of Hepatitis C according to expert opinion at trial was given to be in the range of 1 – 2.5 percent. Hepatitis C is a blood-borne pathogen which is considered to have a much lower rate of sexual transmission than HIV. The trial judge accepted the expert testimony without realizing it had to be in error. Although the Chief Justice makes no mention of this problem, the case provides an odd example to cite for making an attempt to determine whether there existed a “realistic possibility of transmission,” a test which the Court has indicated is HIV-specific.

In R. v. J.A.T., a case which originated in British Columbia, the accused was found not guilty because the trial judge considered the cumulative risk of three instances of unprotected insertive
anal intercourse to be 0.12%, lower than the “realistic possibility” threshold. Obviously, the Chief Justice would have found the person guilty given the requirement that both condom use and low viral load are required to avoid conviction. Given that the trial judge came to a decision that is different than what would result if one used the Chief Justice's definition of “realistic possibility of transmission,” it is peculiar that the case is provided as an example with no mention as to the difference in outcome resulting from the two interpretations of “realistic possibility.”

**Scientific Evidence at Trial on the Risk of HIV Transmission**

The Chief Justice reviews the scientific evidence and expert opinion presented by Dr. Smith:

- A systemic review and meta-analysis of the HIV transmission risk for vaginal intercourse which "put the risk in high-income countries at 0.08% per sexual act (1 in 1250);

- Results of the widely accepted Cochrane review (2002) determined consistent condom protection further reduces the risk of HIV transmission by 80 percent;

- “Antiretroviral therapy is not a safe-sex strategy"

- "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"; and,

- "Dr. Smith did not accept, and presented as controversial, the 2008 announcement by the Swiss Federal Commission for HIV/AIDS that an HIV-positive person with an undetectable viral load is not sexually infectious.” (pp, 621-622).

**“Realistic possibility of transmission” – Does it withstand (statistical) scrutiny?**

Before attempting to consider whether “realistic possibility of transmission,” as defined by the Court, is arguably “realistic” given the statistical probability of the sexual transmission of HIV under certain conditions, it may be worth taking note of what Scott Burris has to say about defining risk:

> But the objective risk, to the extent it can be accurately determined in any given situation, is hardly determinative in policy making, in court, or in human behaviour. Risk assessments are more heavily influenced by psychological and social biases than objective statistics. (2008, p. 5).

Burris is also quick to remind us that individuals often approach the issue of risk differently than the way the courts consider it under the criminal law:

> Every day, millions of people have unprotected sex with partners they must assume might be infected. They evidently rate the risks and benefits of sex differently than people who pass judgement on sexual behaviour in the criminal justice system. (p. 6).

In *Mabior*, the Court determined that the *Cuerrier* test (i.e., “significant risk of serious bodily harm”) should be interpreted to mean “a realistic possibility of HIV transmission.” The Chief Justice writes:

> This leads to the conclusion that on the evidence before us, the combined effect of condom use and low viral load precludes a realistic possibility of transmission of HIV. (p. 622).
Does this conclusion stand up to scrutiny when it is translated into a statistical probability? Of course, this is in part a subjective matter based on one's own personal perspective. Nevertheless it is possible to calculate the comparative risk of transmitting the virus during a single act of vaginal intercourse using the probability of transmission for vaginal intercourse under each of the following circumstances, as considered by the Court in *Mabior*:

- **Unprotected sex** – 0.08% (1 in 1,250 acts)
- **Use of condom** – 0.016% (1 in 6,250 acts), based on 80% reduction of unprotected risk
- **Use of HAART with undetectable viral load** – 0.032% (1 in 31,250 acts), based on 96% reduction of unprotected risk (1 in 31,250 acts), and
- **Use of condom and undetectable viral load** – 0.00064% (1 in 156,250). (This level of risk is comparable to that of the “condom and low viral load” standard adopted by the Supreme Court in *Mabior*.)

The Supreme Court rejected the option of requiring “use of condom and undetectable viral load” (1 in 156,250) – the option chosen by the trial judge, calling it a “no risk” approach. It also rejected the “use of condom or undetectable viral load” option (1 in 31,250) – selected by the Manitoba Court of Appeal – as being “High risk.” The Court settled on the “use of condom and low viral load” option as being “low risk,” although the level of risk is comparable to the “no risk” option which had been rejected. In our view, “use of condom or low viral load” should be an acceptable level of risk.

Writing about the *Mabior* and *D.C.* decisions in *The Court*, a widely followed on-line blog covering Canadian legal issues, Nikita Rathwell provides this analysis about the decision: “What is troubling about *Mabior* is that the decision barely addresses the issue of whether criminalization is an appropriate means of addressing rising rates of HIV transmission at all.” She continues by saying that, “the SCC is skirting some of the real issues at stake in this case, such as public health considerations and HIV-related stigma” (2012a).

**Can *Mabior* be implemented in a fair and practicable manner?**

In *Cuerrier*, Justice McLachlin criticized the proposals put forward by Cory J and L’Heureux-Dubé J. on both theoretical and practical grounds, as follows:

The changes proposed are of great consequence. The law does not presently make it an offence to engage in sexual contact without disclosing to one’s partner possible risks, as Cory J. proposes. Nor does it make every deception inducing consent to physical contact a crime, as proposed. What we know about the spread of HIV and other venereal diseases suggests that thousands of people engage in just such conduct every day. Henceforward, if the sweeping changes suggested are accepted, these people will be criminals, subject to investigation, prosecution and imprisonment. Literally millions of acts, which have not to date been regarded as criminal, will now be criminalized. Individual liberty will be curtailed. Police, prosecutors, the courts and the prisons will be dramatically affected. (p. 404a).
Some may argue that this potential problem was circumvented when Cuerrier restricted the use of the criminal law for non-disclosure of an STD to those diseases, such as HIV, which can result in a “significant risk of serious bodily harm.” Unwittingly, however, the very low per-act risk of transmission for HIV created just such a challenge, since both exposure and transmission events are subject to criminal prosecution when HIV-positive status has not been disclosed. Consider the following points, then try to imagine the resources that would be required to administer justice “fairly”:

- Both HIV exposure and transmission events can result in a serious consequence charge;
- Since it is not easy to transmit HIV sexually (i.e., 1 in 1,250 per act probability for vaginal intercourse), a very large number of potential transmission events are required to result in the estimated incidence of new HIV infections in Canada.
- There are an estimated 3,175 new HIV infections in Canada each year (PHAC, 2013); and,
- The Supreme Court ruled in Mabior that in the absence of disclosing HIV-positive status prior to intercourse, people living with HIV can face criminal prosecution in each of the following circumstances:
  - Unprotected sex
  - Only condom protection used, and
  - Only on ARV therapy with low viral load.

For illustrative purposes only, consider the following situation. Just over one-third of new HIV infections (1,180 out of 3,175 cases or 36%) are the result of heterosexual transmission. (The other main sources of transmission are men who have sex with men (MSM) and injection drug use.) If all 1,180 new heterosexual infections were to result from each of the three situations listed above, how many acts of vaginal intercourse would probably be required? These are the answers:

- Unprotected sex – 1,475,000 exposures
- Only condom used – 7,375,000 exposures
- Only undetectable viral load – 36,875,000 exposures.

According to the Supreme Court's definition of "realistic possibility of transmission," each and every act of penile-vaginal intercourse listed above represents an exposure or transmission event which can be criminally prosecuted. Even without any protection, almost 1.5 million acts of vaginal intercourse would be required to infect 1,180 persons. With condoms only, over 7 million acts of vaginal intercourse would be required. If the 1,180 new infections were all to come from people with an undetectable viral load who use no other protection, almost 37 million acts of vaginal intercourse would be required. The Supreme Court believes that each of these many millions of acts of intercourse represents a "realistic possibility of transmission."

Only those persons living with HIV who use a condom and have a low viral load would escape being captured by the “realistic possibility of transmission” standard. (As we discussed above, this risk of transmission would be speculative, just as it would be for those who use a condom and have an undetectable viral load.) In order to achieve 1,180 transmission events using this speculative method, a total of 184,375,000 acts of intercourse would have to occur.

Justice McLachlin's comments on her colleagues' proposals in Cuerrier seem appropriate here as well: "Literally millions of acts, which have not to date been regarded as criminal, will now be criminalized. Individual liberty will be curtailed. Police, prosecutors, the courts and the prisons will be dramatically affected" (p. 404). Unfortunately, Chief Justice McLachlin gives no hint that she is the least bit aware of the situation that the Court has created. With all due respect to the Chief Justice
and the Court, the application of the criminal law to HIV non-disclosure events is not a matter of complex calculus; it requires nothing more than a bit of grade-school arithmetic.

It is unfortunate that Chief Justice McLachlin failed to heed her own advice from Cuerrier. As it stands, there are probably hundreds of thousands — if not millions — of HIV exposure and transmission events occurring in Canada each and every year. One might be forgiven for asking how the police and Crown prosecutors determine which of these many instances to prosecute. It also seems arbitrary and unjust that the same instance of HIV exposure could result in such different outcomes simply based on whether a complaint initially were filed with the police or with public health officials. Almost all — if not all — cases involving HIV exposure and transmission which are brought to the attention of Public Health officials are likely to be resolved without the laying of criminal charges. Is it possible to explain the notion that “Justice is fair” under these circumstances?

**R. v. D.C.**

The Supreme Court of Canada released its decision in R. v. D.C. on October 5, 2012, concurrent with R. v. Mabior. D.C. provides an example of how an abusive ex-partner can use the criminal justice system to satisfy his desire for vengeance. When D.C. first met the complainant she did not disclose her HIV-positive status prior to a single act of vaginal intercourse. She claimed to have used a condom during the encounter, but it is unclear what actually took place. Her viral load was undetectable at the time.

Subsequent to that encounter, D.C. disclosed her HIV status to the complainant, after which they entered into a common law relationship spanning a number of years. During this time, her partner became increasingly abusive. Following an incident of domestic violence, criminal charges were laid against the spouse and D.C. terminated the relationship. (D.C.’s ex-spouse received an absolute discharge when his case went to trial.)

In what was apparently an act of vengeance, D.C.’s now former partner went to the police concerning the earlier incident alleging that she had neither disclosed her HIV-positive status nor used a condom. D.C. claimed that she had used a condom which broke during sex. As a result of the ex-husband's complaint D.C. was charged with sexual assault and aggravated assault. At trial, the judge found neither party to be a credible witness. However, based on a doctor’s note written seven years earlier which referred to a broken condom, the judge inferred that D.C. had lied and convicted her. The Court of Appeal concluded that the trial judge had made a reasonable inference about whether a condom was used but set aside the conviction due to the fact that D.C.’s viral load at the time of the encounter was undetectable, interpreting that to mean that there had not been a “significant risk of serious bodily harm.”

A great deal of concern has been expressed about this case. Just prior to the appeal being heard by the Supreme Court, Isabel Grant provided this assessment:

> This case demonstrates why prosecutorial guidelines are essential in this context. What is to be gained in prosecuting this woman for one isolated incident of non-disclosure, followed by disclosure and ongoing protected sex, especially where the risk of transmission was so low? D.C. also raises the problem of disclosure for women in potentially abusive relationships. (2011, pp. 28-29).
On appeal to the Supreme Court of Canada, the Court focused on whether D.C. had used a condom during the single act of vaginal intercourse which took place prior to when she disclosed her HIV-positive status to her partner, in order to determine if there had been a “realistic possibility of transmission.” The Court decided that the trial judge had made an error in speculating that no condom had been used, since it was based on “a single hearsay note made seven years before the trial...” (D.C., 2012. p. 637). The Court set aside the verdict at trial on the basis “that the prosecution failed to prove D.C.’s guilt on the charges against her beyond a reasonable doubt” (p. 637). Except for the trial judge’s error with respect to the doctor’s note, the Court made it clear that it would have allowed the earlier conviction to stand despite evidence that the risk of transmission was 1 in 10,000.

The “White Paper on Justice Reform” (Part 2) called on the justice system to protect marginalized women: “A goal of the justice system should be to increase the safety of vulnerable members of society.” The “White Paper” report was released shortly after the report of the Missing Women Commission of Inquiry, which reported on one of the darkest chapters in our history. The “White Paper” highlighted a number of the Commission’s findings, including the following:

The MCWI Report focuses on the justice system’s failed response to the missing women, the systemic discrimination inherent in this failure, and the need to improve the response to specific needs of marginalized persons and Aboriginal women in particular. […]

The women who went missing from the Downtown Eastside were marginalized by a number of factors, including poverty, addictions and mental health.

We all share responsibility for acknowledging what happened to these women, for allowing such inequities to continue, and for seeking lasting solutions.

To the extent that people living with HIV/AIDS continue to face stigma and discrimination, the Mabior decision is both troubling and disappointing. Isabel Grant provides this synthesis of this one aspect of the decision:

Most notable among the things not discussed by the Court in Mabior is the context of HIV for those who live with it. There was one reference to persons with HIV as a vulnerable group but with no elaboration. (2013, p. 476).

The decision in R. v. D.C. represents no victory for women living with HIV who face abuse and violence. Grant provides this assessment:

That the Court had some difficulty with its own test is evident from the efforts it went to bring about an acquittal for DC. […] Beyond justice in the individual case, we should get little comfort from DC’s acquittal, as it simply distracts attention from the expansion of the test from Cuerrier. (2013, p. 483).
4. Three Different Approaches
that address HIV Non-Disclosure

As a result of the Mabior and D.C. Decisions by the Supreme Court of Canada, it is clear that revisions will be required to the current Charge Assessment Guidelines. In the interest of providing the Ministry of Justice with our recommendations on how to revise the guidelines, we have taken a look at three sets of current guidelines:

- BC’s existing Charge Assessment Guidelines (2007)
- BC Guidelines for Medical Health Officers in dealing with persons with HIV/AIDS who may pose a risk of harm to others (2010), and
- Scotland’s 2012 prosecutorial guidelines.

