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Criminal Justice System's Response to Non-Disclosure of HIV

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INTRODUCTION

On December 1, 2016, the Minister of Justice committed to engage provincial and territorial (PT) colleagues, affected communities and medical professionals to examine the criminal justice system's response to non-disclosure of the human immunodeficiency virus (HIV) (see Annex 1). To support that commitment, Justice Canada has studied the issue with the assistance of the Public Health Agency of Canada (PHAC), PT counterparts, and with input from various stakeholders. This report is the result of that study.

The criminal law does not require disclosure of HIV in every case. In 2012, the Supreme Court of Canada (SCC) held that the criminal law imposes a duty to disclose HIV positive status prior to sexual activity that poses a "realistic possibility of transmission" on the basis that, in such cases, the HIV negative sexual partner must be afforded the opportunity to choose whether to assume such a risk. "HIV non-disclosure" is the term used to describe these cases, i.e., criminal cases involving transmission, or exposure to the risk of transmission, of HIV through sexual activity that posed a realistic possibility of transmission. Since HIV transmission and exposure cases can raise different legal and policy issues, this report refers to HIV transmission or HIV exposure cases when necessary to distinguish between them, but otherwise uses the term "HIV non-disclosure" to describe both types of cases collectively.

Although HIV was originally a fatal sexually transmitted and blood-borne infection (STBBI), it is now considered to be a manageable condition, thanks to significant medical advancements in HIV treatment. Antiretroviral treatment is highly effective for most patients; remaining on treatment substantially improves quality of life and results in low viral loads,[1] which prevents the onward transmission of HIV. However, HIV continues to have significant health implications for those who contract it and treatment may not work for some patients and can have significant negative side effects. Controlling the spread of HIV therefore remains a public health imperative.

For that reason, on December 1st, 2016, the Minister of Health committed Canada to global targets towards the elimination of AIDS as a public health threat by 2030, as established by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization, including their 90-90-90 targets, i.e., that by 2020, 90% of all people living with HIV know their status, 90% of those diagnosed receive antiretroviral treatment, and 90% of those on treatment achieve viral suppression.[2] HIV in Canada, the effectiveness of HIV treatment, and the effects of both HIV and its treatment on patients, are discussed in Part A.

The most recent medical science on HIV transmission risk, which has evolved since the SCC last considered HIV non-disclosure, is instrumental in defining the scope of the criminal law. In 2012, the SCC found that future advances in HIV treatment must be taken into account in determining whether a "realistic possibility of transmission" has been established. PHAC has provided a summary of its in-depth analysis of the most recent medical science in Part B.

The development of the SCC's "realistic possibility of transmission" test was informed by relevant policy considerations, including the importance of striking an appropriate balance between the complainant's interest in autonomy, dignity and equality and the need to prevent over-extension of criminal sanctions of an already vulnerable group, i.e., persons living with HIV. The applicable criminal law, including the SCC's observations on the complex policy issues at play in HIV non-disclosure cases, is discussed in Part C.

Many stakeholders have expressed significant concern with the criminal law approach developed by the SCC, and in particular the application of its "realistic possibility of transmission" legal test post-2012, including on the basis that the approach results in over-criminalization of persons living with HIV, who are already marginalized and vulnerable. These perspectives are outlined in Part D. The criminal law's application to HIV non-disclosure has also been the subject of significant discussion and debate at the international level; Part E provides a review of certain like-minded jurisdictions' approaches.

Given that HIV is first and foremost a medical and public health issue, public health sector responses were examined and are discussed in Part F. Criminal justice system responses may complement public health responses, while seeking to achieve their own objectives, including promotion and maintenance of a safe, just and peaceful society, by establishing a shared set of minimum standards of acceptable human behavior. These responses, including information on victim impact, are discussed in Part G. Parts F and G also discuss to what extent public health and criminal justice responses are coordinated.

Finally, Part H provides a brief summary of the evidence reviewed and an overview of the conclusions that can be drawn from it. These conclusions may inform any future steps to address the way in which the criminal justice system responds to HIV non-disclosure cases.

PART A: HIV AND CANADA

HIV is a retrovirus that causes HIV infection and, over time, acquired immunodeficiency syndrome (AIDS). AIDS is a condition that involves progressive failure of the immune system, which allows life-threatening infections and cancers to thrive. HIV infection can occur through transfer of blood, semen, vaginal fluid, pre-ejaculate and breast milk. The Canadian AIDS Society also considers rectal fluid to contain sufficient virus to transmit HIV sexually.[3] HIV is both a blood borne and sexually transmitted infection.

According to national HIV estimates released in December 2016 by PHAC[4], 65,040 persons (range: 53,980-76,100) were living with HIV in Canada at the end of 2014. Of those, 52,220 persons (range: 47,230-57,440) or 80% (range: 73-87%) were diagnosed, i.e., were aware of their HIV positive status. Among persons who were diagnosed, 39,790 persons (range: 36,470-43,140) or 76% (range: 70-82%) were on antiretroviral treatment, and among them, 35,350 persons (range: 32,430-38,260) or 89% (range: 84-93%) had a suppressed viral load (i.e., less than 200 copies of HIV per ml of blood).

The available data on the epidemiology of HIV in Canada, the groups that are disproportionately affected, the impact of HIV on those who contract it and the effects of antiretroviral treatment, are summarized below. These data show that HIV, once a fatal condition, is now manageable, thanks to significant advances in HIV treatment. However, it remains incurable and has serious implications for those who contract it, both physical and psychological. The data also show that an increasing number of Canadians living with HIV are accessing treatment, which is critical to stopping the spread of HIV. Timely initiation of treatment and remaining on HIV medication are important to achieving viral load suppression, which is a key marker for successful treatment, prevents HIV-related illness and optimizes health. Sustained treatment also reduces the potential for onward HIV transmission in the community.

1. Statistical Data on HIV in Canada

HIV diagnoses in 2015 increased from 2014

According to PHAC's 2015 surveillance data,[5] which is the most recent data available, there were 2,096 new cases of HIV diagnosed in Canada in 2015, up 2.2% from the 2,051 diagnosed in 2014. Ontario reported the highest number of cases, followed by Quebec, British Columbia and Alberta.

The most significant increases in HIV diagnoses in 2015 were among those aged 25 to 29

Females made up 24.1% of HIV cases in 2015, down slightly from 24.3% reported in 2014. Youth aged 15-24 represented 10.8% of cases in 2015, down from 11.4% in 2014. The largest increases with respect to the proportion of HIV diagnoses by age group were among those aged 25-29, up from 11.8% in 2014 to 15.8% in 2015, and those aged 50 years and older, up from 21.9% in 2014 to 23.9% in 2015.

The most common exposure category in 2015 was men who have sex with men (MSM), followed by heterosexual contact

In 2015, the exposure categories (also known as risk factors) reported among adults (i.e., older than 15 years) who were diagnosed with HIV were as follows:

- men who have sex with men (MSM) (45.1%);
- heterosexual contact (31.9%); and,
- injection drug use (16.3%).

Among males, the MSM category accounted for 59.7% of cases, followed by heterosexual contact at 21.4% and injection drug use at 12.5%. Among females, heterosexual contact accounted for 64.4% of cases, and injection drug use accounted for 27.9%.

In 2015, 45.6% of cases were reported as "White," followed by 18.7% as "Black" and 17.5% as "Indigenous". There were 232 infants perinatally exposed to HIV in 2015; three of these infants were confirmed to be HIV-infected.

Persons from countries where HIV is endemic continue to be over-represented among those living with HIV in Canada

According to PHAC's 2014 HIV estimates,[6] in 2014, an estimated 358 new infections (range: 250-470) involved heterosexual contact among people born in HIV-endemic countries (primarily countries in sub-Saharan Africa and the Caribbean). This category accounted for 13.9% of new infections in Canada in 2014, although people born in HIV-endemic countries represented approximately 2.5% of the overall Canadian population. The HIV incidence rate for this population was 6.3 times higher than the rate for other Canadians.

Indigenous people continue to be over-represented among those living with HIV in Canada

According to PHAC's 2014 HIV estimates,[7] in 2014, an estimated 278 new HIV infections (range: 200-360) occurred among Indigenous people, which represented 10.8% of all new infections in 2014. By contrast, Indigenous people represent approximately 4.3% of the total Canadian population. This 2014 estimate is slightly lower than the estimate for 2011, which was 349 (range: 250-450) new infections and 12.5% of all new infections. The HIV incidence rate for Indigenous people was 2.7 times higher than the non-Indigenous Canadian population in 2014. Nearly half (45.3%) of these new infections were attributed to injection drug use, followed by heterosexual contact (40.3%), MSM (10.4%) and a combination of injection drug use and MSM (4.0%).

2. Onward Transmission by Persons whose HIV is Undiagnosed vs. Diagnosed

U.S. data indicate that persons who are diagnosed but not treated were responsible for the majority of new infections in 2009

Canada does not have national data on the rate of onward transmission by persons whose HIV is diagnosed vs. undiagnosed. However, a 2015 U.S. study found that persons who were infected but undiagnosed (18.1% of the total HIV-infected population) were responsible for 30.2% of the estimated total number of HIV transmissions in the U.S. in 2009, and persons who were diagnosed but had not received medical treatment were responsible for 61.3% of those transmissions.[8]

Québec data indicate that early HIV infections accounted for half of onward HIV transmissions in 2007

In 2007, researchers in Québec published the results of a study indicating that early HIV infections, i.e. occurring less than 6 months after the development of detectable antibodies to HIV in the blood as a result of infection (i.e., seroconversion), accounted for 49% of onward transmissions of HIV in an urban setting.[9] Early HIV infections are often undiagnosed.

3. Mortality Rates from HIV/AIDS

HIV-related deaths have been steadily declining

Based on the most recent Vital Statistics available, there were 241 deaths from HIV infection in Canada in 2013. The data reflects a steady decline in deaths from HIV infection since 2009; there were 276 deaths from HIV in 2012, 306 in 2011, 336 in 2010 and 355 in 2009.[10] However, there are several limitations associated with the use of vital statistics data to estimate HIV-related deaths, including delays in reporting and under-reporting.[11]

Furthermore, researchers have recently found that, among persons receiving antiretroviral therapy in British Columbia, there were significant decreases in HIV-related deaths between 2001-2002 and 2011-2012 (down from 2.34 per 100 person-years[12] in 2001-2002 to 0.56 per 100 person-years in 2011-2012).[13]

4. HIV Testing Rates

HIV testing rates have increased since 1996

Although national HIV testing rates are not available, the British Columbia Centre for Excellence has reported an overall increase in HIV testing from 2009 to 2014 in the province of British Columbia (3674.3 to 5942.7 tests per 100,000 population, an increase of 61.7%).[14] In other provinces that have published their HIV testing rates, an overall increase in HIV testing has also been reported, for example, in Saskatchewan from 2006 to 2015 (42,955 tests to 72,659 tests, an increase of 69.2%),[15] in Ontario from 1996 to 2012 (2520.0 to 3230.0 tests per 100,000 population, an increase of 28.2%),[16] and in Québec from 2005 to 2014 (3,655 to 4,056 tests per 100,000 population, an increase of 11.0%),[17] although the increase was less pronounced in Québec than in other provinces.

5. The Impact of HIV and HIV Treatment

HIV has significant implications for the health and well-being of those infected

Persons living with HIV can be affected by a range of medical conditions related to their HIV infection, including illnesses related to AIDS, treatment side effects, and HIV-associated non-AIDS conditions. PHAC has described the following impacts:[18]

- In the absence of antiretroviral treatment, HIV infection will progress to AIDS, which is defined by the presence of one or more of a list of "AIDS-defining illnesses," such as certain types of cancers (e.g., lymphoma or cervical cancer), tuberculosis and wasting syndrome. However, advances in treatment have rendered progression to AIDS far less common in Canada with proper adherence to antiretroviral medications.

- Despite the advances made in HIV treatment, there is still a significant impact on life expectancy and, although there has been a dramatic decline in AIDS mortality since 1996, deaths from AIDS continue to occur.

- Co-morbidities, i.e., the presence of one or more diseases in addition to HIV, can present challenges in treating and managing both the HIV and the co-morbidities. Persons living with HIV who are on antiretroviral medication experience higher rates of certain diseases, including cardiovascular disease, diabetes, bone loss, and certain cancers.

- Co-infections with other illnesses with a shared transmission route or increased susceptibility due to lower immune response may also pose health problems for persons living with HIV, including elevated morbidity and mortality. Common co-infections in Canada include tuberculosis and STBBIs such as hepatitis B, hepatitis C and syphilis. The presence of HIV can significantly impair the ability of the immune system to stave off co-infections while the presence of many STBBIs can increase vulnerability to, or the infectiousness of, HIV.

- For many, HIV is an episodic disability, which means that periods of good health can be interrupted by unpredictable periods of ill health and disability. Disability includes: physical and mental challenges, such as pain, fatigue, and/or decreased memory; difficulties with day-to-day activities, such as walking or climbing stairs; and, limitations on social participation, such as difficulty working or participating in social activities. Some may have chronic, long-term disabilities, but many HIV-related disabilities come and go, without following a clear pattern of duration or severity. However, new HIV treatments are resulting in considerable improvements in symptom management and quality of life for people living with HIV, whereby periods of disability may be significantly less common for those accessing early treatment.

- Mental health can affect vulnerability to HIV infection, and mental health conditions can result from HIV disease, HIV treatment side effects or a combination of both. HIV may be associated with depressive disorders, neurocognitive disorders, psychological problems and post-traumatic stress disorder. Diagnosing mental health disorders in the context of HIV is an ongoing challenge, complicated by the complex biological, psychological, and social factors associated with HIV. Mood disorders, particularly depression, are the most common psychiatric complication associated with HIV disease. Depression is in itself a risk factor for mortality, even for people living with HIV on treatment, and can influence their ability to adhere to treatment.[19]

Transmission of HIV may be prevented by post-exposure prophylaxis

Post-exposure prophylaxis (PEP) is a prevention intervention which consists of administering a combination of antiretrovirals within 72 hours of HIV exposure and continuing daily treatment for four weeks. PEP can be used for occupational exposures when people are exposed in the workplace to bodily fluids that may contain HIV (for example, a healthcare worker who accidently suffers a needle-stick injury). PEP can also be used after exposure to HIV in other situations (non-occupational exposure) to reduce the chances of infection, such as after condomless sex, a condom breaking during sex, needle sharing or sexual assault.[20] PEP reduces the risk of HIV transmission by over 80%.[21]

However, there are a number of challenges for patients that may limit completion of currently available PEP regimens. These include pill burden from having to take up to 4 pills per day, taking pills more than once daily, cost, and toxicities. PEP has been associated with side effects such as nausea/vomiting, diarrhea, headache, and fatigue/weakness. Clinical trials from different countries have demonstrated better tolerability, completion rates, and fewer drug–drug interactions with newer antiretroviral agents.[22]

HIV is now considered a chronic yet manageable illness, largely due to antiretroviral medication

There has been a significant and progressive increase in life expectancy and decrease in mortality among persons living with HIV who have been treated with antiretroviral medication (ART), also known as "highly active antiretroviral therapy" (HAART) or "combination antiretroviral therapy" (cART). The increased availability and uptake of ART has been associated with improved virological outcomes, decreased drug-resistance and dramatic reductions in the incidence of AIDS-defining illnesses.

Various challenges are associated with treatment

In one study, which looked at the effects of antiretroviral therapy on quality of life, persons living with HIV viewed treatment as a trade-off between diminished quality of life and extended longevity. They identified issues such as the consequences of side effects, including impacts on self-esteem, social and sexual health, and the impact of drug toxicities. Other negative factors identified included tensions with health care workers, loss of independent decision making, disincentives to returning to work, the burdens of taking medication and the stress of hiding their HIV positive status.

Treatment in Canada is publicly available through PT health systems

Most persons living with HIV access treatment, care and support. However, not all persons living with HIV in Canada can or do access recommended treatment. The decision of when to begin treatment involves weighing a number of important considerations. Once treatment is commenced, patients are advised to remain on treatment for the remainder of their lives. A number of personal and social barriers may impact the ability and willingness of persons living with HIV to follow treatment when it is recommended by a doctor.

A variety of factors influence treatment success

Persons living with HIV must take their medications daily; treatment interruptions will impact effectiveness, cause viral loads to increase and may result in drug resistance. Patients may also respond differently to various treatment regimens and deferred or delayed uptake of treatment has an impact on mortality. Significantly, food insecurity, where access to nutritionally adequate food is limited or unstable, has been associated with treatment interruptions, poorer treatment outcomes and HIV-related mortality.

Treatment regimens can cause side effects

Side effects of treatment can negatively impact health and quality of life. It may be difficult to distinguish whether health problems and symptoms experienced by persons living with HIV are caused

by HIV medications or HIV infection itself. In many cases, these health challenges may be a result of both treatment side effects and HIV infection. Side effects of HIV treatment vary between patients and between antiretroviral medication regimens. While some patients experience severe side effects from treatment, others may observe mild to no adverse reactions. Reported side effects include: loss of appetite; nausea and vomiting, digestive problems such as diarrhea and gas; fat redistribution; cardiovascular problems including strokes, heart attack; insulin resistance and diabetes; bone problems including bone death; liver problems; pancreatitis; skin problems; muscle and joint pain and muscle weakness; headaches; and mental health challenges such as depression and anxiety. Nonetheless, treatment has substantially improved the lives of persons living with HIV despite the negative impact of side effects on some.

Late HIV testing/diagnosis contributes to longer periods of time where HIV may be unknowingly transmitted and is associated with higher rates of morbidity/mortality

During the early stages of infection, there is a higher risk of HIV transmission, as the newly infected person has a higher viral load during this period. Those who are recently infected are more likely to be undiagnosed and may continue to engage in risk behaviours, while those who have knowledge of their infection are more likely to take active measures to prevent transmission to others. Furthermore, early detection and treatment of HIV contributes to improved health outcomes for the individual.

PART B: HIV TRANSMISSION RISKS AND SEXUAL ACTIVITY

PHAC has performed a comprehensive synthesis of the currently available medical science on sexual HIV transmission [23] to determine the risk of sexual transmission between serodiscordant partners (i.e., one individual is HIV positive and the other is HIV negative), when one or more of the following are in place: HIV treatment (i.e., antiretroviral therapy or ART), a suppressed level of HIV in the blood (due to effective treatment), and/or male condom use.