**BC’s Current Charge Assessment Guidelines (2007)**

Almost a decade after the Cuerrier decision, the Office of the Assistant Deputy Attorney General in British Columbia released charge assessment guidelines related to the non-disclosure of sexually-transmitted diseases (STDs). Before proceeding further, we wish to consider those guidelines, including acknowledging our appreciation for certain aspects which have served to avoid some of the less meritorious prosecutions that have occurred in some other jurisdictions, most notably Ontario. For example, we have been heartened by the requirement that the medical health officer be notified of all cases in which criminal charges are contemplated.

When we discuss 'charge assessment guidelines' or 'prosecutorial guidelines' in British Columbia, we are making reference to two documents which form part of the Ministry of Justice Crown Counsel Policy Manual: "Charge Assessment Guidelines" (CHA 1) and “Sexually Transmitted Diseases” (Sex 2). ("CHA 1" provides general guidance, while “Sex 2” addresses possible criminal charges arising from exposure to or transmission of sexually transmitted diseases and must be read in conjunction with “CHA 1”.)

**“Charge Assessment Guidelines” (CHA 1)**

“CHA 1,” effective October 2, 2009, is applicable to all cases in which Criminal Code charges are being considered. It merits noting that the policy includes the following quote from Sir Hartley Shawcross Q.C., former Attorney General of England (and later Lord Shawcross OBE), regarding the public interest principle:

> It has never been the rule in the country and I hope it never will be that suspected criminal offences must automatically be the subject of prosecution. Indeed, the very first regulations under which the Director of Public Prosecutions worked provided that he should...prosecute...“wherever it appears that the offence or the circumstances of its commission is or are of such a character that a prosecution in respect thereof is required in the public interest.” That is still the dominant consideration. (2009, BCAG, 2009).
In order to proceed with criminal charges, a case must satisfy both the 'evidentiary test' (which determines if there is a substantial likelihood of conviction); and the 'public interest test' (which weighs the comparative merits of public interest factors that favour prosecution against those which mitigate against it).

The policy lists a substantial number of public interest factors which must be considered in conducting all criminal charge assessments. A smaller sub-set may warrant careful consideration in the assessment of possible HIV non-disclosure cases, including the following:

Public interest factors in favour of prosecution:
- The alleged offender was in a position of authority or trust
- Considerable harm was caused to the victim
- The victim was a vulnerable person
- There is a significant difference between actual or mental ages of the alleged offender and victim, and/or
- There are grounds for believing that the offence is likely to be continued or repeated.

Public interest factors against prosecution:
- There is a strong likelihood of achieving the desired result without a prosecution by the Criminal Justice Branch
- The offence was committed as a result of a genuine mistake or misunderstanding (factors which must be balanced against the seriousness of the offence), and/or
- The loss or harm can be described as minor and was the result of a single incident, particularly if caused by misjudgement.

Additional factors to consider in the public interest:
- The youth, age, intelligence, physical and mental health, and additional personal circumstances of witness/victim
- The length and expense of a prosecution in relation to the social benefit to be gained
- The time which has elapsed since the offence was committed
- The need to maintain public confidence in the administration of justice. (BCAG, 2009).

It appears that the public interest principle continues to enjoy broad support. In reporting on his review of the Crown Prosecutions Branch as part of the recent Justice reform process, Gary McQuaig, Q.C., stresses the important role of Crown Counsel in determining the "appropriate use of limited resources and acknowledgment of [the] long-accepted view that not all criminal records need to be prosecuted" which should be the "last response to anti-social behaviour." People living with HIV/AIDS and their legal advocates have said much the same thing, although perhaps in a more pointed fashion: "The Crown does not have to prosecute people who use condoms or have a low viral load, just because they can" (GNP+ and HIV Justice Network, 2013).

"Sexually Transmitted Diseases" (Sex 2)

"Sex 2," effective May 16, 2007, is the specific policy which applies when criminal charges are being considered due to the non-disclosure of sexually transmitted diseases (STDs), including HIV. The policy includes references to provisions in both the Criminal Code and applicable public health legislation, which suggests an awareness that exposure to and transmission of STDs are an area of shared – or overlapping – responsibility between the Ministry of Justice and the Ministry of Health.
The duty to disclose an STD to a sexual partner is discussed from a Criminal Code perspective simply by providing a summary of the 1998 SCC decision in *Cuerrier*. At a minimum, the policy must be updated to reflect the 2012 SCC decisions in *Mabior* and *D.C.*, in addition to other health-related legislative changes. The policy references the requirement for a person to report to the medical health officer if one knows or suspects another person to have an STD, as required under Section 2 of the “*Health Act Communicable Disease Regulation.*” The policy also provides information on the enforcement powers of a medical health officer under the *Health Act* or the *Venereal Disease Act*. Obviously, anachronistic references to legislation and regulations must be brought up-to-date in any revised policy.

In our view, the “Sex 2” policy provides Crown Counsel with valuable and helpful advice in three areas:

- Upon receipt of a Report to Crown Counsel, if the MHO has not been involved, ensure that the matter is reported as soon as possible;
- Prosecution decision should take into account conditions which the medical health officer may order under pertinent legislation; and
- Any proposed charge involving possible transmission of a sexually transmitted disease, including HIV, should be reviewed by Regional or Deputy Regional Crown Counsel. (BCAG, 2007).

The “Sex 2” policy is applicable to all STDs, consistent with recommendations by UNAIDS and civil society organizations so as to avoid further stigmatization of persons living with HIV/AIDS. Unfortunately, in this instance the breadth of the policy may come at the expense of clarity, especially if an uninformed lay person reads the list of possible offences which are listed at the end of the “Sex 2” policy, which states:

> Depending on the facts, possible offences involving communicable disease might include offences under the *Health Act*, the *Venereal Disease Act* or *Criminal Code* offences such as aggravated assault, aggravated sexual assault, criminal negligence causing bodily harm, unlawfully causing bodily harm, or threatening. (BCAG, 2007).

The policy is designed to apply to all instances in which use of the criminal law is under consideration as a result of a person's failure to disclose one or more STDs, but in practice it has been functionally restricted to HIV-related matters. Since *Cuerrier*, the Criminal Code has been used almost exclusively to prosecute instances of HIV non-disclosure (including both exposure and transmission events), resulting in one of two charges: aggravated assault or aggravated sexual assault.

With the exception of a handful of charges across Canada related to herpes simplex and hepatitis C, serious consequence charges have resulted from HIV non-disclosure, involving more than 150 cases to date. Although it may arguably be preferable to have a single STD policy so as to prevent further stigmatization of HIV/AIDS, this cannot be achieved at the expense of clarity. The “Sex 2” policy lacks the clarity required for application by Crown Counsel and, just as important, in order that lay persons may fully comprehend the policy’s intent as it relates to application in practice.

As noted above, there are many good aspects to “Sex 2” which warrant retention in the revised policy. The suggestion/requirement that Crown Counsel discuss any proposed criminal charges arising from non-disclosure of STDs with Senior Crown Counsel may result in prosecutorial restraint which fosters greater consistency. Unfortunately, since the policy lacks transparency with respect to practical intent and outcome, it fails to satisfy contemporary expectations for openness and
accountability. At present, the lack of consultation with people living with HIV/AIDS and their representatives both during the development and periodic review of charge assessment guidelines is not in keeping with the MIPA principle.

**BC's Public Health Approach to HIV Non-Disclosure Events**

It is our view that using the Public Health system to address incidents involving HIV non-disclosure are in the vast majority of cases preferable to the criminalization option for a number of important reasons. British Columbia has developed an excellent set of guidelines for Medical Health Officers (MHOs) which outline the broad range of voluntary and involuntary options which can be used to address situations in which HIV-infected individuals may pose a risk of harm to the public, entitled “Guidelines for Medical Health Officers: Approach to persons with HIV/AIDS who may pose a risk of harm to others” (December 2010) which can be located in Chapter 5, Section II of the *BCCDC Communicable Disease Control Manual*. Additional guidance is also available in "Guidelines for Medical Health Officers: Frequently Asked Questions" (January 2011). The guidelines are also available to the general public and advocates of persons living with HIV/AIDS.

The guidelines, which utilize provisions included in the 2009 *Public Health Act*, are based on a number of principles and values, including:

- Prevention is the primary objective, not punishment.
- The “least intrusive, most effective” intervention should be followed.
- The guidelines provide guidance to medical health officers but are not prescriptive.
- The Public Health response should be proportional to the risk of transmission.
- “Except in the most extraordinary situations, public health legislation should be sufficient to protect public health.” (BCCDC, 2011b. “Topic...”).

The guidelines also provide detailed guidance to medical health officers on navigating the three steps in the process:

1. Determination of risk to others;
2. Interventions, which include both voluntary and involuntary measures, as well as obtaining and enforcing a detention order; and
3. Enforcement options, which include: the laying of charges and applying to the court for either an injunction or a detention order. (2011b, “Topic...”).

Although the guidelines provide detailed advice covering a range of options, they are not intended to be prescriptive. One of their most notable aspects is that the guidelines make clear reference to the importance of context and setting in determining the appropriate response to any given situation, as the following example demonstrates:

Individuals at a bath house who engage in anonymous sexual intercourse with a number of partners, or individuals exchanging goods or money for sex, are aware of the likely higher prevalence of HIV in these situations and that the risk of HIV infection is significant.

Likewise, participants in group sharing of equipment for drug injection may be assumed to understand that they are putting themselves at risk of HIV infection. [...]
In some situations it would be unreasonable to expect the infected person to disclose his or her HIV status to each risk partner, and any intervention should be focused on the infected person's use of risk reduction techniques. (BCCDC, 2011b).

Additional guidance is contained in a list of frequently asked questions which is helpful in making an assessment of whether a person living with HIV/AIDS is facing danger due to violence from pimps and johns, or if their status were to be revealed in certain small communities (e.g., on-reserve).

**Prosecutorial Guidelines – Scotland's Approach**

While most Commonwealth countries do not criminalize exposure to HIV infection, that is not the case in Scotland, although there have been few criminal cases resulting from exposure to, or transmission of, HIV. For this and several others reasons, the prosecutorial guidelines (“Intentional or Reckless Sexual Transmission of, or Exposure to, Infection”) released by the Crown Office and Procurator Fiscal Service Scotland in early 2012 are of particular interest and warrant consideration as a model which could be adapted to British Columbia.

The Scots guidelines are not specific to HIV; they apply to all STDs. There are two crimes which may apply to the transmission of an STD, including HIV:

- **Assault**, which requires evidence that the accused intentionally infected the victim; and
- **Culpable and reckless conduct**, which requires that the victim contracted the infection from the accused; that the accused knows he is infected; and, that he acted with the "requisite degree" of recklessness. (Scotland, 2012).

Scotland also provides for the prosecution of “Reckless exposure of the Infection.” The following example is provided in the guidelines:

A prosecution may be raised in cases where an accused embarks on a flagrant course of conduct, having unprotected intercourse with several partners, failing to disclose his or her infection status, but through good fortune alone, fails to transmit the infection. (Scotland, 2012).

An individual who follows medical advice and who takes appropriate precautions during the sexual activity is unlikely to meet the degree of recklessness required for criminal prosecution, as follows:

- The person infected is receiving treatment has been given medical advice that there is a low risk of transmission or that there was only a negligible risk of transmission in some situations or for certain sexual acts; and

- The person infected took appropriate precautions such as using a condom or other safeguards throughout the sexual activity.... (Scotland, 2012).

A person living with HIV who has an undetectable viral load (below 50 copies/ml) is considered to have "minimal or negligible risk of transmission...." (Additional information on ARV therapy is provided in an appendix.) The guidelines continue by making the following general statement:
In cases of exposure alone, and in view of the negligible risk of transmission, there is a very strong presumption against prosecution in these circumstances. (emphasis in original)

The guidelines pay particular attention to medical and scientific considerations. With respect to the use of experts, the following advice is given:

Given the medical and scientific complexities associated with the sexual transmission of infections, in particular HIV, it will be necessary to use expert medical opinion to establish the necessary standard of proof.

The policy includes a discussion of public interest factors in favour and against prosecution which are quite similar to a number of the points included in the BC Charge Assessment Guidelines policy (CAG 1). “Factors tending against prosecution” include: consent by the victim, whether the accused has particular vulnerabilities, and whether precautions were taken and medical advice had been given regarding the risk involved in specific sexual acts or situations. It is interesting that consent by the victim is considered as a public interest factor, although: “Consent on the part of the victim to the conduct, even if instigated by the victim, is not a defence to a charge of assault or culpable and reckless conduct in Scots law...” (Scotland, 2012). “Factors tending in favour of prosecution” include: deliberately misleading or concealing information from a partner; whether the victim has any particular vulnerabilities; and, whether there is evidence of “a course of flagrant conduct” (Scotland, 2012).