Sexual transmission of HIV requires that: (1) there is a source of infection; (2) there is a means for transmission to occur; (3) there is a host who can get the infection; (4) there is a way for the virus to get to the cells in the host's body; and, (5) there is enough virus delivered to the host to start an infection.[24] The Canadian AIDS Society (CAS) uses two factors to classify the level of HIV transmission risk associated with an activity: (1) whether transmission could occur based on the five conditions above; and (2) whether there is known evidence that transmissions have occurred due to the activity. These criteria are used to classify risks as:

- **no risk** (no potential for HIV transmission; no confirmed transmission);
- **negligible risk** (potential for HIV transmission though efficiency greatly diminished; no confirmed transmission)**;**
- **low risk** (potential for transmission; few reports of transmission under specific conditions); and,
- **high risk** (potential for transmission; repeatedly associated with transmissions in scientific studies).[25]

The following conclusions can be drawn from the 2017 evidence synthesis prepared by PHAC:

Sexual activity with an HIV positive person poses a negligible risk of transmission where that person is taking HIV treatment as prescribed and has maintained a suppressed viral load based on consecutive tests done every four to six months

In cases involving sexual activity between HIV-serodiscordant partners, the risk of HIV transmission is **negligible** where:

- The partner living with HIV takes their treatment consistently, and has a viral load less than 200 copies per ml of blood (i.e., a suppressed viral load) on consecutive tests done every four to six months.
    - This is true whether a condom is used or not, and regardless of the sexual activity at issue;
    - Studies found zero transmissions under these conditions, though a statistical risk of 0.00-0.28 transmissions per 100 person-years[26] could not be ruled out.

Sexual activity with an HIV positive person poses a low risk of transmission where that person is on HIV treatment but has not achieved a suppressed viral load

In cases involving sexual activity between HIV-serodiscordant partners, the risk of HIV transmission is **low** where:

- The partner living with HIV is taking treatment but does not have a suppressed viral load less than 200 copies per ml of blood on consecutive tests done four to six months apart.
    - This is true regardless of the sexual activity at issue;
    - Absolute risk is estimated to be 0.14-0.33 transmissions per 100 person-years;[27]
    - Adding the use of a condom in this scenario is likely to give additional protection against HIV transmission, but the risk would still be classified as low;
    - There is insufficient evidence to estimate HIV transmission risk for oral sex when ART (with variable viral load) and condoms are used together.

Sexual activity with an HIV positive person poses a low risk of transmission where that person is not on HIV treatment but a condom is used

In cases involving sexual activity between HIV-serodiscordant partners, the risk of HIV transmission is **low** where:

- The partner living with HIV is not taking treatment but condoms are used consistently during sex.
    - Absolute risk is estimated to be 0.56-2.04 transmissions per 100 person-years.[28]

The United States Center for Disease Control and Prevention has estimated the risk associated with oral sex as follows:

Oral sex with an HIV positive person poses a low risk of transmission

The risk of oral sex (without a condom or use of ART) is low but non-zero (approximately 0-4 transmissions per 10,000 exposures).[29]

- While many studies have been unable to observe transmissions due to oral sex, there are confirmed reports of transmission in others.[30]
- Risks associated with oral sex are higher if the HIV positive individual is receiving oral sex, and if ejaculation occurs. When the tissue in the mouth of the HIV-negative individual is damaged (e.g., open cuts or sores, or recent dental work), the risk of transmission is also increased.[31]

Important factors to consider:

- A negligible risk does not mean zero risk; a theoretical possibility of transmission cannot be ruled out based on the scientific data.
- In the studies examined, most participants on ART took their medication very consistently, and regularly had their viral loads tested, which allowed many of them to achieve and maintain a very low viral load. Taking medication consistently is extremely important for achieving and maintaining a viral load less than 200 copies per ml of blood.
- When consecutive viral load tests done every four to six months show less than 200 copies per ml of blood, this likely means there is sustained viral load suppression. However, it is not possible to know the viral load on a continuous basis. It is therefore important for health care providers and people living with HIV to understand factors that may result in their viral load going back above 200 copies per ml of blood (referred to as virological failure), such as: not taking medication consistently or correctly, having a drug resistant virus, drug and/or alcohol abuse, and previous HIV medication history (e.g., types of medications taken in the past, and whether past treatments have been successful in reducing the viral load).[32]
- Latex condoms create an impermeable physical barrier to HIV and other STIs[33], but a potential for transmission remains due to breaks, slips, leaks, and other incorrect use that may occur; it is not possible to know prior to a sexual encounter whether perfect or correct use versus condom failure may happen.
- The risks associated with oral sex under protective scenarios (e.g., when ART and/or condoms are used) are difficult to determine. However, they would not be expected to be higher than the risks for other acts.
- Although sex is the primary mode of HIV transmission in Canada,[34] the risk of transmission for a single act (even without condoms or ART) is lower than is often thought. Although PHAC did not examine unprotected risks in their evidence synthesis, other groups have estimated risk for a variety of unprotected acts. According to modelled estimates, risk ranges from 4-138 transmissions per 10,000 sex acts, depending on the act (see Table 1 below), suggesting that HIV is transmitted relatively inefficiently by sexual means. These small risks for individual acts are however cumulative, such that risk rises with the number of acts performed.

Table 1. Modelled per-act risks of HIV transmission for unprotected (i.e., without condoms or ART) sexual acts

Sexual act	**HIV transmissions per 10,000 acts (95% confidence interval**)**
Receptive anal intercourse	138 (102-186)
Insertive anal intercourse	11 (4-28)
Receptive vaginal intercourse	8 (6-11)
Insertive vaginal intercourse	4 (1-14)
Performing penile-oral intercourse	Low but non-zero (0-4)
Receiving penile-oral intercourse	Low but non-zero (0-4)

Adapted from: Patel P, Borkowf CB, Brooks JT, Lasry A, Lansky A, Mermin J. Estimating per-act HIV transmission risk: A systematic review. AIDS. 2014;28(10):1509-1519. ** The 95% confidence interval indicates the range within which we would expect the results to fall 19 times out of 20, if a study were repeated many times over.

PART C: THE CRIMINAL LAW AND HIV NON-DISCLOSURE

The focus of this report is on the criminal justice system's response to HIV non-disclosure cases. Other HIV-related cases were also examined, such as cases involving forced sexual activity where transmission of HIV, or exposure to it, is an aggravating factor for sentencing purposes, as well as spitting, needle stick and other types of assaultive conduct aggravated by transmission, or the risk of transmission, of HIV. However, these types of cases raise different legal and policy issues, given that the precipitating conduct itself (e.g., forced sexual activity, spitting, needle sticks etc.) constitutes an assault.

In HIV non-disclosure cases, the criminal law applies where a person, who knows they are HIV positive and infectious, transmits HIV to others or exposes others to a realistic possibility of HIV transmission without affording their sexual partner the opportunity to choose whether to assume that risk. In Canada, a range of *Criminal Code* offences have been applied in HIV non-disclosure cases, depending on the facts of the case, including criminal negligence causing bodily harm (section 221), and common nuisance, (section 180).[35] Courts have found that a complainant's consent to sexual activity may be vitiated by fraud if the accused misrepresented or failed to disclose their HIV status. In such circumstances, the assault (sections 266 to 268) or sexual assault (sections 271 to 273) offences have been applied; most HIV non-disclosure cases have involved aggravated assault or aggravated sexual assault charges, given the serious health consequences posed by HIV/AIDS. These offences may also apply in cases involving other sexually transmissible infections (STIs), although most of the STI cases that come to the attention of law enforcement concern HIV. The *Criminal Code* contains no HIV or other infection-specific offences.

The Supreme Court of Canada (SCC) has considered HIV non-disclosure on four occasions, i.e., in 1998 (*Cuerrier*), 2003 (*Williams*) and 2012 (*Mabior* and *D.C.*, companion cases that were decided at the same time). *Cuerrier* establishes the test that determines when fraud vitiates consent for the purposes of the assault and sexual assault offences in HIV non-disclosure cases, *Mabior* further refines this test and *Williams* addresses when a person may be convicted of attempted aggravated assault/sexual assault in HIV non-disclosure cases. The *Cuerrier* and *Mabior* decisions also address important policy considerations that provide guidance on the SCC's intended scope of the law in this context.

This Part discusses the law establishing when fraud vitiates consent to sexual activity in HIV non-disclosure cases with reference to the relevant SCC jurisprudence, as well as to post-*Mabior* jurisprudence interpreting it. It also includes a discussion of the SCC's policy considerations in developing the law in this context, as well as both a quantitative and qualitative analysis of reported HIV non-disclosure case law from 1998, when the SCC handed down its *Cuerrier* decision, to April 2017.

1. Fraud Vitiating Consent in HIV Non-Disclosure Cases

The SCC's *Mabior* decision establishes that persons living with HIV have a duty to disclose their HIV status prior to sexual activity that poses a "realistic possibility of transmission." This legal test determines when non-disclosure or misrepresentation of HIV status (i.e., fraud) vitiates consent to sexual activity. In other words, the legal test determines when the law will not recognize the HIV negative partner's consent to sexual activity with an HIV positive partner who has not disclosed their

status. The SCC also found that future advances in HIV treatment should be taken into account when applying this test. Although courts have come to differing conclusions about when that test may be met post-*Mabior*, the most recent medical science on HIV transmission, summarized in Part B of this report, is relevant to that determination. These and other considerations are discussed below.

The criminal law imposes a duty to disclose HIV positive status prior to sexual activity that poses a "realistic possibility of transmission" of HIV

In its 1998 *Cuerrier* and 2012 *Mabior* decisions, the SCC established that consent to sexual activity will be vitiated by fraud under paragraph 265(3)(c)[36] of the *Criminal Code* for the purposes of the assault and sexual assault offences where:

- the accused does not disclose, or misrepresents, their HIV status;
- the sexual activity in question causes, or poses a significant risk of, serious bodily harm; and,
- the complainant would not have consented to the sexual activity had they known of the accused's HIV positive status.[37]

Where HIV transmission occurs in this context, serious bodily harm has been established[38] and consent to the sexual activity that resulted in HIV transmission is vitiated.

Where HIV transmission does not occur in this context, a significant risk of serious bodily harm is established by a "realistic possibility of transmission" of HIV.[39] If a realistic possibility of HIV transmission is established, consent to the sexual activity that resulted in exposure to risk is vitiated.

The accused must know both that they are HIV positive and that they are at risk of transmitting HIV to others. Evidence that the accused has received counselling from a medical practitioner about that risk is usually sufficient to show knowledge of infectiousness.

The law is clear, therefore, that persons living with HIV must disclose their HIV positive status before engaging in sexual activity that poses a realistic possibility of HIV transmission in order to avoid criminal liability.

A "realistic possibility of transmission" is negated where viral loads are low and condoms are used
On the basis of the medical evidence before the SCC in 2012, in *Mabior*, the Court found that a realistic possibility of transmission is negated by evidence that the accused's viral load was low or undetectable at the time of the sexual activity in question and condom protection was used, which is a finding of fact. Consistent with that finding, the Court also found that evidence of non-disclosure and sex without a condom establishes the Crown's case on a *prima facie* basis. At that point, "a tactical burden"[40] may fall on the accused to raise a reasonable doubt as to whether the realistic possibility of transmission test was met, e.g., by calling expert evidence as to the degree of risk posed by the sexual activity in question.

The SCC also expressly acknowledged that advances in medical treatment of HIV may narrow the circumstances in which there is a duty to disclose HIV positive status. The general proposition that a low viral load and condom use together do not give rise to a duty to disclose does not preclude the common law from adapting to future advances in treatment or to circumstances where risk factors other than those considered by the SCC are at play.[41]

Courts have come to differing conclusions on when the realistic possibility of transmission test is met
In its 2013 *Felix* decision, the Ontario Court of Appeal upheld the accused's conviction for aggravated sexual assault in an HIV exposure case in circumstances where the accused failed to use a condom and evidence as to transmission risk or viral load was not adduced. The Court found that the accused's actual viral load and the degree of risk posed as a result of his viral load were irrelevant in these circumstances

because unprotected sex and failure to disclose HIV positive status had been established.[42] In its 2013 *Murphy* decision, the Ontario Superior Court of Justice, following *Felix*, found another accused guilty of aggravated sexual assault in an HIV exposure case in circumstances where the accused engaged in one act of unprotected sexual intercourse and the medical evidence adduced at trial showed that her viral load was extremely low, i.e., under 50 copies per ml of blood, as a result of treatment taken over the previous 10 years.[43] The realistic possibility of transmission test was found to have been met in these circumstances because unprotected sex and failure to disclose HIV positive status had been established.

In contrast, Nova Scotia case law has found the realistic possibility of transmission test not to have been met in circumstances involving unprotected sex and low viral loads. For example, in its 2013 *JTC* decision, the Nova Scotia Provincial Court acquitted an accused in an HIV exposure case involving unprotected vaginal intercourse where his viral load was under 500 copies per ml of blood. Expert evidence adduced at trial indicated a very low risk of HIV transmission in these circumstances, which was found to have negated the realistic possibility of transmission test.[44] The court held that the SCC's factual finding in respect of low viral load and condom use does not preclude courts from considering expert evidence indicating low HIV transmission risks in other circumstances, including in cases involving unprotected sex. In its 2016 *Thompson* decision, the Nova Scotia Supreme Court made a similar finding, citing *JTC*.[45] In this case, although the court found that the realistic possibility of transmission test was negated by expert evidence indicating a very low risk of transmission, the accused was convicted of sexual assault causing bodily harm (section 272) for HIV exposure. The psychological harm experienced by the complainants was considered to be sufficient to vitiate their consent. This case has been appealed.[46]

Since April 2017 when this report's case law review concluded, a new HIV non-disclosure case[47] has been reported, i.e., the Ontario Court of Justice's August 2017 *C.B*. decision, which comes to the same conclusion as did the Nova Scotia case law noted above. In this HIV exposure case involving unprotected sexual intercourse and a very low viral load (i.e., under 60 copies per ml of blood),[48] the Ontario Court of Justice acquitted the accused of aggravated sexual assault. Citing the SCC's *Mabior* and the Ontario Court of Appeal's *Felix* decisions, the court held that proof of low viral load and condom use is not the only way to negate the realistic possibility of transmission test. Medical evidence adduced in this case indicating a very low risk of HIV transmission was found to have raised a reasonable doubt.[49]

There is lack of agreement on which offences may apply in HIV non-disclosure cases

Although a range of offences have been applied in HIV non-disclosure cases, including in the cases decided by the SCC,[50] the Court noted, in *obiter*, in its 2012 *Mabior* decision that aggravated sexual assault is the "operative offence" in HIV non-disclosure cases because HIV endangers life.[51] Some have interpreted this statement as a direction to use aggravated sexual assault in all HIV non-disclosure cases, while others take the view that this statement was not intended to fetter prosecutorial discretion in respect of which charge to lay or offence to prosecute.[52]

2. Public Policy Considerations in the SCC Jurisprudence

In its 1998 *Cuerrier* and 2012 *Mabior* decisions, the SCC considered the common law on fraud vitiating consent, the legislative history of the provision specifying that fraud may vitiate consent, and the role of the *Charter of Rights and Freedoms (Charter)* in interpreting it, including numerous matters of public policy. These considerations provide an indication as to the type of HIV non-disclosure cases envisaged by the SCC to demonstrate sufficient culpability to merit the application of the criminal law, along with

its attendant consequences. The SCC's observations in this regard illustrate the complex and sometimes competing interests that the Court was attempting to balance. For example, the Court notes the following:

- Where public health interventions have failed, the criminal law has a role to play in deterring persons living with HIV from putting others' lives at risk and in protecting the public from those who refuse to abstain from high risk activities.[53]
- The relevant legal test in HIV non-disclosure cases should be interpreted in light of the *Charter* values of equality, autonomy, liberty, privacy and human dignity, which require respect for sexual partners as autonomous, equal and free persons with the right to refuse sexual intercourse.[54] The law must strike a balance between these interests and "the need to confine the criminal law to conduct associated with serious wrong and harms."[55]
- Subjecting HIV positive persons who act responsibly and pose no risk of harm to others to the criminal law "is arguably unfair and stigmatizing to people with HIV, an already vulnerable group." Such persons "should not be put to the choice of disclosing their disease or facing criminalization."[56]
- The bar for criminal liability must not be set too high or too low. A standard of any risk arguably sets the threshold for criminal conduct too low; whereas, limiting the criminal law to cases where the risk is high "might condone irresponsible, reprehensible conduct."[57]

3. Quantitative Analysis of Reported HIV-Related Cases (1998 to April 2017)

All reported HIV-related cases in Canada from 1998 to April 2017, including HIV non-disclosure cases, were reviewed to illustrate the types of HIV-related cases that come to the attention of law enforcement, how HIV non-disclosure cases are situated within this context, as well as the nature of HIV non-disclosure cases generally. That information is provided below:

- Ninety (90) reported HIV-related cases[58] from 1998 to April 2017, were identified. Of these 90 cases:
    - 59 involved HIV non-disclosure (66%);
    - 17 involved non-sexual contact (19%); and,
    - 14 involved forced sexual contact (16%).
- Of the 59 HIV non-disclosure cases, 45[59] resulted in findings of guilt (76%):
    - 22 of the 45 findings of guilt were the result of a trial;
    - 22 of the 45 findings of guilt were the result of a guilty plea; and,
    - One of the 45 findings of guilt involved both a guilty plea to some charges and a trial on others.

- Of the convictions per count charged (some cases involved multiple charges):
    - 72% were for aggravated sexual assault;
    - 15% were for other offences, such as attempted murder, administering a noxious thing or common nuisance; and,
    - 13% were for aggravated assault.
- Of the 45 HIV non-disclosure cases that resulted in a conviction:
    - 19 cases involved transmission of HIV to at least one victim (42%); and,
    - 26 involved exposure to risk of transmission (58%).
- Of the 45 HIV non-disclosure cases that resulted in a conviction:
    - 36 involved male offenders and female victims (80%);
    - 5 involved female offenders and male victims (11%); and,
    - 4 involved male offenders and male victims (9%).

*Where described by the court, the nature of the sexual acts included vaginal, anal, and oral sexual contact.

Sentencing information was available in 43 cases. Four cases involved non-custodial sentences (one absolute discharge and three conditional sentences). The remaining 39 cases involved the following periods of imprisonment:

- 1 day to 2 years less a day (7 cases or 18%);
- 2 to 5 years less a day (12 cases or 31%);
- 5 to 7 years less a day (7 cases or 18%);
- 7 to 10 years less a day (4 cases or 10%);
- 10 to 15 years less a day (6 cases or 15%);
- 18 years (2 cases or 5%); and
- Life imprisonment and dangerous offender designation (1 case or 3%).