We believe that the Scots model is pragmatic and fair in its approach. As such, it warrants careful consideration as an approach that would also be appropriate in the British Columbia context. Simply stated, we believe that incidents of HIV non-disclosure involving exposure alone might more properly be handled by the Provincial Health Officer in British Columbia, given his authority and powers under the Health Act, thereby serving the causes of both justice and public health more effectively. Scarce public resources should be directed to cases in which intentional transmission has taken place or where there is a clear, ongoing pattern of reckless disregard for the safety of others – both of which circumstances can be assessed by and, as warranted, referred from the Provincial Health Officer.

**Recommendations:**

1. The development of prosecutorial guidelines in regards to HIV non-disclosure should include meaningful consultation with persons living with HIV, HIV experts, and other key stakeholders.

2. Approved guidelines should be subject to ongoing review and revision. The three areas in which we find the current “Sex 2” guidelines to be helpful should be retained, they being:
   - Upon receipt of a Report to Crown Counsel, if the MHO has not been involved, ensure that the matter is reported as soon as possible,
   - Prosecution decision should take into account conditions which the medical health officer may order under pertinent legislation, and
   - Any proposed charge involving possible transmission of a sexually transmitted disease, including HIV, should be reviewed by Regional or Deputy Regional Crown Counsel.
3. Public health options should be exhausted before resorting to the criminal law, except when a deliberate transmission event has taken place or a person engages in an ongoing pattern of deliberately reckless and dangerous sexual activities. Such behaviour may warrant a charge under the Criminal Code.

4. There should be a strong presumption against prosecution in cases of exposure alone (i.e. where transmission of the virus does not occur), especially when the risk of transmission was low or negligible (e.g., oral sex), or based on a single occurrence.

5. Persons living with HIV who have followed public health and/or medical advice by practicing safer sex, such as using a condom or maintaining a low viral load through adherence to ARV treatment, should not be subject to prosecution.
5. The Science of HIV Transmission – Post-Mabior

It is important to stress the remarkable progress which has been achieved in the fight against HIV/AIDS since the introduction of HAART in 1996. For example, the highest number of new AIDS cases ever reported in Canada occurred in 1993 where there were 1,827 cases. This can be compared to 2011, in which there were only 151 new AIDS cases reported across Canada, representing an overall reduction in the number of new AIDS cases of 91.7%. There has been a similar reduction in the number of deaths from AIDS in Canada. In 1995, there were 1,501 deaths from AIDS reported across Canada, the highest number on record. In 2008, there were only 45 deaths from AIDS reported in Canada, representing a reduction in AIDS mortality of 97% (McLay, 2013).

Scientific and medical research into the epidemiology, prevention, transmission and treatment of HIV continues to advance quickly. In the 18 months since the Supreme Court decisions in Mabior and D.C., there have been additional research findings which confirm the efficacy of ARV therapy. In particular, there is a growing body of evidence which supports “Treatment as Prevention” (TasP), the hypothesis that wide-based treatment not only results in near-normal life expectancy for persons living with HIV who are on ARV treatment, but that this leads to the secondary public health benefits of reduced community viral load and, consequently, a decline in the incidence rate of new HIV infections. The declining rate of perinatal (or mother-to-child at birth) transmission provided the first insight into the possibility that treatment of those living with HIV may result in this secondary – but very substantial – public health benefit. Treatment as Prevention gained international attention in 2006 when Dr. Julio Montaner and other researchers at the BC-CfE published an article in The Lancet and concurrently introduced the concept at the 2006 International AIDS Society conference in Toronto.

In Mabior, the Chief Justice had expressed reservations about the evidentiary support for Treatment as Prevention, as the preliminary HPTN 052 clinical trial results had only been published in August 2011 in the New England Journal of Medicine. The earlier Swiss Consensus statement remained controversial and many experts did not believe that Treatment as Prevention was a “safe sex” strategy. Subsequent research findings and the resulting growth in expert opinion supporting the efficacy of Treatment as Prevention has broadened the base of international support for the concept.

Recently David McLay summarized the emerging consensus on the efficacy of Treatment as Prevention, as follows:

There is strong agreement that effective antiretroviral therapy significantly reduces the risk of HIV transmission during sex and thus has an important role to play in the prevention of HIV transmission. Several national and international health authorities, including the WHO, the Swiss National AIDS Commission, the US Centers for Disease Control and the British HIV Association, have released statements or guidelines on the use of antiretroviral therapy for the prevention of sexual transmission of HIV. (2013).

In early 2013, the US Centers for Disease Control (CDC) issued a statement, “Background brief on the prevention benefits of HIV treatment,” which included this assessment:
This landmark study [HPTN 052] validated that early HIV treatment has a profound prevention benefit: results showed that the risk of transmitting HIV to an uninfected partner was reduced by 96%. (USCDC, 2013).

Around the same time, the British HIV Association (BHIVA) and the Expert Advisory Group of AIDS (EAGA) issued a joint report, “Position statement on the use of antiretroviral therapy to reduce HIV transmission,” in support of Treatment as Prevention and the earlier Swiss Statement, which included the following assessment:

There is now conclusive randomized clinical trial evidence, from heterosexual couples where one partner has HIV and the other does not, that if the partner who is HIV positive is taking effective ART, transmission of HIV through vaginal sex is significantly reduced (by 96%).

The risk of a person living with HIV, who is taking effective ART, passing HIV on to sexual partners through vaginal intercourse is extremely low, provided the following conditions are fulfilled:

• No other STIs in either partner;
• The HIV positive partner has sustained plasma viral load below 50 HIV RNA copies/ml for more than six months;
• The viral load for the HIV positive partner was under 50 copies on the most recent test; and
• Viral load testing should be undertaken every 3-4 months. (BHIVA and EAGA, 2013).

Given the lack of comparable research pertaining to anal sex (which has a higher HIV transmission rate than vaginal intercourse), the British experts have nevertheless provided the following supportive statement which should temporarily satisfy critics and the courts until confirmatory research becomes available:

There are insufficient data to conclude that successful ART use can provide similar levels of protection in relation to other sexual practices, including unprotected anal intercourse between men or between men and women. However, it is expert opinion that an extremely low risk of transmission can also be anticipated for these practices, provided that the same conditions stated above are met. (BHIVA and EAGA, 2013).

In March 2014, British researcher Alison Rodger presented the preliminary results from the PARTNER study at the 21st Conference on Retroviruses and Opportunistic Infections (CROI) in Boston. The PARTNER study involves mixed-status couples at 75 sites across 14 European countries, including 445 heterosexual couples and 282 MSM couples. The couples had to report using condomless sex and viral loads below 200 during the preceding year. In total, 94% of the HIV-positive partners reported ARV treatment adherence of over 90%. There were zero HIV infections reported during 894 couple-years of follow-up. As one branch of this ongoing study investigates the prevention benefit of ARV treatment in serodiscordant MSM couples involved in condomless anal intercourse, the zero percent transmission rate achieved to date is most encouraging. (Wilton, 2014).

**Canadian Consensus Statement on HIV Transmission and the Criminal Law**

Arguably the most compelling – and certainly the most recent – development of scientific and legal interest in Canada was the release on May 2, 2014 of the “Canadian Consensus Statement on HIV and its Transmission in the Context of Criminal Law”. The Statement, authored by a distinguished
panel of six Canadian scientists and researchers – including Dr. Julio Montaner from the BC-CfE – and formally endorsed by more than 70 additional such persons, can be taken to be the "gold standard" of scientific assessment of transmission risks of various sorts in Canada.

Among the Consensus Statement’s key findings are:

- "... that scientific and medical evidence clearly indicate that HIV is difficult to transmit during sex. Even activities generally considered risky, such as unprotected (i.e., without a condom) anal and vaginal sex, carry a per-act possibility of transmission that is much lower than is often commonly believed. It is our expert opinion that the actual per-act possibility of HIV transmission through sex, biting or spitting lies along a continuum from low possibility, to negligible possibility, to no possibility of transmission.”

- “Where a condom is used or where the HIV-positive individual is on effective antiretroviral therapy, vaginal-penile intercourse poses a negligible possibility of transmitting HIV... (and)... Where a condom is used, anal-penile intercourse poses a negligible possibility of transmitting HIV regardless of the HIV-positive individual being on effective antiretroviral therapy. Where the HIV-positive individual is on effective antiretroviral therapy, anal-penile intercourse likely poses a negligible possibility of transmitting HIV even in the absence of condom use.” (emphases in the original)

- “The life expectancy for someone infected with HIV is approaching that of the general population. Simply put, in Canada and other developed countries with advanced health care, HIV is no longer fatal. With early and proper care, individuals living with HIV can live long, healthy lives.” (emphasis added)

- “When used correctly and no breakage occurs, condoms are 100% effective at stopping the transmission of HIV because they prevent the contact between HIV-containing bodily fluid and the target cells of an HIV-negative individual. Studies at a population level have also shown that even when factoring in possible instances of incorrect use or breakage, the consistent use of condoms dramatically reduces the possibility of HIV transmission. Where the present consensus statement discusses the possibility of HIV transmission in the context of condom use, it is assumed that the condom was applied to the penis and worn throughout sex, and that no condom breakage occurred.” (Loutfy et al., 2014).

One can argue endlessly whether “negligible possibility of transmitting HIV” equates to an absence of “a realistic possibility of HIV transmission”; but one doesn’t require a degree in law, medicine or linguistics to understand the scientists’ meaning: the likelihood of transmission of the virus in the circumstances described is so small as to not warrant its being addressed in the criminal law.

Confusion about HIV Transmission Risk: The meaning of “High” versus “Low”

The sheer magnitude of the global AIDS pandemic over the past three decades can turn any discussion about the risk of HIV transmission into a highly contentious and emotional debate. After all, more than 70 million people have been infected with HIV globally, half of whom have died from AIDS. For people who do not follow HIV developments in the media, the major decrease in onward transmission in British Columbia, like the tremendous reduction in the mortality rate in developed countries, may come as a surprise.
In recent years, there has been a trend towards reporting the statistical probability of HIV transmission given a particular set of circumstances. It is difficult to comprehend small statistical probabilities. Early on in the AIDS epidemic, research into the statistical probability of HIV transmission was unavailable; even today gaps remain in the research findings. People were advised to practice safer sex by giving up “high risk” activities in favour of “low risk” ones.

For more than a decade, the Canadian AIDS Society (CAS) has adopted a system which categorizes the HIV transmission risk for a given act, as one of the following: no risk, negligible risk, low risk, and high risk. The CAS guidelines state that: “If these categories or levels were represented graphically on a continuous line, negligible and low risk would be much closer to the ‘no risk’ end of the continuum. There is no ‘middle’ level of risk.” This system of categorizing risk has been adopted by the BC Centre for Disease Control. The British HIV Association (BHIVA) recommends using a similar approach.

In anticipation of the Mabior appeal, Matthew Cornett argued in the *McGill Journal of Law and Health* that:

Judicial assessments of the significance of this risk of HIV-transmission should be consistent with available epidemiological data, and thus preclude oral sex, and other low-to-no-risk activities from leading to criminal prosecution. (MJLH, 2012).

His view was that the “level of risk required to attract criminal liability ought to accord with public health guidelines” (MJLH, 2012). He came to the conclusion that strong prosecutorial guidelines should be established in which criminal penalties are “proportionate to the possible harm created and achieve a balance between public objectives” (MJLH, 2012).

Professor Isabel Grant makes much the same argument when she writes: “The law should encourage behaviour that reduces the risk of HIV transmission, such as the use of condoms and low-risk sexual activities. Over-reliance on disclosure shifts the focus away from the consequences that we are trying to avoid” (Grant, 2011).

Over the past 15 years there has been increasing variation in how terms such as “high risk” and “low risk” are being used by scientific and medical researchers, HIV/AIDS educators, public health officials and by the courts. For example, unprotected vaginal intercourse is considered to be a “high risk” activity, although the risk is higher for the receptive partner than it is for the insertive partner. Yet the per-act risk of HIV transmission for vaginal intercourse is generally accepted to be 0.08% (1 in 1,250), representing a fairly low possibility. (McLay, 2013).)

David McLay tries to explain the differences in perceived risk:

Even those activities considered risky, such as unprotected sexual intercourse, carry a risk of transmission much lower than is often commonly believed. Indeed, most unprotected vaginal and anal intercourse involving an HIV-positive person and his or her HIV-negative partner does not result in transmission. (McLay, 2013).

It quickly becomes apparent that there is considerable difficulty in synthesizing scientific research and presenting a consensus statement on risk that most people will be able to understand. For example, M-C Boily et al, authors of the leading systematic review and meta-analysis of heterosexual risk of HIV-1 infection, write in a 2009 article in *Lancet Infectious Diseases* that: “Transmission estimates in high-income countries indicated a low risk of infection in the absence of antiretrovirals.” (emphasis added) (Boily et al., 2009). However, the authors demonstrate the
complexity of HIV transmission risk assessment when they later state: “Estimates for the early and late phases of HIV infection were 9.2 (95% CI 1.4-19.5) times versus 7.3 (95% CI 4.5-11.9) times larger, respectively, than for the asymptomatic phase” (Boily, 2009). How is a reasonable, reasonably educated, average citizen to make sense of this?

The complexities of determining the scientific risk of HIV transmission are further complicated when the courts change the way in which they use “high risk” and “low risk” from one judgement to the next. This particular problem is readily apparent when comparing Justice McLachlin’s reasons for judgement in Cuerrier to Chief Justice McLachlin’s reasons for judgement in Mabior.