4. Qualitative Analysis of Reported HIV Non-Disclosure Cases (1998 to 2017)

A qualitative analysis of reported HIV non-disclosure cases decided since the SCC's 1998 *Cuerrier* decision (59 cases) shows that HIV non-disclosure cases involve a broad range of blameworthy conduct. For example, according to the case law, factors indicating a higher level of culpability include:

- Failure to comply with public health interventions;[60]
- Specific intent to infect others or consciously placing others at risk of infection;[61]
- Continuing non-disclosure of HIV;[62]
- Deliberate non-use of antiretroviral medication;[63]
- Transmission of HIV;[64]
- Active misrepresentation of HIV positive status;[65]
- Absence of remorse;[66] and,
- Vulnerability of complainants, for example due to youth or cognitive impairment.[67]

And factors indicating a lower level of blameworthiness include:

- Reckless conduct;[68]
- Difficult life circumstances;[69]
- Spontaneous or "one-off" sexual acts without disclosure, as opposed to an ongoing pattern of risky behavior;[70]
- Remorse;[71]
- Compliance with the efforts of authorities to address any risks posed by the accused to others;[72]
- Use of condoms;[73] and,
- Evidence that the accused was abused by the complainant.[74]

Generally, cases involving high levels of blameworthiness tend to involve a pattern of conduct that routinely places numerous, and often vulnerable, complainants at a high level of risk, which indicates intention to transmit HIV. Such cases often involve conduct that shows a complete disregard for public health interventions and the well-being of others for the sole purpose of achieving sexual gratification. These cases may involve transmission of HIV to some, but not all, of the complainants or, in some cases, no transmission, despite the high risk behavior of the accused. HIV non-disclosure cases reflecting factors that indicate higher levels of blameworthiness tend to involve male accused and female complainants.

Cases involving lower levels of blameworthiness generally involve spontaneous or isolated sexual acts where the accused has not turned their mind to the risk posed, sometimes as a result of difficult life circumstances, which in some cases explain their contraction of HIV in the first place. Case law refers to such conduct as reckless, as opposed to intentional. HIV non-disclosure cases reflecting factors that indicate lower levels of blameworthiness tend to involve Indigenous and female accused.

Notably, some cases involve factors that indicate both higher and lower levels of blameworthiness: for example, transmission of HIV but in the context of difficult life circumstances that may have resulted in a lack of, or reduced, access to health care and other services.

PART D: STAKEHOLDER PERSPECTIVES AND RECOMMENDATIONS

This Part provides an overview of criminal law and public health policy considerations, as well as recommendations concerning the criminalization of HIV non-disclosure, as expressed by stakeholders, including legal academics, social scientists, organizations that represent persons living with HIV and international organizations. The concerns identified by stakeholders with respect to Canada's criminal law approach to HIV non-disclosure and its impact on public health efforts include:

- Treating all HIV non-disclosure cases involving a "realistic possibility of transmission"[75] as aggravated sexual assault has led to the over-criminalization of persons living with HIV. Courts have found that the legal test is met even in cases involving the "slightest possibility of endangerment," where HIV is not transmitted, resulting in persons living with HIV being convicted of, or charged with, Canada's most serious sexual offence for failing to disclose their HIV status;[76]

- The relevant SCC jurisprudence failed to explore the possibility of treating exposure cases less severely.[77] Canada's approach to HIV non-disclosure cases is exceptionally punitive,[78]

particularly toward persons who have no intent to, and do not, transmit HIV to their sexual partner;[79]

- The existing criminal law fails to reflect medical and scientific advances in HIV treatment, which have significantly reduced risk of HIV transmission, also resulting in over-criminalization;[80]
- HIV is treated in an exceptional way by the criminal justice system compared to other transmissible diseases (e.g., hepatitis B, C and human papillomavirus).[81] Prosecutions for non-disclosure of HIV appear disproportionate and discriminatory given their relatively high number in comparison to prosecutions for non-disclosure of other transmissible diseases.[82]
- Using the sexual assault framework in cases of HIV non-disclosure is inappropriate, since cases involving consensual sexual activity and HIV non-disclosure are fundamentally different from forced sexual assaults;[83]
- Canada's criminal law approach to HIV non-disclosure increases stigmatization of, and discrimination against, marginalized persons, including Indigenous persons and racialized populations, such as Black Caribbean and African persons, who are disproportionately represented among persons living with HIV;[84]
- Participants in the criminal justice system lack knowledge about HIV generally, and the most recent medical science on HIV transmission in particular, which increases stigmatization;[85]
- Criminalization of HIV non-disclosure negatively impacts public health efforts since fear of prosecution may discourage persons living with HIV from seeking testing, counselling and education, and obtaining treatment, which could exacerbate HIV transmission;[86]
- Fear of prosecution may also discourage persons living with HIV from disclosing their status immediately after potential exposure (e.g., after condom breakage), thereby preventing the HIV negative sexual partner from obtaining post-exposure prophylaxis treatment if desired;[87] and,
- Media releases of HIV-related prosecutions negatively impact public health initiatives, such as HIV testing and de-stigmatization messaging.[88]

Stakeholders have made a number of recommendations that address some of the concerns noted above. These include:

Public health responses should be exhausted before pursuing a criminal law response
The criminal law should only be used in limited circumstances for the most blameworthy conduct, where public health measures have been exhausted and have failed to change the behaviour of persons who engage in a pattern of non-disclosure that exposes others to risk.[89] Coercive public health interventions could form part of the response in cases where a person living with HIV has access to the tools needed to prevent HIV transmission, but nonetheless engages in behaviour that poses a significant risk.[90]

Criminal justice responses, where appropriate, should involve public health authorities
A coordinated public health and criminal justice response could result in provision of services to those engaged in risky behaviours and, as a result, fewer cases being prosecuted; however, some public health officials view such collaboration with caution because they may not support a punitive response.[91]

Criminal liability should be limited to intentional transmission of HIV
The use of the criminal law should be restricted to cases involving deliberate transmission of HIV[92] or cases where a person acts purposefully, with conscious or "malicious" intent to transmit HIV.[93]

The criminal law should be applied to reckless conduct and exposure cases with caution
Jurisdictions that criminalize reckless conduct should narrowly define recklessness as "conscious disregard" of a "significant risk" of HIV transmission.[94] Furthermore, the use of the criminal law should be exceptional in exposure cases, require proof of an appropriate culpable mental state (i.e., an intent to transmit), and be limited to circumstances where there was a "significant risk" of HIV transmission, as defined by the most recent medical science.[95]

The scope of the criminal law should be informed by the best available scientific and medical evidence
The most recent medical and scientific evidence on HIV transmission risk must be the basis for determining if and when conduct should attract criminal liability.[96] Criminal liability should not result where condoms were used effectively, other forms of safer sex were practiced (e.g., oral sex), or the person living with HIV was on effective HIV treatment or had a low viral load.[97]

Criminal offences of general application should be used and their elements should be clearly defined
HIV-specific offences violate international human rights standards and should be avoided;[98] only offences of general application should apply to those exceptional cases involving intentional HIV transmission and elements of foreseeability, intent, causality and consent should be clearly defined in law.[99]

Non-sexual offences should be used in HIV non-disclosure cases
Similar to the approach in the UK,[100] police should lay, and prosecutors should pursue, charges for offences that do not include a sexual element,[101] such as nuisance, criminal negligence, and assault.[102] These offences would provide prosecutors with greater flexibility to ensure both protection of the public and fairness to the accused and the complainant, through a wider range of resolution and sentencing options.[103] Such an approach would also not result in registration in the National Sex Offender Registry.[104]

Prosecutorial guidelines should be developed
Clear prosecutorial guidelines should be developed in every province and territory in Canada to address the risk of over-criminalization,[105] curb arbitrary laying of charges, and achieve improved interaction between public health, criminal law and community-based organizations.[106] As in the UK,[107] guidelines should be developed in consultation with persons living with HIV, experts, service providers, and their development should be informed by the most recent medical science on HIV transmission.[108]

Options for legislative reforms should be explored
Defences related to condom use, low viral loads, and lower risk sexual activity (e.g., non-penetrative and oral sex) should be available to avoid application of the criminal law in cases where persons living with HIV have taken appropriate steps to protect others from infection.[109]

Education of criminal justice system actors is required
Training resources for judges, police, prosecutors, defence counsel and prison staff about HIV transmission and the realities of living with HIV, including the relevant science, the social context, and the impact of prosecution on public health initiatives, should be developed.[110]

Further education on HIV and research on the public health implications of criminalization is required
Additional tools to educate the public and destigmatize HIV/AIDS should be developed in collaboration with community experts, people living with and affected by HIV, the criminal justice system, public health departments, researchers and policymakers.[111] Further areas of research should include: exploring restorative justice approaches and innovative public health case management approaches; studying the underlying social, cultural and behavioral factors contributing to HIV criminalization; and, exploring how criminal justice practitioners understand HIV.[112]

PART E: INTERNATIONAL COMPARISON OF APPROACHES

Criminal law responses to HIV non-disclosure cases vary across the world. Some countries use criminal laws of general application to criminalize both HIV transmission and exposure cases or transmission cases only, while others have enacted HIV-specific criminal offences. Various U.S. states were the first to adopt HIV-specific criminal statutes in 1987, quickly followed by other jurisdictions.[113] Today, some jurisdictions in every region of the world have enacted HIV-specific criminal laws, including over thirty states and 2 territories in the United States.[114] According to a 2012 Background Paper commissioned by UNAIDS, high-income jurisdictions are the most active in prosecuting HIV non-disclosure cases[115] and the United States and Canada account for the majority of reported prosecutions of HIV-related cases based on absolute numbers of convictions, while Sweden and Norway have the highest numbers of known convictions *per capita*.[116]

In addition to reviewing variations in international approaches to HIV non-disclosure generally, the applicable laws of eight liked-minded, common law jurisdictions were reviewed in more depth, given the shared origin of our legal systems: England and Wales, Scotland, New Zealand, the Australian states of Victoria and New South Wales and the U.S. states of Iowa, Colorado and California. Although these jurisdictions take different approaches, the following general observations can be made:

- Most of the jurisdictions reviewed apply non-sexual offences of general application to HIV non-disclosure cases:
    - England and Wales, Scotland, New Zealand, Victoria, New South Wales and Colorado use longstanding offences of general application to address STI non-disclosure cases, including HIV, e.g., offences that prohibit inflicting grievous bodily harm, assault and causing serious injury to another.
    - In 2014, Iowa enacted new HIV-specific offences that apply to intentional transmission of HIV and reckless transmission of, and exposure to, HIV.
    - In 1998, California enacted an offence prohibiting engaging in unprotected sexual intercourse with intent to transmit HIV. However, on February 6, 2017, a Bill was introduced in California's Senate that would repeal this offence and create a new misdemeanor offence prohibiting the transmission of any disease that is determined to have significant consequences for the physical health or life activities of the person infected.

- All of the jurisdictions reviewed criminalize intentional HIV transmission and most criminalize reckless transmission (only California does not specifically criminalize reckless transmission);

- All of the jurisdictions reviewed criminalize HIV exposure, but some more narrowly than others. For example, England and Wales and New South Wales only criminalize HIV exposure where intent to transmit HIV can be proven; in such cases, charges for attempt to inflict grievous bodily harm may be brought in both England and Wales and New South Wales;

- All of the jurisdictions reviewed apply more serious offences that carry higher maximum penalties to cases involving intentional HIV transmission and less serious offences that carry lower maximum penalties to cases involving reckless transmission or exposure;

- Two of the jurisdictions reviewed have issued prosecutorial guidelines:

- In England and Wales, a policy statement and prosecutorial guidelines were developed to instruct prosecutors on the legal and policy considerations that apply when proceeding with a criminal prosecution in STI non-disclosure cases, including HIV.[117] The guidelines require that the Director's Legal Advisor review all charging decisions and provide advice in appropriate cases;
- In Scotland, a similar policy statement sets out guidance on how prosecutors should deal with STI non-disclosure cases, including HIV.[118] Notably, the Scottish prosecution policy specifies that a prosecution should only be contemplated in exposure cases in exceptional circumstances, e.g., where the accused embarks on a flagrant course of conduct, having unprotected sexual intercourse with several partners after failing to disclose their HIV status but, through good fortune alone, fails to transmit HIV.[119] The policy also specifies that there is a very strong presumption against prosecution when the person's viral load is below 50 copies per ml of blood, given the minimal risk of transmission.[120]

PART F: PUBLIC HEALTH RESPONSES TO HIV CASES

This Part provides an overview of public health responses to HIV cases, as described by FPT public health partners in various Canadian jurisdictions,[121] given that HIV is primarily a public health issue. This overview was informed by a review of the relevant PT public health legislation, as well as applicable guidance documents, manuals or protocols, collectively referred to as "guidelines," that assist public health authorities in the exercise of their discretion when handling HIV cases. Information on how HIV cases are reported and managed in Canada, as well as the nature of the relationship between public health authorities and law enforcement when handling HIV non-disclosure cases, is summarized below.

1. Reporting HIV Cases in Canada

PT public health legislation requires reporting of persons with HIV positive test results to public health authorities

The administration and delivery of healthcare services, including those related to communicable diseases, are primarily the responsibility of the PTs.[122] PT public health legislation and corresponding guidelines, where applicable, establish the processes that physicians and other primary care providers must follow when reporting communicable diseases, including HIV, to public health authorities. These processes vary among jurisdictions.

PT public health legislation requires HIV positive test results to be reported to public health authorities.[123] Generally, the testing laboratory and/or responsible healthcare professional, such as the most responsible physician or nurse, must report prescribed information on persons diagnosed with HIV to local public health authorities.[124]

All PTs voluntarily notify PHAC of newly diagnosed HIV positive individuals

All PTs voluntarily notify PHAC by providing non-identifying information on newly diagnosed HIV positive individuals in order to support the production of national level reports on the epidemiology of HIV/AIDS in Canada.[125]

2. Managing HIV Cases

Guidelines in many jurisdictions provide direction on managing HIV cases

Various public health authorities have issued guidelines to support healthcare professionals in managing HIV cases. A common emphasis in these guidelines is the importance of HIV testing and counselling as methods to reduce the risk of transmission to others and facilitate follow-up care. Many guidelines expressly recommend counselling HIV positive persons to take steps to prevent the transmission of HIV, such as by receiving treatment and disclosing their HIV status to sexual and any drug equipment sharing partners, including advising that there may be a legal requirement to do so.[126]

Healthcare professionals disclose HIV positive test results and provide counselling

The healthcare professional that is primarily responsible for a particular person's health care typically discloses HIV positive test results in person, which provides an opportunity for counselling. Some PT public health legislation specifies that healthcare professionals must provide counselling and identify any "contacts" (i.e., the HIV positive person's sexual or drug equipment sharing partners) through a contact tracing process (see below), within a specific period of time following an HIV diagnosis.[127]

Public health authorities assist in contacting and locating HIV positive persons who cannot be reached

Some public health partners noted that healthcare professionals may engage the assistance of public health authorities in contacting and locating an HIV positive person who is difficult to reach so that they can be informed of their status and take steps to avoid transmitting HIV to others. Some also indicated that public health authorities employ a variety of strategies to contact the person, such as home visits, visiting public sites the individual may frequent, sending a registered letter, leaving phone messages, sending emails and texts, and placing an alert on the person's electronic medical record for the next healthcare provider who sees them.

Limited information was available on what happens when an HIV positive person simply cannot be located. Two public health partners noted that if a person cannot be reached after repeated attempts, their file is closed but could be re-opened if they come to the attention of public health authorities at a later date. A number of public health partners noted that, if the person moves to another jurisdiction, their case will be referred to public health authorities in that jurisdiction.

"Contact tracing" is common practice

Following an HIV diagnosis, notification of sexual and any drug equipment sharing partners (i.e., "contact tracing") is typically carried out by either healthcare professionals, public health authorities or a combination of both. Protecting the privacy and confidentiality of HIV positive persons and their contacts is a critical aspect of public health practices and is governed by PT legislation.[128]

In most PTs, public health authorities are responsible to ensure that an HIV positive person's contacts are notified.[129] Contact tracing generally involves informing an HIV positive person's sexual partners, as well as any drug equipment sharing partners, of their potential exposure to HIV and counselling the person's contacts to seek testing and healthcare services.[130] While practices differ across PTs, the majority of public health partners indicated that their guidelines outline the processes for identifying and notifying an HIV positive person's contacts. Many guidelines reference PHAC's Canadian Guidelines on Sexually Transmitted Infections, which include guidance on contact tracing.[131]

Some PT public health legislation imposes an obligation on healthcare professionals or public health authorities to undertake contact tracing[132] and some authorizes public health authorities to compel an HIV positive person to provide information about their contacts.[133]

Guidelines addressing high risk cases are available in some PTs

Several public health partners have issued specific guidelines on how to address HIV positive persons who public health authorities have reason to believe have engaged, or will engage, in conduct that poses a high risk of transmitting HIV.[134] How to manage such persons is generally assessed on a case-by-case basis; preventative and voluntary measures are the preferred means.

Public health orders are available in the majority of PTs but not necessarily used

The majority of public health partners have the authority to issue and enforce public health orders requiring compliance with certain measures that reduce the risk of HIV transmission, such as requiring the HIV positive person to: submit to a medical examination; isolate themselves; conduct themselves in a manner that will not expose others to infection; receive treatment; provide information on contacts; and, comply with measures to prevent the spread of HIV (e.g., use a condom, inform contacts of their HIV positive status).[135]

Enforcement measures may involve apprehending and detaining a person who fails to comply with the provisions of an order.[136] Some PT public health legislation allows public health authorities to apply to the court to enforce the order and/or to seek additional measures against the individual, such as compelling a medical examination or treatment.[137] Some PT public health legislation also includes an offence scheme, which allows for the imposition of a fine or term of imprisonment for failure to comply with an order.[138]

Although issuing and enforcing public health orders is possible in the majority of PTs, many public health partners indicated that they prefer to engage with HIV positive persons using supportive and voluntary measures. Orders and judicial measures are used when and if needed, for example, when other measures have been exhausted.

The public can be notified where there is risk of HIV transmission

Most PT public health legislation authorizes notification of members of the public in circumstances where individuals are known to engage in conduct that poses a high risk of HIV transmission.[139] However, a few public health partners noted that information on HIV positive persons is only made public when required in the context of court proceedings, i.e., criminal or public health proceedings,[140] or through actions taken by law enforcement.

3. Relationship between Public Health and Law Enforcement

Engagement of law enforcement is limited, including in cases involving risky behaviour

A few public health partners indicated that they do not generally contact, or engage with, law enforcement on potential HIV non-disclosure cases, including those involving conduct that poses a high risk of HIV transmission. Some indicated that legal advice and internal direction would be sought prior to involving law enforcement. However, one public health partner noted having a close relationship with law enforcement and indicated that charges against an individual had been withdrawn as a result of public health involvement. Engagement with law enforcement may also be limited by privacy-related provisions in PT legislation.

A few public health partners have issued guidelines that address the appropriate procedure to follow when involving law enforcement in cases involving a high risk of transmission.[141]

Public health authorities are rarely contacted by police or prosecutors

A number of public health partners indicated that public health authorities are rarely, if ever, contacted by police or prosecutors in HIV non-disclosure cases. In circumstances where public health authorities had contact with police or prosecutors, some public health partners indicated that the HIV positive persons who had come to the attention of law enforcement had received counselling prior to their involvement with law enforcement.