As discussed above, in writing the minority judgement in Cuerrier, Justice McLachlin says using her interpretation of significant risk would only capture “high risk” activities involving unprotected sex. In writing the unanimous judgement in Mabior, Chief Justice McLachlin calls the Manitoba Court of Appeal’s decision (i.e., condom use or achieving a low viral load through ARV treatment) a “high risk” approach, in fact one that still has a “realistic possibility of HIV transmission.” The Chief Justice rejects the trial judge’s approach (i.e., both condom use and an undetectable viral load are required) as being “no risk.” Yet there is little that distinguishes the Supreme Court’s “low risk” standard in Mabior from the “no risk” approach taken by the trial judge. In effect, McLachlin J’s “low risk” in Mabior carries a smaller possibility of HIV transmission than McLachlin J’s “low risk” (i.e., condom-protected sex) activities from Cuerrier, thus demonstrating unexpected inconsistency and incoherence in her arguments. However, she is hardly the only one who has shifted the meaning of “high” and “low.” Although to a lesser extent, perhaps, the scientific/medical research community and the public-health/education community have been changing how they describe HIV/AIDS and the probability of various types of transmission events. Alas, it is the people living with HIV and those trying to keep themselves safe who are left uncertain of possible criminal charges or the likelihood of transmission.

**Recommendations:**

6. **It is imperative that all new charge assessments and criminal prosecutions related to HIV be informed by complete, accurate and up-to-date understanding of relevant medical and scientific research in such areas as: the risk of HIV exposure and transmission, treatments, changes in morbidity, mortality and life expectancy, the social context of HIV as experienced by persons living with HIV who are members of marginalized and vulnerable groups, and the impact of stigmatization and discrimination.** Specifically, until such time as a more authoritative source is published, the Canadian Consensus Statement on HIV Transmission and the Criminal Law should be the principal source for information regarding transmission risks on the basis of which new charge decisions are made. Further, in instances where the defence seeks to introduce the Consensus Statement during court proceedings arising from charges involving HIV non-disclosure, the Crown should not oppose the motion.

7. **Reference to the Consensus Statement notwithstanding, it is necessary to seek the advice of a qualified medical expert during the charge assessment process and at trial.**

8. **No prosecution should be undertaken in cases where the sexual activity engaged in by the non-disclosing person living with HIV did not involve vaginal and/or anal penetrative sex (i.e., oral sex, digital sex, masturbation, etc.).**
6. Living with Stigma and Discrimination

“What is stigma?” One prominent HIV/AIDS web site – aidsmap.com – answers the question this way:

Stigma means different things to different people.

This is one dictionary's definition: “The shame or disgrace attached to something regarded as socially unacceptable.”

There may be a feeling of ‘us and them.’ People who are stigmatised are marked out as being different and are blamed for that difference. (Pebody, 2012).

Writing prior to the Mabior appeal, Isabel Grant cautioned that the criminalization of HIV can lead to greater stigmatization of HIV/AIDS:

It is important to bear in mind that every accused person in these cases is a member of a highly stigmatized and disadvantaged group in Canadian society. This is not to justify non-disclosure but rather to suggest that criminalization must be approached with great caution because of the danger to further marginalizing persons with HIV. (2011, p. 58).

Alison Symington, senior policy analyst with the Canadian HIV/AIDS Legal Network, has studied the disproportionate impact of the criminalization of HIV non-disclosure on women and other marginalized people. For the following reasons, she argues that the Mabior and DC decisions will contribute to worsening the already disproportionate impact, as follows:

The history of non-disclosure prosecutions gives reason to believe that certain segments of the population of PHAs [persons living with HIV/AIDS] will bear a disproportionate and unfair burden of threatened charges, investigations, prosecutions, and convictions, as well as related anxiety and stigma. Consider, for example, newcomers to Canada – in particular those from racialized communities. […] Consider also those who are vulnerable to violence or in coercive relationships. DC is a perfect example. […] How many women will remain in abusive relationships because their partners threaten to go to the police with non-disclosure allegations if they leave, whether the allegations are true or not? [2013, pp. 491-492].

There are many ways that marginalized and disadvantaged persons living with HIV/AIDS face additional challenges due to the criminalization of HIV and the Court's decisions in Mabior and DC. Alison Symington outlines a number of these problems:

• Women have less power and ability to require the use of condoms;
• “Access to HAART, HIV care, and viral load testing is a challenge for many...”;
• “Marginalized PHAs face significant challenges to accessing health and social services”; and
• “Moreover, if access to treatment or testing is impeded by poverty, mental health or addiction issues, unstable housing, physical or psychological abuse, where one lives, or any number of other factors, individuals are deprived of the evidence to defend themselves in a prosecution.” (2013, pp. 492-494).

HIV/AIDS and the Law – Context and Social Meaning

Matthew Cornett critiques the application of the “significant risk” test from Cuerrier, in anticipation of the Mabior appeal being heard by the Supreme Court of Canada, by exploring HIV non-disclosure from the perspective of competing discourses. Drawing upon the work of Matthew Weait, Cornett explores the construction of social meaning in the following way:

Context of transmission and social meaning of infection are explicitly rejected by the liberal theory of law which depends on neutrality and objectivity that determines whether it is proper and appropriate to treat those who infect others as having committed a wrong deserving of moral and legal censure. [...] Context and meaning form part of a legal framework “that with every conviction affirms the idea that HIV infection is something that is in and of itself harmful, and by implication, that those people who are HIV positive are somehow ‘damaged,’ ‘abnormal’ and lacking.” [...] Because infected individuals are categorized as unhealthy and abnormal, they become potential criminals and ‘harmers.’ (2011).

As discussed earlier, the over-criminalization of HIV exposure and transmission is a substantial problem in Canada, one which is exacerbated by the fact that under the criminal law both HIV exposure and transmission are viewed as serious consequence crimes. We firmly hold the view that the Supreme Court will eventually revisit this position and redefine HIV non-disclosure. However, prosecutorial guidelines provide an opportunity for making certain adjustments in the interim. After all, it took more than a century for the common law to return to its pre-Clarence position on fraud vitiating consent in sexual matters.

Similarly, Isabel Grant is helpful in clarifying how HIV exposure events differ from those in which transmission takes place:

There are also compelling public policy reasons to be cautious about over-prosecution of non-disclosure which do not apply to situations where someone is pushed off a balcony or hurled into oncoming traffic. This is not to trivialize the psychological harm to the complainant when he or she learns of the accused’s HIV status. However, the harm is much greater where the complainant contracts HIV than where he or she does not. It is the increased harm that warrants labeling the assault "aggravated." (2011, p. 48).

Grant continues by providing the following sound advice:

Prosecutors need to be cautious in their exercise of discretion before laying charges for isolated acts of non-disclosure where no transmission occurs. The English prosecutorial guidelines are instructive here. They provide that the level of fault or recklessness required will only be met where there is an ongoing course of non-disclosure. Similarly, where reasonable precautions are taken, criminal charges are not appropriate: reasonably careful use of a condom should preclude prosecution. (p. 58).
Does the Law pick favorites? (What about drunk driving?)

Many Canadians like to hold onto the belief that Canada is a kinder, gentler place than our neighbour to the south. Some of us can even recall a time when Pierre Trudeau talked about the “Just Society.” Unfortunately, when it comes to the criminalisation of HIV non-disclosure and the treatment of persons living with HIV, the US isn’t as different from us as we might like to think. Although the US deals with HIV criminalization through federal guidelines and state statutes, both countries share the problem of over-criminalization of HIV with disproportionate sentences. Based on the sentences handed out for driving under the influence, both countries also seem to be more lenient towards drunk drivers than persons living with HIV who do not disclose, regardless of whether the person involved used a condom, chose low-risk activities, or had an undetectable viral load through using HAART.

Sarah Newman provides the following analysis of the American situation:

Some scholars have compared the sentences available for HIV exposure and drunk driving. Both crimes are recklessness crimes, where a defendant can be found liable absent actual harm simply by creating a risk of serious harm. Nevertheless, maximum sentences for a first drunk driving offense are generally no longer than a year, while sentences for HIV exposure can range anywhere from five to twenty-five years of more. Another scholar has compared the sentences available under HIV exposure statutes and other general endangerment offenses. Which HIV exposure statutes allow for an average maximum prison sentence of over eleven years, reckless endangerment offenses typically carry sentences of six months to one year.” (2013, pp. 1425-1426).

Obviously none of us condones the deliberate or reckless transmission of HIV during sex. However, why is it that HIV non-disclosure is considered to be a serious consequence crime – especially with respect to exposure-only events – when other social problems like drunk driving are treated so lightly? Driving under the influence of alcohol or drugs is a serious, widespread problem resulting in the loss of many lives and associated with enormous social and economic costs. Yet it seems that persons convicted of driving under the influence generally receive sentences that in no way reflect this reality. It is hard to comprehend why a drunk driver is able to run over and kill an innocent bystander without facing a life sentence. Similarly, why is it that a first offence drunk driver who is lucky enough not to have killed an innocent bystander is likely to face no more than a minor charge while every HIV-positive person who exposes a sexual partner to the slightest possibility of HIV transmission can anticipate a charge of aggravated sexual assault?

Isabel Grant discusses the Mabior decision in relation to drunk driving laws in Canada, as follows:

First, the Court assumed, without analysis, that any possibility of transmitting HIV endangers life. […]

To use an imperfect analogy, we punish someone for impaired driving if we catch him or her driving while impaired. We punish the individual for impaired driving causing bodily harm or causing death only where those harmful consequences ensue. (2013, pp. 478-479).

Mothers Against Drunk Drivers (MADD) provides these statistics from 2010 which indicate the magnitude of alcohol and drug-related crash problems in Canada:
The Need for New Charge Assessment Guidelines: HIV Non-Disclosure in British Columbia

- Number of impairment-related motor vehicle fatalities – 1,082
- Estimated number of impairment-related crash deaths, including boating, aircraft, trains, and industrial vehicles – 1,200 to 1,500
- Number of individuals injured in impairment-related crashes – 63,821
- Number of vehicles damaged – 210,932

Context and social meaning can provide a rich, more complete understanding of an issue which has a significant impact of society.

**The Indigenous Peoples Example**

Although the HIV/AIDS epidemic among Indigenous peoples in British Columbia has stabilized over the past decade, HIV incidence and prevalence continues to be approximately three times (12-15%) the Indigenous share of the provincial population (5%) (BCCDC, 2012, p5). Obviously, Indigenous peoples in British Columbia make up a heterogeneous group, but due to the effects of inter-generational poverty, poor educational outcomes and employment opportunities, homelessness and sub-par housing, food security and health care, violence and family breakdown, poverty exacts a large toll on Indigenous peoples, communities, and nations. As a result, Indigenous peoples must withstand a disproportionate share of social problems like alcoholism and drug addiction, mental illness, and chronic illnesses like diabetes, Hepatitis C and tuberculosis. These effects are even more pronounced among Indigenous people who are living with HIV. (BCPHO, 2009).

Dr. Perry Kendall, BC Provincial Health Officer, points out the impact of European arrival in British Columbia in his 2009 annual report. Along the Coast, "as many as 20,000 were killed in the smallpox epidemic of 1862-1863." Under the section “Disease, Devastation and Population Decline,” the Indigenous population in British Columbia is given by date, as follows:

- Mid-1700s - 250,000
- 1835 - 100,000
- 1885 - 28,000
- 1929 - 23,000

British Columbia's tremendous success in bringing the HIV/AIDS crisis under control is in part the result of the hard work and resilience of Indigenous people living with HIV. BC's success in fighting HIV/AIDS is nowhere more apparent than in the phenomenal reduction (> 90%) in HIV incidence among injection drug users. This province stands in stark contrast to the deteriorating HIV epidemic among Indigenous peoples in Saskatchewan and Manitoba. For starters, harm reduction measures readily available in many parts of this province – plus the experience with InSite – have helped to stabilize many people while they become linked and retained in HIV healthcare. Even so, the life expectancy of HIV-positive Indigenous peoples is still more than 25-years less than the general population (Hogg et. al., 2013).

It is important to reflect upon the underlying social reasons which explain the origins of the oppression and marginalization of Indigenous people in British Columbia. For example, it becomes easier to understand the roots of the present-day inequality of Indigenous peoples when we are aware of the historical roots of Indigenous social problems in colonialism, racism and the Euro-centric world view. Most Canadians are only now becoming aware of the impact of the residential
school policy which removed multiple generations of Indigenous children from their families and communities. Residential schools were part of a government-sanctioned policy of forced assimilation and cultural genocide. (Globe and Mail, 2012).

Many Indigenous people living with HIV continue to have difficulty obtaining access to the full spectrum of healthcare needs, such as basic, specialist and community-based healthcare, treatment for addictions and mental health issues, and access to culturally-appropriate HIV prevention education and treatment. Indigenous people living with HIV will consequently suffer disproportionately as a result of the 2012 Supreme Court decisions.

The incarceration rate of Indigenous people is a national disgrace, especially in the western provinces and northern territories. Whereas Indigenous offenders in Ontario make up only eight percent of incarcerated males and 13 percent of incarcerated females, in Saskatchewan they make up 77 percent of incarcerated males and 90 percent of incarcerated females. Indigenous adults make up 22 percent of prison admissions in Canada, despite making up only 3.6 percent of the Canadian population. One-third of incarcerated females are Indigenous. (Therien, 2011).

The rate of incarceration among Indigenous Canadians is nine times the Canadian average. The rate of HIV infection among prison inmates is seven-to-ten times higher and the rate of Hepatitis C infection is 30-to-40 times higher than the Canadian average. Nevertheless, inmates are denied access to life-saving harm reduction tools which are readily available in many communities. (PHAC, 2010. pp. 25-26).

The Provincial Health Officer’s 2007 Annual Report was the second report on the health and well-being of BC’s Indigenous people. Dr. Kendall reported on changes in health performance of Indigenous British Columbians since his first report using a set of 64 indicators. What is his biggest concern? He gave the following response to the question:

The most concerning outlier [of the 10 out of 64 indicators that had worsened since the first report] is the widening gap between Status Indians and other residents for HIV/AIDS disease, which is clearly reflective of both increased vulnerability and a lack of access to Highly Active Antiretroviral Therapy (HAART). (BCPHO, 2007).

Research into at-risk youth who use illicit drugs has found a strong connection between drug/alcohol addiction and early childhood experiences. Launched in the early 2000s, the Cedar Project is a collaborative research project involving St. Paul’s Hospital, UBC, Carrier Sekani Family Services, and Positive Living North; it has determined that almost 60 percent of all HIV infections among young Indigenous people were the result of injection drug use. (Miller et al., 2011).

The Cedar Project has included over 500 young Indigenous people who had recently smoked or injected illicit drugs either in Vancouver's Downtown Eastside or in Prince George. Almost two-thirds had been taken from their biological parents when they were four or five years old. Almost half had been forced to have sex and/or had been molested by age six. Almost 40 percent had attempted suicide. Between 35-40 percent were involved in survival sex work, beginning at age 16. Over seventy percent of participants in Vancouver (and 60% in Prince George) had been incarcerated, with a median age of 15-16 years at first incarceration. (Miller, 2011).

How such persons dealing with such life experiences are to be presumed to be aware of the pronouncements of the Supreme Court in Mabior and D.C. – much less be able to parse their meanings and then conduct themselves accordingly – is a near perfect mystery. What remains is
little more than one more device for jailing Indigenous people. The preventive impact in Indigenous communities must be assumed to be near nil; the punitive impact can be readily imagined.

**Recommendation:**

9. We believe that prosecutorial discretion should be exercised when considering use of the Criminal Code to address HIV non-disclosure among women and members of marginalized groups. In particular, we believe that no prosecutions should be undertaken in instances where the non-disclosing person living with HIV reasonably believed that their disclosure of their HIV status would lead their sex partner or some other third party to do serious harm to them (e.g., harm of a sort that could reasonably be supposed to result in a charge of assault causing bodily harm, sec. 267 of the Criminal Code).

**In the Heat of the Moment**

As discussed earlier under the “Reasonable Partner” approach, McLachlin CJ expresses concern that:

[A] ‘contextually-grounded’ reasonableness approach could be unfair to the accused, since in the heat and anticipation of the sexual moment, assessments of what a reasonable partner would expect might be mistaken. Is the person then to be criminalized and sent to prison for perhaps years, for what is at its base the result of misjudgment? (Mabior, 2012. p. 614).

What was the Chief Justice’s solution? To draw a “clear bright line” which separates criminal from non-criminal activity. (The Chief Justice has no difficulty comprehending that an appreciation for context can enrich our understanding about individuals and the situations in which they find themselves. However, as soon as she acknowledges this fact she returns to her overarching preoccupation regarding the certainty of the law.)

It is difficult to imagine how some vague memory of the “clear bright line” this will be of any assistance to those who are caught “in the heat and anticipation of the sexual moment.” Even so, we were left to wonder if the Court’s “compassion” – or the notion of compassion – could not be extended to other situations which may also arise out of “the heat of the moment?”

For example, let’s consider the following scenario:

A young man and the young woman he fancies (and who fancies him) are out on the town on a Saturday night. They drink too much. They laugh too loud. They dance with joyful abandon and with the assistance of further chemical amusement aids. They get back to his place (much more cheaply reached by cab than hers) around 3:00 am. Both are feeling happy and energetic. One thing leads to another, the clothes come off, and some of the best sex either will ever experience occurs,

But, in the heat of the moment, he doesn’t tell her about his being HIV-positive, and she doesn’t bother with the condoms in her purse.

The morning comes much too soon. She must be up and off to her clerking job at Pacific Centre. He slowly realizes the implications of the previous night’s activities.
The young man is immediately remorseful and scared. He knows that he is unlikely to be infectious because of his undetectable viral load, but feels it is important to call his partner from the previous evening to inform her. Just in case she wants to go to the Emergency Department at St. Paul’s where she can discuss her concerns about transmission and the possibility of starting on Post-Exposure Prophylaxis (PEP). But is it safe to call or is he placing himself in legal jeopardy?

What is the value in prosecuting a one-time occurrence like the above? Like the situation in D.C., when an individual has either used a condom or has a low viral load, there is no public interest in prosecution. Or if a condom breaks during sex, a person living with HIV should be encouraged to advise his/her partner immediately without attracting prosecution. Similarly, if an individual immediately contacts a recent sexual partner to inform him/her of his HIV-positive status so that the individual may immediately seek medical advice and, if recommended, start taking Post-Exposure Prophylaxis (PEP) within the 72 hour limit, there should be no use of the criminal law.

In fact, the prospect of prosecution in such instances almost certainly has the perverse effect of working against public health goals by encouraging the person potentially in legal jeopardy not to notify the other person of his or her HIV-positive status, thereby avoiding a fearful prosecution, but thus denying the other person the possibility of securing appropriate PEP treatment.

The Tactical Burden in Prima Facie Cases

In giving the reasons for judgement in Mabior, McLachlin CJ states the following with respect to prima facie cases:

The usual rules of evidence and proof apply. The Crown bears the burden of establishing the elements of the offence – a dishonest act and deprivation – beyond a reasonable doubt. Where the Crown has made a prima facie case of deception and deprivation as described in these reasons, a tactical burden may fall on the accused to raise a reasonable doubt, by calling evidence he had a low viral load at the time and that condom protection was used. (Mabior, 2012. p. 623).

The Chief Justice expressed her concerns about the “onerous burden” the case-by-case approach imposed on the prosecution in cases such as Mabior. In our view, concern for prosecutors should not come at the expense of defendants in HIV non-disclosure trials. A person living with HIV may face significant bias at trial, for the following reason: “Along with biased risk assessments, judges and juries may consciously or unconsciously take into consideration the race, nationality or social position of the accused” (Burris et al., 2008. p. 6).

Such bias can result in an HIV-positive defendant facing a problem with credibility, a problem which Sarah Newman sees occurring in American HIV non-disclosure cases:

Credibility is a tremendous hurdle for many HIV-positive defendants. In many consensual-sex cases, the testimony elicited at trial becomes one person’s word against another’s. Because of the stigma still attached to being HIV positive, many...face insurmountable hurdles when trying to convince a jury of their credibility in the face of mounting evidence. (Newman, 2013. p. 1423).

Newman proposes this interesting remedy:
Placing the evidentiary burden on the prosecution would help to balance the bias that many HIV-positive defendants face during HIV-exposure prosecutions, would encourage more widespread HIV testing, and would promote greater joint responsibility for choices regarding consensual sex. (p. 1432).

In our opinion, Professor Newman’s proposal makes sense. However one might parse the Chief Justice’s comments in a way indicating that a tactical burden may fall upon the HIV-positive defendant when the prosecution has made a prima facie case, we take the view expressed by Lord Sankey in Woolmington v. DPP [1935] UKHL1:

Throughout the web of the English common law one golden thread is always to be seen – that it is the duty of the prosecution to prove the prisoner’s guilt.

**Recommendations:**

10. Police and Crown Counsel must handle HIV-related criminal complaints and prosecutions in a fair, non-stigmatizing and non-discriminatory manner that respects the privacy and human rights of persons living with HIV while avoiding any reinforcement of societal prejudices, preconceptions and irrational fears.

11. Crown Counsel and the police must respect the privacy rights of persons living with HIV and limit the negative impacts inevitably attendant on publicly disclosing a person’s HIV-positive status by avoiding activities which promote media sensationalism or unnecessary breaches of personal privacy, or which contribute to ongoing stigmatization of HIV and discrimination against persons living with HIV.

12. Current cultural awareness and sensitivity training for municipal police forces, the RCMP operating in BC, and all Crown Prosecutions counsel should be maintained and, indeed, extended in scope and content to include the lived experience of persons living with HIV, up-to-date scientific and medical information in the areas of epidemiology (including incidence, prevalence and mortality within various demographic cohorts), treatment and prevention, HIV/AIDS stigma and discrimination, and the social contexts of those living with HIV/AIDS (particularly those who are members of society’s most marginalized groups). No decision to prosecute arising from an instance of HIV non-disclosure should be taken by a Crown Counsel who has not gone through such training.

13. In all cases and instances, the burden of proof should rest with the Crown and, where conflicting evidence boils down principally to a matter of the accused’s “credibility”, all of the considerations in Recommendation #12 ought to be brought into play. In other words, the presumption of innocence ought to be especially strong in such cases.
7. British Columbia –

A World Leader in “Treatment as Prevention”

British Columbia is widely recognized as a world leader in the fight against HIV/AIDS. We consider our province to be “The Home of “Treatment as Prevention.”” Given the recognition that British Columbia has received for its achievements in the fight against HIV/AIDS, we believe that it is reasonable to ask that any use of the criminal law in HIV non-disclosure cases be restricted to individuals who have either deliberately transmitted the virus or who have engaged in a pattern of reckless behaviour and disregard for the safety of others, focusing on those limited instances in which HIV-positive individuals have failed to modify their high-risk behaviours in contravention of public health orders.

Declining Rate of New HIV Infections

Relative to the size of the provincial population, in the early 1990s British Columbia had the largest AIDS epidemic in Canada. Since 1987, more than 4,000 British Columbians living with HIV/AIDS have died in our province. (Lima et al., 2007). It is a truly remarkable achievement that the number of new HIV cases reported on an annual basis has declined from the high of 929 cases in 1987 (30.5 cases per 100,000 population) to the low of 238 cases in 2012 (5.1 cases per 100,000 population). By comparison, the 2012 rate of new HIV cases per 100,000 population was 6.2 in Alberta, 6.2 in Ontario and 5.6 in Quebec (PHAC, 2013).

“Near-Normal” Life Expectancy

Life expectancy for persons living with HIV has increased dramatically since 1996. Today a person infected with HIV who commences ARV therapy before sustaining significant immune system damage will enjoy near-normal life expectancy. Dr. Reka Gustafson, Medical Health Officer of the Vancouver Coastal Health Authority, and Dr. Julio Montaner reported in the December 2012 Canadian Medical Association Journal that:

Today a 20-year-old who receives a diagnosis of HIV and treatment with HAART can expect to live until the age of 73 years. (Gustafson, Montaner et al., 2012).

In mid-December 2013, the North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD), in which the BC-CfE is a participating site, published its latest findings in PloS ONE, in an article titled "Closing the Gap: Increases in Life Expectancy among Treated HIV-Positive Individuals in the United States and Canada." The study investigated changes in life expectancy among HIV-positive individuals on ART from 2000 – 2007 in Canada and the US. For a person commencing ARV treatment at age 20, life expectancy increased from 36.1 years (i.e., death at age 56.1 years) in 2000-2002 to 51.4 years (i.e., death at age 71.4 years) in 2006-2007 (Samji et al., 2013). Recently, the “Canadian Consensus statement on HIV Transmission and the Criminal Law” reported that the scientific experts confirm that a person who becomes HIV-positive at age 20 can expect to live another 50-60 years following diagnosis, in large part due to HAART and other advances in treating HIV disease. (Loutfy et al., 2014).
BC Leads Ontario and Quebec in HAART coverage

BC-CfE researchers investigated the relationship between HAART uptake in British Columbia, Ontario and Quebec and the provincial rates of HIV/AIDS incidence, morbidity and mortality between 1996 and 2008. The results were published in PloS ONE in November 2012 under the title, “Disparities in the Burden of HIV/AIDS in Canada.” During the period of the study, British Columbia had the highest HAART coverage of the three provinces (based on the number of persons on HAART as a percentage of the estimated HIV prevalent cases in each province). In 2008, 45% of the estimated total number of persons living with HIV in BC were on HAART, compared to 32% in Ontario and 37% in Quebec (Hogg et al., 2012). (Unfortunately, more recent comparative information is unavailable.)

Although these results are already somewhat dated, HAART coverage in BC is still likely to exceed that in Ontario and Quebec, in part because universal access to free ARV therapy is available in this province and due to the "seek and treat" initiatives within the STOP HIV/AIDS project which emphasizes the importance of bringing "Treatment as Prevention" to hard to reach populations by improving performance in all stages of the "Cascade of Care."

All three provinces experienced large declines in HIV morbidity and mortality over the study period, but BC was the only province in Canada which achieved a significant reduction in the rate of new HIV cases (measured as the number of new cases per 100,000 population) – declining from 18 cases to 8 cases per 100,000. (It should be noted that the rate of new HIV infections in Ontario and Quebec was already below 10 cases per 100,000 population in 1996, which was the start of the study period.) (Hogg, 2012.).

The Provincial Health Officer, Dr. Perry Kendall, is quoted as follows in the UBC media release announcing the study results:

This comprehensive study provides us with clear evidence that expanding Treatment as Prevention in the context of comprehensive harm reduction supports is the best way forward to fight HIV/AIDS. (UBC, 2012).

Lead researchers and study authors, Dr. Julio Montaner and Dr. Robert Hogg, attribute BC’s success in part to the availability of free universal access to ARV therapy in this province, without any requirement for deductibles and co-payments. The researchers have called on governments in other provinces/territories to follow the BC example. (UBC, 2012).