Information about potential HIV non-disclosure cases is typically provided to law enforcement by way of courts orders

Some public health authorities have worked with, and provided information to, law enforcement on potential HIV non-disclosure cases, although some public health partners noted that this collaboration occurs only when a warrant or subpoena for information has been served or in circumstances involving a high risk of transmission to others.

The limited exchange of information between public health authorities and law enforcement was, in some PTs, the result of concerns over patient privacy and the preference for public health responses over criminal law ones. Information may, however, be provided to peace officers when issuing and enforcing public health orders under some PT public health legislation.[142]

Public health authorities have expressed concern about law enforcement involvement

A few public health partners expressed concern about law enforcement involvement in HIV cases and some of these concerns also appear in guidelines.[143] Some indicated a preference for engaging a broad range of public health measures and working directly with HIV positive persons on a case-by-case basis to reduce risky behaviour. One noted that public health authorities do not want to compromise the relationship with HIV positive persons, who do not want law enforcement involvement. Another indicated that engaging law enforcement is viewed as an absolute last resort as public health authorities are responsible for managing HIV transmission risk, not the criminal justice system.

PART G: CRIMINAL JUSTICE SYSTEM RESPONSES TO HIV NON-DISCLOSURE CASES

This Part provides an overview of criminal justice responses in HIV non-disclosure cases,[144] including information received from law enforcement partners in various jurisdictions on: the nature of HIV-related criminal cases that have come to the attention of law enforcement; charging and prosecutorial practices and considerations; and, the experience of victims.

The provinces are responsible for investigating and prosecuting *Criminal Code* offences in their respective jurisdictions, while the federal government does so in the territories. Police are responsible for laying charges in every province except for British Columbia, New Brunswick and Québec, where charging is subject to pre-approval by the Crown. Generally, in each jurisdiction, charges are laid where there are reasonable and probable grounds to believe an offence has been committed and prosecutions are pursued where there is a realistic prospect of conviction and doing so is in the public interest, although these thresholds vary slightly by jurisdiction.

1. Nature of HIV-Related Criminal Cases

The majority of HIV-related cases involve HIV non-disclosure
While some law enforcement partners have handled a few HIV-related cases involving non-sexual conduct (e.g., spitting, biting, needle stabs, blood donations), the majority of HIV-related cases that have come to the attention of law enforcement involve non-disclosure of HIV status. However, some law enforcement partners have also reported cases involving forced sexual activity with HIV exposure and/or transmission as an aggravating factor for sentencing purposes.

Law enforcement partners noted that HIV non-disclosure cases often involve members of the opposite sex and vaginal intercourse though other types of sexual activity (e.g., anal sex and oral sex) were also at issue in many instances. Many also indicated that cases have concerned members of the same sex and various forms of sexual activity (e.g., anal sex, vaginal penetration, i.e., with a shared sex toy, and oral sex).

HIV non-disclosure cases often involve multiple complainants
Most law enforcement partners noted that HIV non-disclosure cases have involved multiple complainants and, as a result, multiple allegations against the accused. Such cases may involve complainants who contract HIV, as well as those who are exposed to HIV.

Complainants typically report to police
Most law enforcement partners indicated that HIV non-disclosure cases typically come to the attention of law enforcement because the complainant makes a report to police. Some indicated that the complainant usually does so after learning that they are HIV positive or finding out from the accused or another person that the accused was HIV positive when they engaged in sexual activity. In some instances, complainants have come forward as a result of information in a media release.

2. Charging Practices and Considerations

Involvement of public health authorities prior to law enforcement involvement is common
Most law enforcement partners indicated that, in many cases, public health authorities had been involved with the accused prior to the case coming to the attention of law enforcement. In some cases, the accused had been counselled to disclose their HIV positive status to sexual partners and, in a few cases, the accused was under a public health order.

Law enforcement does not generally consult public health authorities pre-charge
Consultation with public health authorities at the pre-charge stage is limited. Although a few law enforcement partners noted that public health authorities may be asked to provide information related to the accused's knowledge of their HIV status and any counselling they may have received, as well as to assist in the production of any medical records relevant to determining whether a charge should be laid, some also indicated that public health authorities have no involvement or influence at the pre-charge stage.

Pre-charge Crown consultation is not standard practice
In most PTs that do not have Crown pre-charge approval, it is not normal practice for law enforcement to contact prosecutors prior to the laying of charges. However, a few law enforcement partners noted

that prosecutors with experience handling HIV-related cases are available for consultation with police or other prosecutors on an informal, case-by-case basis.

Aggravated sexual assault is the offence usually charged but other offences may apply
The majority of law enforcement partners indicated that aggravated sexual assault is the charge typically laid in HIV non-disclosure cases. According to some, other charges could be considered depending on the facts of the case and available evidence, including: assault; aggravated assault; sexual assault; sexual assault causing bodily harm; criminal negligence; administering a noxious substance; and, public nuisance.

A few law enforcement partners noted that cases involving young offenders or a guilty plea could impact on the type of charge laid or offence for which a conviction is entered. For example, one explained that, in one case involving three victims and a marginalized young offender with a low viral load, the Crown accepted a plea to public nuisance. The young offender received a conditional discharge with one year probation.

Attempted murder/murder charges are rare
While reportedly rare, murder or attempted murder charges may be laid where the accused has a history of engaging in high risk conduct, despite ongoing public health interventions, that results in transmission to others who may die or have died from complications associated with HIV/AIDS.

Non-criminal responses are unavailable in most HIV non-disclosure cases
Some law enforcement partners expressed the view that non-criminal responses were not appropriate or available in HIV non-disclosure cases. Some reasons for not pursuing non-criminal responses included the high level of risk that the accused posed to the public and the severity of the alleged conduct, for example because the accused failed to disclose their HIV positive status to multiple complainants and failed to follow advice from public health authorities. One law enforcement partner noted that alternative measures and treatment programs currently available in that jurisdiction exclude all sexual assault offences. Another noted that non-criminal responses are considered in appropriate cases, depending on the circumstances of the offence and the offender.

Police issue media releases where there are concerns about other potential complainants
In some PTs, media releases are typically issued by police in circumstances where they have reason to believe that other potential complainants, who should seek medical attention, have been or may be at risk of HIV exposure.

3. Prosecutorial Practices and Considerations

Policies and guidelines to assist prosecutors are generally not available
Most law enforcement partners indicated that prosecution services do not have in place formal policies or guidelines specific to addressing HIV non-disclosure cases.

Role of public health authorities is limited post-charge
The role of public health authorities is reported to be either limited or non-existent following a charge. Two law enforcement partners noted that, in some cases, public health authorities may be contacted to discuss appropriate bail conditions, such as requiring the accused to receive counselling by public health on ways to reduce the risk of transmission and to follow terms often found in orders issued by public health (e.g., inform contacts of their HIV positive status).

Informal consultation with experienced prosecutors is common practice

Several law enforcement partners indicated that their practice was to consult with designated prosecutors who have experience handling HIV non-disclosure cases or to assign such cases to experienced prosecutors. One noted that some police and prosecutors are not always aware of the availability of experienced prosecutors until after charges have been laid or the case has concluded.

A range of factors may be considered when determining whether to pursue a prosecution

A few law enforcement partners indicated that the following factors may be considered when determining whether to pursue a prosecution in HIV non-disclosure cases:

- Risk level posed by the sexual activity at issue (e.g., the accused's compliance with antiretroviral therapy);
- Nature and frequency of the risky conduct (e.g., the number of complainants/potential complainants, the accused's conduct in seeking out sexual partners, such as luring sexual partners on the internet and dating websites, and whether the accused has engaged in a pattern of non-disclosure);
- Vulnerability of complainants;
- Accused's level of knowledge about their HIV positive status (e.g., whether the accused received any information about their diagnosis and made efforts to reduce the risk of transmitting HIV); and,
- Accused's prior involvement with public health (e.g., whether the accused received counselling or complied with voluntary and preventative measures, or was subject to a public health order).

Evidentiary issues in HIV non-disclosure cases are complex

Type of relevant medical evidence: The type of medical evidence sought to be adduced in HIV non-disclosure cases was described as including: records from the accused's treating physician; public health records (e.g., laboratory test results and counselling records); complainant's medical records; and, potentially also the records of complainant's sexual partners in transmission cases. Expert evidence linking the complainant's HIV infection to that of the accused, or on the risk of transmission posed by the sexual activity in question, may also be adduced.

Purpose of the medical evidence: Law enforcement partners indicated that medical evidence may be relevant to determining whether to lay charges or to pursue a prosecution. In particular, one noted the importance of medical evidence on the effectiveness of treatment in reducing risk to assess whether there is a realistic possibility of transmission. A few also highlighted the importance of obtaining evidence about the accused's knowledge of their HIV positive status and any counselling on risk of transmission received by the accused to assist in determining whether the accused had a sufficiently culpable mental state to warrant criminal liability.

Law enforcement partners indicated that expert medical evidence is typically used at trial in transmission cases to establish that the accused transmitted HIV to the victim, since HIV transmission is an aggravating factor for sentencing purposes. It may also be used at trial in exposure cases to show that the realistic possibility of transmission test is met. However, law enforcement partners expressed divergent views on the use and necessity of expert medical evidence. For example, some PTs indicated that expert medical evidence is required in exposure cases to establish a realistic possibility of transmission, while others noted that such evidence is not required in every exposure case (e.g., where unprotected sexual activity is at issue).