Declining HIV Incidence among Injection Drug Users

Perhaps the most notable achievement in British Columbia over the past 15 years in the fight against HIV/AIDS is the reduction in HIV incidence, morbidity and mortality among current and former injection drug users (IDUs). The raging HIV epidemic among IDUs in Vancouver’s Downtown East-Side (DTES) was brought under control through a combination of improved access to HAART, the opening of InSite and the expansion of other harm reduction measures – the effort to “flood” the area with clean needles and injection supplies in the wake of the 1997 declaration of a “public health emergency” that was unprecedented in Canada – and the shift away from injection drugs like heroin to smokeable options like crack cocaine.

Tremendous efforts were focused on objectives such as increasing the availability of social housing for the homeless and those at-risk of homelessness, greater access to addictions treatment and the
implementation of innovative approaches to criminal justice. In addition, the STOP HIV/AIDS pilot project utilized a "seek and treat" approach to engage and retain in treatment hard-to-reach populations at high-risk for HIV, as part of the comprehensive "Treatment as Prevention" initiative.

In "HIV Annual Report 2012," the BC Centre for Disease Control reports that:

> The number of new HIV diagnoses in people who use injection drugs (IDU) continued to decrease (12.2% of all new HIV diagnoses in 2012) for both males and females in most age groups. The decrease in new diagnoses among IDU since 2008 is the main driver of the overall provincial decrease in new HIV diagnoses. (BCCDC, 2013).

A retrospective study on the impact of HAART expansion in British Columbia between 1996 and 2012 determined that: "New HIV diagnoses decreased by 92% (p-value 0.0013) among individuals with a history of injection drug use..." (Nosyk, Montaner et al., 2014). It is important to note that the 92% reduction in IDU-related HIV incident infections reported in the 2014 *PLoS ONE* study was achieved without making any use of the criminal law to prosecute IDUs who failed to disclose their HIV-positive status.

**CMA Honours Dr. Montaner for BC’s Success in Fighting HIV**

Last year, the Canadian Medical Association awarded its highest honour to Dr. Julio Montaner in recognition of his contribution to the global fight to end AIDS and for the exemplary progress that BC has achieved in the fight against HIV/AIDS. In announcing the award, the CMA summarizes that progress:

> British Columbia has in the last 20 years seen the incidence of AIDS decline by more than 80 per cent, AIDS mortality rates decline by more than 95 per cent, and new diagnoses of HIV drop by 60 per cent, from about 900 cases a year in the 1990s to fewer than 289 cases in 2011. B.C. is the only region in Canada with consistently declining rates of new HIV infections. (CMA, 2013).

British Columbia is recognized as a world leader in HIV/AIDS research and practice. The provincial government continues to be a strong supporter of these efforts by putting in place the necessary policies and financial resources required to help enable people living with HIV to live longer and better lives. Supporting the implementation of innovative harm reduction measures (such as InSite), providing universal free access to ARV treatment to eligible British Columbians living with HIV/AIDS, and allocating targeted funding to “seek and treat” initiatives such as the STOP HIV/AIDS pilot project are three examples of how the provincial government has provided leadership together with the necessary financial resources to implement Treatment as Prevention on a province-wide basis.
8. British Columbia –

“Cascade of Care” Implementation Challenges

British Columbia’s achievement in the fight to end the AIDS epidemic has been extraordinary. However, the battle against HIV/AIDS is far from over. Although substantial reductions in the rate of new HIV diagnoses, morbidity and mortality in British Columbia have occurred since the peak of the epidemic, significant remaining challenges must be addressed before the vision of an AIDS-free generation can be secured. It is critical that provincial policy on HIV/AIDS must be coordinated and integrated. The Ministry of Health and the Ministry of Justice cannot develop their responses to HIV/AIDS from separate silos that remain cut-off from stakeholders and the broader community. While we respect judicial and prosecutorial independence as cornerstones of the Justice system, we do not believe it is reasonable in today’s complex world to imagine that the Office of the Assistant Deputy Attorney General should ever develop provincial policy on the use of the criminal law to address HIV non-disclosure in splendid isolation. The policies of the Ministry of Health and the Ministry of Justice which address HIV/AIDS must be coherent and complementary.

In the absence of a cure or a vaccine, Treatment as Prevention is the best opportunity available to substantially reduce the onward transmission of HIV. ARV treatment protects – and can help to restore – the immune systems in people living with HIV. All the cumulative evidence indicates individuals on HAART with an undetectable viral load are, by and large, not infectious. However, scientists do not yet know the extent to which HIV transmission can be eliminated in real-world populations, which differ substantially from the controlled settings of clinical trials. Although increasing HAART coverage of persons living with HIV within a population will result in declining community viral load, the inability to identify and successfully treat a large proportion of those who are infected may cause the secondary prevention benefits of Treatment as Prevention to reach an insurmountable plateau.

The Supreme Court of Canada’s decisions in Mabior and D.C. will make it easier (and cheaper) to convict a larger number of persons living with HIV on criminal charges resulting from HIV non-disclosure events. No one denies that the criminal law in Canada can be used to lay serious charges against HIV-positive individuals who fail to disclose their HIV status and expose their sexual partners to a “realistic possibility of transmission.” Even so, based upon the excellent results in fighting HIV/AIDS in British Columbia, it may now be more appropriate to ask the Minister of Justice and the Crown Prosecutions Branch to communicate their intentions regarding the prosecution of HIV non-disclosure cases and to provide a convincing argument that such actions will not disrupt the success of public health efforts in reducing the size and impact of the HIV/AIDS epidemic.

**The Cascade of Care’s Eight Stages**

There are eight successive stages in the HIV “cascade of care” model that help to clarify where the major challenges remain within a population or jurisdiction, if Treatment as Prevention is going to achieve maximum benefit:

- **Stage 1** – Total estimated number of HIV-positive individuals (i.e., prevalence)
- **Stage 2** – Individuals living with HIV who are diagnosed
- **Stage 3** – Individuals living with HIV who are linked to HIV care
Stage 4 – Individuals living with HIV who are retained in HIV care
Stage 5 – Individuals living with HIV for whom HAART is indicated
Stage 6 – Individuals living with HIV who are on HAART
Stage 7 – Individuals living with HIV who are adherent to HAART
Stage 8 – Individuals living with HIV who are virologically suppressed.

Indicators of our progress are not all of equal value. One of the most important indicators is what proportion of the estimated number of people living with HIV in British Columbia has been diagnosed. Another important indicator is what proportion of the estimated number of people living in our province has an undetectable viral load. In January 2014, Lancet Infectious Diseases published research findings from the BC-CfE (B Nosyk, J Montaner et al.) in an article titled “The cascade of HIV care in British Columbia, Canada, 1996-2011: a population-based retrospective cohort study.” Two of the key findings are presented below:

Based on prevalence estimates, the proportion of unidentified HIV-positive individuals decreased from 49.0% (estimated range 36.2-57.5%) in 1996 to 29.0% (11.6-40.7%) in 2011, and the proportion of HIV-positive people with viral suppression reached 34.6% (29.0-43.1%) in 2011. (Nosyk et al., 2014).

Undiagnosed HIV Cases

Although the progress in fighting HIV/AIDS in British Columbia has been remarkable, it can hardly be considered good news that roughly 3,400 (29%) of the estimated 11,700 people living with HIV in the province remain undiagnosed at the end of 2011. (For comparison purposes, the Public Health Agency of Canada provides the slightly lower estimate of 25%, roughly 2,900 (2012). The high percentage of undiagnosed cases is troubling news from a couple of perspectives: first, no one knows whether or not the estimate is accurate; and, second, assuming that it is, there has been remarkably little progress over the past decade in reducing the percentage of undiagnosed cases in British Columbia.

A person reading the January 2014 article is left with the impression that BC-CfE researchers are scratching their heads trying to figure out what to do next: “Further expansion of HIV testing is also a priority; however, uncertainty exists with respect to the number, distribution, and characteristics of undiagnosed HIV-positive individuals in British Columbia” (Nosyk, 2014).

The problem of undiagnosed HIV cases is also the subject of a 2013 article that was published in the Canadian Journal of Public Health, titled “The Holy Grail: The search for undiagnosed cases is paramount in improving the cascade of care among people living with HIV.” Authors O Eyawo, RS Hogg and J Montaner provide the following assessment: “In the absence of a vaccine and cure for HIV, undiagnosed HIV cases represent the biggest challenge yet in the fight against HIV/AIDS” (Ewayo et al., 2014).

Why is this issue so important? First, HIV-positive persons who have not been diagnosed remain outside of the “cascade of care” despite the likelihood that most of them should be on ARV treatment. Second, safe sex behaviour goes up significantly following diagnosis. “Hidden positives” likely behave in the same way as three-quarters of HIV-negative people: They don't practice safe sex. Since they aren't on HAART, their viral loads likely span a wide range of values. Since they are unaware of their HIV-positive status, they cannot logically be required to inform potential partners of their status. The fact that in the absence of an HIV-positive diagnosis, they can remain beyond the
The reach of the criminal justice system demonstrates how the criminal law can "incentivize ignorance", a term coined by Newman (2013).

Good News/Bad News: Routine Testing in Acute- and Primary-Care Settings

Shouldn't the “hidden positives” have been substantially "captured" by the decision, announced over two years ago, to introduce universal offering of HIV testing in Vancouver acute care hospitals, emergency rooms and primary care settings? (The policy has since been implemented province-wide.) At the recent April Treatment as Prevention workshop in Vancouver, Dr. Reka Gustafson reported on the success of these initiatives to an international audience. The acute care testing initiative has been successful in identifying substantial numbers of previously undiagnosed HIV-positive cases. Even so, 35% of those people diagnosed had seriously compromised immune systems, with CD4 counts under 200 cells/ml, indicating they had been living with the disease for some considerable time, probably a decade or more (Cairns, 2014). In total, 94% of those patients who were offered an HIV test agreed to be tested. However, only 44% of acute care patients received a test offer from their healthcare provider (Cairns, 2014), surely a disappointing result for the proponents of this well-publicized initiative.

Dr. Gustafson wrote to all primary care physicians in Vancouver on two occasions to seek their compliance with the new HIV testing policy, as follows:

We are asking all family physicians in Vancouver to recommend an HIV test to all adult patients who have not had one in the past year when ordering bloodwork for any reason regardless of perception of risk.... (Gustafson, 2012).

In the 2011 letter, physicians were asked to support efforts to reconnect with HIV-positive patients who had been lost to care. The 2012 letter indicated that, “an HIV test is also recommended as part of routine care for everyone who is tested or diagnosed with a sexually transmitted infection, hepatitis C or tuberculosis” (Gustafson, 2012).

Evidently the extent of physician uptake at the primary care level has also been less than stellar. Although Dr. Gustafson reported that over 500 primary care physicians had signed up for the pilot, the number of tests only increased “from 650 a month during 2011 to 2,000 a month in the first half of 2013” (Cairns, 2014). Although this was not described as being a disappointment in media reports on the conference, according to our calculations the pilot generated an increase of only 2.7 tests per month for each of the 500+ participating physicians.

Does this represent a success or a failure? While it is true that large initiatives such as these require time to get off the ground – training is required and physicians are already busy – how are persons living with HIV supposed to reconcile the Supreme Court’s willingness to extend criminalization of HIV non-disclosure with the slow response of acute- and primary-care physicians to comply with the Vancouver Coastal’s policy that all adults are to be offered a routine HIV test? In May 2014, British Columbia became the first province in Canada to establish — through the Office of the Provincial Health Officer — a policy that requires all primary care physicians to offer all adult patients under their care a routine HIV test over the next five years.

It has taken at least five years to get this policy approved in British Columbia, although a number of other jurisdictions have had one in place for some time now – for example, the US in 2006, followed by the UK and France. Let’s hope that no one waits five years to determine what kind of progress is being made. The secondary benefits of Treatment as Prevention cannot be realized unless those
persons living with HIV in this province are diagnosed and supported through the stages of the Cascade of Care. Over-criminalization of HIV non-disclosure will make it more difficult to succeed with this challenge.

**Acute- and Late-Stage HIV Infections among the Newly-Diagnosed**

There has been progress in increasing the proportion of people who are newly diagnosed with HIV who have acute infection (in order words, who are diagnosed in the early stages of the disease when they are most infectious, and so are prevented from infecting as many people as they may have done otherwise). About 20% of new diagnoses are in the acute stage, yet 20% continue to be late-stage infections (Cairns, 2014). A 2009 meta-analysis of heterosexual transmission risk published in the *Journal of Infectious Diseases* reported that: “Estimates for the early and late phases of HIV infection were 9.2 (95% CI 1.4-19.5) times versus 7.3 (95% CI 4.5-11.9) times larger, respectively, than for the asymptomatic phase” (Boily et al., 2009).

An American study determined that undiagnosed persons living with HIV are linked to the onward transmission of HIV at a rate which is 3.5 times higher than the one for persons who have already been diagnosed as HIV-positive (Remis et al., 2012). If this fact were to hold true for British Columbia, then approximately 60% of onward transmission of HIV can be attributed to the 30% of persons living with HIV who have not been diagnosed. The 70% who have been diagnosed as HIV-positive only account for 40% of onward transmissions. Since undiagnosed individuals are outside the long reach of the law, it is time for the justice system to rethink Canada’s position on the criminalization of HIV non-disclosure. In the meantime, new Charge Assessment Guidelines can help on an interim basis.

**Retention in Care Lags Behind Linkage to Care**

Nosyk and Montaner report in *Lancet Infectious Diseases* that: “Retention in HIV care lagged far behind linkage, reaching 80.5% of those diagnosed in 2011” (2014). This means that 19.5% of the 71% who have been diagnosed have been lost to care, representing 15% of the total estimated HIV cases in BC. Adding together the 15% lost to care with the 29% of estimated HIV cases who are undiagnosed, the net effect is that almost half (44%) of the total estimated number of HIV cases in British Columbia are either undiagnosed or lost to care. This is a very significant percentage which confirms our earlier assessment that there is an urgent need to expand efforts to diagnose all those persons living with HIV who have not yet been identified, and to return to care those who have been lost. Testing must be conducted on a voluntary basis which is mindful of human rights, including the right of patients to privacy and confidentiality. Total viral suppression at the population level may never be possible, but if Treatment as Prevention is to maximize its potential, a concerted effort (and a little good luck) will be required. To repeat our argument one more time, increased criminalization of HIV non-disclosure will only make the challenge of securing an AIDS-free generation more difficult to achieve.

**The Bottom Line on Viral Suppression**

There is one final point that warrants careful consideration. The results of the BC HIV retrospective study indicate that only one-third (34.6%) of the estimated number of prevalent HIV cases in BC were virologically suppressed at the end of 2011 (Nosyk, 2014). Simply stated, this means that the remaining two-thirds of all persons living with HIV in BC – representing almost 8,000 people – do not
have suppressed viremia. If this result were to hold true across Canada, it would mean that over 45,000 of the 70,000+ people living with HIV do not have suppressed viremia at present. These individuals cannot possibly meet the "condom use and low viral load" threshold to escape the "realistic possibility" test.

As a result, these people cannot avoid the legal duty to disclose their HIV status, despite the fact that they may use condom protection, have a low viral load in consequence of using ARV therapy, and/or practice lower-risk activities. In effect, nearly two-thirds of all people living with HIV/AIDS in Canada are being forced to follow the "absolute disclosure" approach that the Court itself had rejected in Mabior, out of concern that it might contribute to increased stigma and discrimination. Is it too cynical and impertinent to ask whether, in rejecting the absolute disclosure approach, the Court's primary objective was not so much to be compassionate, but rather to make itself appear to be compassionate? The Court's decision in Mabior better fits the description of "an iron fist in a velvet glove."
9. Improving Public Education on HIV Criminalization and Prevention

A cursory look at public education on HIV prevention and the use of the criminal law to address instances of HIV non-disclosure in British Columbia is likely to yield a mess of conflicting messages and inconsistent information. Public health web sites and those of AIDS service organizations (ASOs) in British Columbia mostly seem reluctant to provide public information on HIV non-disclosure in Canada, including information on the legal requirements to avoid prosecution under the Criminal Code. There is little evidence that the Ministry of Justice accepts any responsibility to provide public education on HIV criminalization. In fact, the Office of the Assistant Deputy Attorney General has been unwilling to meet with persons living with HIV and their representatives to discuss prosecutorial guidelines.

Despite the overwhelming amount of online public health information on HIV transmission and prevention, there is a disturbing lack of consistency – and at times accuracy – in core messages. Public-health and government-funded ASO web sites often discuss the seriousness, urgency and course of HIV infection as if it were a different disease than the one characterized in recent Supreme Court decisions.

Sometimes the tone of HIV prevention education is too relaxed; occasionally it is too harsh. The BCCDC can appear to be overly cautious in commenting on the benefits of Treatment as Prevention, whereas the BC-CfE can seem to be overly enthusiastic. For example, one month after the Supreme Court of Canada issued its decisions in Mabior and D.C., Dr. Montaner made the following comment during a November 2012 interview with Bob Leahy, Editor of PositiveLite.com:

So I'm perfectly comfortable to tell people that if you want to go forward and have, for example, unprotected sex while you are being protected by antiretroviral therapy, that is perfectly acceptable. On the other hand, you need to know, that in the process of doing that, if there was a breakdown in adherence for example, you put yourself at risk. As long as you are willing and able to live with that kind of small risk, I'm perfectly happy to live with it.

(Leahy, 2012b).

At the time, there was considerable uncertainty about whether the results from the HPTN 052 clinical trial would withstand additional scrutiny. People living with HIV are being caught in the middle between the Supreme Court which has toughened its stance on HIV non-disclosure and the ebullient optimism of the global champion of Treatment as Prevention.

Sample Web Pages on HIV Prevention and Treatment

To investigate our perceptions further, we decided to take a cursory look at a small number of public health web pages on HIV/AIDS, including one site that was positively recommended, to assess the accuracy and consistency of core messaging. Our main objective was to gather sufficient data to make a recommendation for further work in this area.
Information on the criminal law in Canada regarding HIV Non-Disclosure

Information on HIV and the criminal law in Canada was available on only two of the four web sites. No site provided up-to-date information that provided a complete overview of the law with sufficient detail to make informed choices that are either in compliance with the legal requirements, or based on an understanding of the consequences if one is non-compliant.

Smart Sex Resource provides the following information under the “Telling Partners” section of its “HIV and AIDS” web page:

By voluntarily letting your sex partners or people that you have shared drug equipment with know that they should be tested, they can then make decisions about how to protect themselves.

Under the Criminal Law in Canada, a person living with HIV has a duty to disclose their HIV status before having sex that poses a ‘realistic possibility of HIV transmission’. The term ‘realistic possibility of HIV transmission’ can depend upon many factors such as type of exposure, whether a condom was used and the level of HIV (HIV viral load) that a person has.

The Canadian HIV/AIDS Legal Network [link provided] is a good source for up-to-date legal information about HIV. (SOGC, 2012b).

There is just enough information here to convince the savvy reader that this is an issue that requires serious attention. Is enough legal information provided to persons living with HIV in order to keep them out of prison? Probably not. And, if not, why not?

BCCDC – “Health Teaching to Prevent the Transmission of HIV”

The “Health Teaching” is taken from the “HIV-1, HIV-2 Counselling and Follow Up Policy” (July 2007) in the BC Centre for Disease Control’s Communicable Disease Control Manual, which is designed to provide advice to public health practitioners, other professionals, and the general public. It includes information to be shared with persons who have been newly-diagnosed with HIV. The following quote is provided as the “general messaging suggestion” and may strike readers as being unnecessarily (and perhaps inappropriately) hard-hitting and outdated:

If you choose to have sex or to share drug using equipment you are leaving yourself vulnerable to getting other infections and to infecting others. (BCCDC, 2007).

The subsequent “sexual transmission prevention messaging” uses a similar sobering approach:

The regular use of latex or polyurethane condoms markedly reduces the risk of sexual transmission of HIV, but does not eliminate transmission risk completely. This is particularly important information for HIV positive persons working in the sex trade.

Only abstinence and absence of risk activities are guaranteed to prevent HIV transmission. (BCCDC, 2007).

The frankness of the message conveys the reality that in real-world settings condom use may only markedly reduce the risk of HIV transmission, due to inconsistent use, improper use, slippage and
breakage. The wording seems to convey a subtle message that HIV-positive individuals should be choosing abstinence over sex; more to the point, by choosing to have sex, they are putting the lives of others at risk.

The next sentence stresses that the information is “particularly important for HIV positive persons working in the sex trade” and misses the mark. The information should be equally applicable to all persons living with HIV. By drawing attention to sex workers, others may think that the message is less relevant to their own situation. Similarly, it could be interpreted as suggesting that sex workers are somehow particularly bad, immoral and diseased.

The meaning of the prevention message on abstinence and choosing no-risk activities needs to be clarified. The emphasis on abstinence does not seem realistic. Once again, the message carries a subtext which seemingly suggests that persons living with HIV are somehow damaged, immoral and dirty.

BCCDC – “Information for persons newly-diagnosed” (Handout)

Given the above-noted concerns about health education messaging, the one-page information handout for newly-diagnosed persons included in the same chapter of the BCCDC Communicable Disease Control Manual is surprisingly different, as the partial answers to the following two questions demonstrate:

*What does being HIV positive mean?*
- HIV infection is a lifelong, treatable infection
- Being HIV positive does not mean that you have Acquired Immune Deficiency Syndrome (AIDS)

*How is HIV Spread?*
- Use condoms for anal, vaginal or oral sex.
- It is important not to share sex toys or drug using equipment.
- Tell you partners or contacts to test for HIV. (BCCDC, 2007).

There is no mention of the criminal law as it pertains to HIV non-disclosure. HIV is not consistently described as a serious, potentially deadly, disease. Sometimes there is no discussion of ARV therapy. Condoms are the mainstay of safe(r) sex. There is no discussion of high-, low- and no-risk activities. (Given the lack of discussion on “risk,” the advice that sex toys should not be shared seems odd, especially since many experts – such as the US Centers for Disease Control – do not believe the risk is significant.)

The accompanying handout for newly-diagnosed persons (marked as Appendix 7) takes a more relaxed approach than the heavy-handed “health teaching” points discussed above. In fact, the approach taken in the handout may have gone too far in the other direction – it is arguably too soft. The answer given to the question, “How do I stop the spread of HIV?” is straightforward and to the point: “Use condoms for anal, vaginal or oral sex.” However, the advice to tell partners and contacts to test for HIV is conveyed without any sense of urgency.
**Ministry of Health – “HIV/AIDS in British Columbia”**

This web page is located in the “Blood-Borne Pathogens” section of the Ministry of Health web site. The following two bullets are taken directly from the “HIV/AIDS” page:

> If left untreated, HIV infection can cause rapid deterioration of the immune system and lead to AIDS (acquired immunodeficiency virus [sic]). With a compromised immune system, AIDS leaves an individual susceptible to certain opportunistic infections and cancers.

> HIV can be spread by having unprotected sex and the sharing of needles for any purpose. (BC Ministry of Health, undated).

The comment about “rapid deterioration of the immune system” in the absence of ARV treatment conflicts with the one made under Smart Sex Resource below. The condom statement conveys the sense that condoms provide total protection, which is somewhat different than what is communicated in the BCCDC message discussed above. Although the web page includes a reassuring message that it is unlawful to discriminate against someone who has HIV/AIDS, there is nothing said about HIV and the criminal law. As this is the Ministry’s site, it is surprising that there is no mention of universal routine HIV testing in acute- and primary-care. The suggestion is made that high-risk populations such as those who engage in unprotected intercourse may require an HIV test.

**Smart Sex Resource – “HIV and AIDS”**

Found under the “A-Z Topics” section of Smart Sex Resource, the following three bullets provide some indication of the approach to HIV/AIDS taken in this web page:

- **There is no cure** for HIV, but medication can reduce the amount of virus in the body and help you to stay healthy. Without treatment HIV damages the immune system and may become Acquired Immunodeficiency Syndrome (AIDS).

- **Early treatment reduces harm to the immune system and helps people live healthier lives.** Taking medications early may also lower the chances of passing HIV to other people.

- **Having HIV does not mean you have AIDS. [...] Even without treatment, it takes a long time for HIV to progress to AIDS, usually 10 to 12 years.** (BCCDC, 2012).

The use of language is quite tentative at times. Without treatment, the vast majority of HIV-positive persons will progress to AIDS and death. This piece is unique in that it talks about the benefit of early treatment. However, it underplays the prevention benefit of ARV treatment by only stating that treatment may lower the chances of transmitting HIV. This stands out, in part, because BC is considered to be the “Home of Treatment as Prevention.” The “early treatment” message is inconsistent with the “take your time, don’t worry” subtext in the last bullet. It is conceivable that some undiagnosed HIV-positive individuals may delay testing, choosing to take comfort in the “don't worry” subtext in the last bullet.
SexualityandU.ca

Under “Types of STIs-STDs,” there is a drop-down menu which lists the following five options:

- Bacterial
- Viral
- Parasitic
- Fungal infections

The site is written at an advanced literacy level. Many site users are unlikely to have sufficient knowledge about which STDs belong in each of the options.

On the web page titled, “How do I protect myself from STIs-STDs”, the following comments stand out:

*It's your responsibility to protect yourself.*

*Avoid having sex when you're drunk or on drugs. When your heads not right, it's easy to make decisions you'll regret.* (SOGC, 2012a).

This was the only one of the four sites reviewed which clearly reinforces the message that each individual must accept responsibility for his/her own health. Although the Supreme Court's Mabior decision emphasized the importance of the Charter values of autonomy and equality, the full legal responsibility for HIV disclosure and for practising safer-sex is placed upon the HIV-positive partner. The Court's emphasis on autonomy and equality makes this view seem oddly old-fashioned and out-of-date, in that the lack of shared responsibility can be interpreted as indicating the HIV-negative partner is completely passive and strangely dependent upon the goodwill of the HIV-positive partner. The emphasis on disclosure seemingly disregards the fact that safe sex is what works, whereas disclosure doesn't.

The STD web page only mentions HIV once, when it mentions that being STD-free reduces the chances of HIV transmission. Since it provides general information on how to prevent getting STDs, the focus in on always using a condom. It would be interesting to find out whether there is research that supports the advice – “avoid having sex when you're drunk or on drugs” (SOGC, 2012a). The site also states: “Don't have sex with someone who has a lot of partners.” There is an edginess to the key message that “It's your responsibility to protect yourself,” – which rings true if one considers the serious potential consequences of becoming infected with HIV.

By clicking on the “viral” section and scrolling down to “Human Immunodeficiency Virus,” a reader will discover a rather dense three-page discussion that is likely ten years old. There is reference to a UNAIDS estimate that 38 million people have HIV worldwide and that more than 20 million have died from it. The web page states that “it takes more than 10 years for HIV to progress to AIDS, but that due to “the growing effectiveness of the antiretroviral drugs that slow the spread of HIV in the body....people who are treated for HIV are taking a longer time to develop AIDS” (SOGC, 2012a).

This is the (rather outdated) prognosis given for someone who is infected with HIV disease: “HIV is an incurable, fatal disease. However, HIV/AIDS treatment is rapidly improving, and people treated for HIV now live longer, healthier lives than before.” With respect to disclosure, the following advice is provided: “If you are diagnosed with HIV while in an ongoing sexual relationship, you need to tell your partner and they need to be tested for HIV...."
Most of the web sites reviewed said nothing about post-exposure prophylaxis. When it was mentioned, the information was unmarked and buried in the middle of a general information web page.

**Discussion**

If these few pages are representative, people living with HIV/AIDS in British Columbia are not receiving essential information on HIV and the criminal law in Canada. Similarly, the information on HIV prevention and treatment presented in our small sample was inconsistent from one site to the next. Information was often incompatible with the (unexplained) legal requirements and at times outdated.

Consideration should be given to implementing a quality assurance process which ensures consistent messaging and periodic review of public and publicly-funded web site information on HIV prevention and transmission. Public health and legal education on HIV must be available in multiple formats, targeted to specific audiences, and delivered in a culturally-sensitive manner. Although general messaging may be part of the solution, prevention materials should be easy-to-read or follow, tailored to specific audiences, and developed in a culturally-sensitive manner. Most important of all, HIV prevention is everyone’s business and responsibility. It is not prudent that almost all available funding be allocated to Treatment as Prevention, to the effective exclusion of alternative approaches to HIV prevention.

The quality assurance process advocated here should be overseen and coordinated by the provincial Health Ministry and should include senior representation from the Assistant Deputy Attorney General’s Office, the BC Centre for Excellence in HIV/AIDS, the First Nations Health Authority, Positive Living BC and the Drug War Survivors BC/Yukon Chapter.
10. BC's response to HIV/AIDS:

Improving coordination and integration

We are of the view that there needs to be better coordination and integration of policy development and application within the provincial response to HIV/AIDS. This is in keeping with the following recommendation from the White Paper on Justice Reform: “The justice system must value integrated and collaborative approaches to the way it serves citizens [that] links justice services with health and social services to facilitate consistent approaches” (Part 2, 2013).

We urge the development of a coherent cross-departmental provincial policy which addresses the matrix of HIV-related policy objectives. Such an approach could address the complementary use of the criminal law and public health to address HIV non-disclosure and to provide guidance on the responsibilities of the relevant Ministries and Branches, including the Ministry of Justice’s Criminal Justice Branch (ADAG), the Ministry of Health, Provincial Health Officer, the BC Centre for Disease Control, and the BC Centre for Excellence in HIV/AIDS. It would be most helpful if representation from AIDS service organizations, other community stakeholders and persons living with HIV could be included in ongoing discussions, with an annual summit to highlight results, new initiatives and changes in emphasis. This would be in keeping with increasing transparency and accountability.

Persons living with HIV are being bombarded with inconsistent, mixed messages on HIV transmission risk and the legal obligations regarding HIV non-disclosure. It is imperative that a review of provincial HIV messaging be completed in order to improve coherence and consistency. Public health and AIDS service organizations appear to be unable, in part due to resource constraints, to provide complete legal information on HIV non-disclosure. At the same time, there is a wide variety of government-operated and funded web sites providing conflicting information on HIV risk assessment, prevention and treatment. Public health messaging appears to be minimizing the seriousness of HIV infection, whereas the Supreme Court has ratcheted up disclosure requirements despite the substantial decline in HIV transmission, morbidity and mortality since Cuerrier.

These inconsistencies – and the gaps in vital information left unaddressed – must be fixed. The only way that “fix” is going to be effected is through far greater coordination and, where helpful, integration of the efforts of all concerned. The people of BC, and especially those living with HIV, deserve (indeed, require) clarity and consistency in these matters. It is up to all of us involved to provide it.

Finally, it is only reasonable that the people of British Columbia – both those living HIV and everyone else – be given some idea as to the problem (in all the applicable senses) as it exists in their province. An annual report from their provincial Government setting out the scope of existing activities and their judicial (and penal) consequences would go a long way toward de-mystifying the existing situation and possibly pointing the way to longer term, more durable solutions.

Recommendation

14. At least until such time as the Supreme Court of Canada has had a chance to revisit its rulings in Mabior and DC, the BC Ministry of Justice publish annually a summary of statistics concerning prosecutions arising out of instance of HIV non-disclosure including the number
of HIV Non-disclosure related investigations, charges, convictions, length of sentence and estimated cost of each case (and in total) that is paid for out of the public purse.
11. Conclusion

The HIV/AIDS epidemic in BC seems to be at yet another turning point. Further progress could be impeded – and gains won to date substantially damaged – if there is an increase in criminal prosecutions arising from the failure to disclose HIV-positive status prior to sexual relations resulting in exposure to HIV, especially if a condom is used or the person has low viral load. The issuance of new charge assessment guidelines developed through respectful dialogue is an important goal that must include the meaningful involvement of persons with HIV/AIDS.

Nearly eighteen-months ago, the Ministry of Health released the provincial HIV/AIDS strategy, “From Hope to Health,” which outlines the vision of achieving the first AIDS-free generation. As the province’s principal organization of British Columbians living with HIV/AIDS, we are committed to working together with government ministries, public health officials, HIV/AIDS researchers, our post-secondary institutions, health authorities and hospitals, providers of health and human services, and other civil society partners to make this vision a reality.

The status quo is scientifically indefensible and socially irresponsible. It must be changed. We stand ready to help in any way we can. But it is first and foremost the Justice Ministry that must act.
A Note of Thanks:

We wish to acknowledge the crucial contributions to the above made by Ms. Cecile Kazatchkine and Richard Elliott of the Canadian HIV/AIDS Legal Network. Their thorough grasp of the subject matter and numerous fundamental contributions to this project have greatly enhanced its scope and quality. Their ever-ready willingness cheerfully to assist when asked and to do so in full measure every time is appreciated by us far more than we can adequately express. What errors of excess or omission remain are ours alone.

Also, the numerous resources assembled and prepared by the Ontario Working Group on Criminal Law and HIV Exposure (CLHE) proved invaluable in the preparation of this discussion paper; we are grateful for their excellent work.

Finally, on behalf of the entire Society and its more than 5,500 members of record, we wish most sincerely to thank and acknowledge former Board member Paul Goyan of Quadra Island for his supererogatory work, under trying conditions, in researching, preparing and writing this document. Paul has a BA from Harvard University and a Master's from University of Toronto; he has held several senior positions in federal and provincial governments, including Deputy Minister of Training and Advanced Education in the Government of Manitoba. He is a model of member empowerment, and has in this particular endeavour served his fellow members exceptionally well.
Appendix A:

List of Recommendations

1. The development of prosecutorial guidelines in regards to HIV non-disclosure should include meaningful consultation with persons living with HIV, HIV experts, and other key stakeholders.

2. Approved guidelines should be subject to ongoing review and revision. The three areas in which we find the current “Sex 2” guidelines to be helpful should be retained, they being:
   - Upon receipt of a Report to Crown Counsel, if the MHO has not been involved, ensure that the matter is reported as soon as possible,
   - Prosecution decision should take into account conditions which the medical health officer may order under pertinent legislation, and
   - Any proposed charge involving possible transmission of a sexually transmitted disease, including HIV, should be reviewed by Regional or Deputy Regional Crown Counsel.

3. Public health options should be exhausted before resorting to the criminal law, except when a deliberate transmission event has taken place or a person engages in an ongoing pattern of deliberately reckless and dangerous sexual activities. Such behaviour may warrant a charge under the Criminal Code.

4. There should be a strong presumption against prosecution in cases of exposure alone (i.e. where transmission of the virus does not occur), especially when the risk of transmission was low or negligible (e.g., oral sex), or based on a single occurrence.

5. Persons living with HIV who have followed public health and/or medical advice by practicing safer sex, such as using a condom or maintaining a low viral load through adherence to ARV treatment, should not be subject to prosecution.

6. It is imperative that all new charge assessments and criminal prosecutions related to HIV be informed by complete, accurate and up-to-date understanding of relevant medical and scientific research in such areas as: the risk of HIV exposure and transmission, treatments, changes in morbidity, mortality and life expectancy, the social context of HIV as experienced by persons living with HIV who are members of marginalized and vulnerable groups, and the impact of stigmatization and discrimination. Specifically, until such time as a more authoritative source is published, the Canadian Consensus Statement on HIV Transmission and the Criminal Law should be the principal source for information regarding transmission risks on the basis of which new charge decisions are made. Further, in instances where the defence seeks to introduce the Consensus Statement during court proceedings arising from charges involving HIV non-disclosure, the Crown should not oppose the motion.

7. Reference to the Consensus Statement notwithstanding, it is necessary to seek the advice of a qualified medical expert during the charge assessment process and at trial.

8. No prosecution should be undertaken in cases where the sexual activity engaged in by the
non-disclosing person living with HIV did not involve vaginal and/or anal penetrative sex (i.e., oral sex, digital sex, masturbation, etc.).

9. We believe that prosecutorial discretion should be exercised when considering use of the Criminal Code to address HIV non-disclosure among women and members of marginalized groups. In particular, we believe that no prosecutions should be undertaken in instances where the non-disclosing person living with HIV reasonably believed that their disclosure of their HIV status would lead their sex partner or some other third party to do serious harm to them (e.g., harm of a sort that could reasonably be supposed to result in a charge of assault causing bodily harm, sec. 267 of the Criminal Code).

10. Police and Crown Counsel must handle HIV-related criminal complaints and prosecutions in a fair, non-stigmatizing and non-discriminatory manner that respects the privacy and human rights of persons living with HIV while avoiding any reinforcement of societal prejudices, preconceptions and irrational fears.

11. Crown Counsel and the police must respect the privacy rights of persons living with HIV and limit the negative impacts inevitably attendant on publicly disclosing a person’s HIV-positive status by avoiding activities which promote media sensationalism or unnecessary breaches of personal privacy, or which contribute to ongoing stigmatization of HIV and discrimination against persons living with HIV.

12. Current cultural awareness and sensitivity training for municipal police forces, the RCMP operating in BC, and all Crown Prosecutions counsel should be maintained and, indeed, extended in scope and content to include the lived experience of persons living with HIV, up-to-date scientific and medical information in the areas of epidemiology (including incidence, prevalence and mortality within various demographic cohorts), treatment and prevention, HIV/AIDS stigma and discrimination, and the social contexts of those living with HIV/AIDS (particularly those who are members of society’s most marginalized groups). No decision to prosecute arising from an instance of HIV non-disclosure should be taken by a Crown Counsel who has not gone through such training.

13. In all cases and instances, the burden of proof should rest with the Crown and, where conflicting evidence boils down principally to a matter of the accused’s “credibility”, all of the considerations in Recommendation #12 ought to be brought into play. In other words, the presumption of innocence ought to be especially strong in such cases.

14. At least until such time as the Supreme Court of Canada has had a chance to revisit its rulings in Mabior and DC, the BC Ministry of Justice publish annually a summary of statistics concerning prosecutions arising out of instance of HIV non-disclosure including the number of HIV Non-disclosure related investigations, charges, convictions, length of sentence and estimated cost of each case (and in total) that is paid for out of the public purse.
Appendix B:
Resources on HIV Transmission Risk

There are a number of new resources which provide up-to-date information on research into the risk of HIV transmission, which are listed below for those who wish to explore the issue in greater detail. These documents provide comprehensive risk information using a wide variety of biological and behavioural factors. Any attempt to summarize and simplify research into HIV transmission risk fails to represent adequately the complexity of risk assessment using statistical methods.

“Canadian consensus statement on HIV and its transmission in the context of criminal law”
M Loutfy, M Tyndall, J-G Baril, JSG Montaner, R Kaul, C Hankins, et al.
*Canadian Journal of Infectious Diseases and Medical Microbiology*, 2014

“Scientific research on the risk of the sexual transmission of HIV infection and on HIV as a chronic manageable infection,” (Updated February 2013)
David McLay et al.

“HIV Transmission: Factors that Affect Biological Risk”
*Canadian AIDS Society*, 2013
<http://www.cdnaids.ca/hivtransmissionguidelinesforassess>

“Insight into HIV transmission risk when the viral load is undetectable and no condom is used”
James Wilton
*CATIE News* 10 April 2014

“HIV Transmission Risk: A Summary of Evidence”
*Public Health Agency of Canada*, 2013

“Condoms and STDs: Fact Sheet for Public Health Personnel”
*Centers for Disease Control and Prevention (U.S.)*
[Last updated: March 5, 2013]
<www.cdc.gov/condomeffectiveness/latex.htm>

“HIV Transmission Risk”
*Centers for Disease Control and Prevention (U.S.)*
[Last updated: June 14, 2012]
<http://www.cdc.gov/hiv/law/transmission.htm>
Appendix C:
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The Need for New Charge Assessment Guidelines: HIV Non-Disclosure in British Columbia


R. v. Cuerrier, 1998 2 SCR 371
R. v. J.A.T., 2010 BCSC 766


R. v. Mabior, 2012 SCC 47

R. v. Williams, 2003 2 SCR 134


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