One law enforcement partner noted that exposure cases involving evidence of condom use still require expert medical evidence on viral loads to determine whether the realistic possibility of transmission test

is met. Another indicated that if oral sex is at issue, expert evidence on the risk of transmission associated with oral sex is needed. One expressed concern about obtaining objective expert evidence because some experts may be unwilling to provide medical evidence on risk of transmission in criminal trials due to their opposition to the use of the criminal law in HIV non-disclosure cases.

Timing of seeking medical evidence: Some law enforcement partners noted that medical evidence relating to the accused's HIV status is generally sought at an early stage in the case, such as during the investigative stage or soon after charges are laid. One indicated that medical evidence is sought post-charge. Another noted that prosecutors wait to see whether the accused will voluntarily produce their medical records prior to seeking production of those records. A few expressed the need for obtaining production orders, with one noting that seeking judicial authorization for production of medical records, or securing consent from the accused to release their records, can impact the timing at which the evidence is received.

HIV transmission and exposure cases are treated similarly

The majority of law enforcement partners noted that transmission cases are generally not treated differently from exposure cases apart from the potential need to call different types of evidence, as described above. However, because transmission cases are generally considered to be more serious, they tend to result in longer sentences.

4. Experience of Victims

Victims experience a range of emotional and psychological impacts

Several law enforcement partners noted that victims experience fear, guilt, anger, stress, embarrassment, and anxiety, including when waiting for medical results or for sufficient time to pass to determine whether they have been infected with HIV. Even after receiving negative test results, some victims continued to worry that the results were in fact false negatives. Victim impact statements[145] frequently revealed victims' sense of betrayal resulting in an inability to trust others. This impact was particularly profound when the offender was a friend, or someone with whom the victim had a long-standing relationship. Many victims reported losing faith in their own ability to judge others' character. Some victims contemplated, and others attempted, suicide and self-harm.

Victims in transmission cases experience more significant harms

Law enforcement partners noted that victims who contract HIV experience even greater impacts on their lives, such as increased stress and stigma associated with being HIV positive, disrupted family and personal lives (e.g., loss of intimacy, the need to disclose their HIV status in certain circumstances, fear of infecting others, isolation, depression), family planning and pregnancy implications, frequent medical appointments, side-effects from medication (e.g., impact on liver and kidneys, tiring more easily, weight gain), costs of medication, compromised health (e.g., complications of pre-existing conditions, insomnia, loss of appetite, nausea) and compromised well-being resulting from living with HIV (e.g., medication may not be fully effective, fear that HIV will progress to AIDS), and loss of employment. Some victims who contracted HIV reported a strong sense of unfairness, hopelessness and doom in their victim impact statements.

Victims experience challenges with criminal justice responses

Some law enforcement partners noted that victims may feel re-victimized by the criminal justice process and blame themselves, or feel judged, for having failed to protect themselves from the risk of

contracting HIV. For example, some victims indicated they had the impression of being treated like "liars" with questionable moral values by participants in the criminal justice system. Other victim concerns include the loss of privacy (e.g., as a result of disclosure of their medical records) and hardships associated with testifying at trial, which involves disclosing details of intimate sexual encounters. Victims also reported hardship associated with preparing for hearings that were subsequently re-scheduled, which was experienced as an emotional "roller-coaster" that added to their anxiety.

A few law enforcement partners also noted that victims who have been infected with HIV often fear public disclosure of their HIV positive status, even where a publication ban is ordered, and feel an intense sense of embarrassment, shame and stigma during criminal justice processes. One indicated that some victims have felt that an accused should not be entitled to withhold their HIV positive status in any circumstance, including where sexual activity poses only a low or negligible risk of transmission. Another noted that victims have expressed the view that sentences are too lenient. Victim impact statements reveal that some victims considered the offender's behaviour to constitute attempted murder and wanted the offender to be punished harshly, while others wanted the offender to know that they did something wrong and learn from their mistakes, but did not want them to be sentenced to a long period of incarceration.

PART H: SUMMARY OF THE EVIDENCE AND CONCLUSIONS

This Part summarizes the evidence examined in this report and outlines the key conclusions that can be drawn from the foregoing broad review of the Canadian criminal justice system's response to HIV non-disclosure. These conclusions may serve as best practices for the development of any new responses to HIV non-disclosure cases.

Key points raised by the evidence include the following:

- The public health and criminal justice systems have very different objectives. While public health objectives include preventing disease, prolonging life and promoting human health, criminal justice objectives include maintaining a just, peaceful and safe society by establishing a criminal justice system that deals fairly and appropriately with culpable conduct that causes or threatens serious harm to individuals or society.[146] Because the criminal law is a blunt instrument, it should be engaged only when other means of social control are inadequate or inappropriate.[147] As the SCC stated in its 1998 *Cuerrier* decision, the criminal law has a role to play in cases involving sexual activity and non-disclosure of HIV, where public health interventions have failed and the sexual activity at issue poses a risk of serious harm.

- HIV is first and foremost a public health issue. Public health authorities' efforts to detect and treat HIV have resulted in significantly improved health outcomes for those living with HIV in Canada and prevention of its onward transmission, as evidenced by the relevant medical science. Accordingly, promotion of HIV testing, particularly in populations at risk of HIV infection, is key to preventing onward transmission of HIV; early detection and treatment improves health outcomes and prevents onward transmission by those who are unaware of their HIV status.

- Canada's efforts to detect and treat HIV have resulted in the majority of persons estimated to be living with HIV in Canada knowing their status and receiving appropriate treatment. Canada's

commitment to the international 90-90-90 targets should result in an even greater number of Canadians living with HIV knowing their status and receiving treatment in the near future. It can, therefore, no longer be assumed that a person living with HIV in Canada is at risk of transmitting it.

- Statistics show that persons from marginalized backgrounds, particularly Indigenous, gay and Black persons, are more likely than others to be living with HIV in Canada. Accordingly, criminal laws that apply to HIV non-disclosure are likely to disproportionately impact these groups. Although HIV testing rates have increased steadily in all Canadian jurisdictions for which that information is available, it is not possible to know whether testing rates in populations vulnerable to HIV infection have increased.

- Sexual activity, regardless of condom use, with an HIV positive person who is taking HIV treatment as prescribed and has maintained a suppressed viral load (i.e., under 200 copies of HIV per ml of blood) poses a negligible risk of transmission.

- Certain types of sexual activity with HIV positive persons pose a low risk of transmission. These include:
    - Sex without a condom or oral sex with a person who is on treatment, but has not maintained a suppressed viral load;
    - Sex with a condom with a person who is not on treatment; and,
    - Oral sex with a person who is not on treatment.

- However, other factors may increase the risk of these otherwise low risk types of sexual activity:
    - In cases involving persons who are on treatment but have not maintained a suppressed viral load, adherence to the prescribed treatment regimen is critical to reducing the risk of transmission;
    - In cases involving persons who are not on treatment, an isolated act of sexual intercourse with effective condom use is highly unlikely to pose a significant risk of transmission; whereas, multiple acts of sexual intercourse over a significant period of time pose higher risks, particularly where condoms are not consistently and effectively used;
    - In cases where condoms are used but subsequently break, disclosure of HIV positive status immediately after exposure allows the HIV negative sexual partner to access post-exposure prophylaxis, which significantly reduces the risk of transmission;
    - In cases involving oral sex, both oral sex without ejaculation and cunnilingus pose a lower risk than does oral sex with ejaculation by the person living with HIV where that person is untreated.

- The criminal law applies to HIV positive persons where they fail to disclose, or misrepresent, their HIV status prior to sexual activity that poses a realistic possibility of transmission. The most recent medical science on HIV transmission is determinative of whether this legal test is met. These cases involve a broad range of conduct, reflecting both higher and lower levels of culpability.

- HIV non-disclosure cases reflecting higher levels of blameworthiness are more likely to involve young, female victims and male offenders, consistent with the gendered power imbalances evident in many coercive sexual conduct cases.

- Cases involving Indigenous and female accused are more likely to involve factors reflecting lower levels of blameworthiness. Furthermore, marginalized persons are more likely to lack access to health care and other services.

- Although HIV non-disclosure has implications for both public health authorities and the criminal justice system, public health and criminal justice responses are not often coordinated.

The following conclusions can be drawn from the evidence reviewed:

- Consistent with the relevant SCC jurisprudence, the criminal law should not apply to persons living with HIV who have engaged in sexual activity without disclosing their status if they have maintained a suppressed viral load (i.e., under 200 copies per ml of blood), because the realistic possibility of transmission test is not met in these circumstances. A person living with HIV who takes their treatment as prescribed is acting responsibly.

- The criminal law should generally not apply to persons living with HIV who: are on treatment; are not on treatment but use condoms; or, engage only in oral sex (unless other risk factors are present and the person living with HIV is aware of those risks), because the realistic possibility of transmission test is likely not met in these circumstances.

- Unprotected sex with an HIV positive person who has not disclosed their status can no longer be considered to establish a *prima facie* case of HIV non-disclosure as evidence of treatment and viral load will always be relevant to determining whether the realistic possibility of transmission test is met. Moreover, the majority of persons living with HIV in Canada are on treatment, which significantly reduces the risk of transmission. Other types of evidence will also always be relevant, including evidence that condoms were used effectively and consistently and that the only sexual activity at issue was oral sex.

- In cases where public health interventions have failed to address high risk conduct, the criminal law has a role to play in protecting the individuals who may be exposed to HIV transmission, as well as the public generally. This requires criminalization of both HIV transmission and exposure cases because:
    - Criminal law responses should not be dependent on a complainant contracting HIV where a person living with HIV is engaging in high risk conduct that has not resulted in transmission only by sheer chance. In these circumstances, both complainants who contract HIV and those who are exposed to it deserve the protection of the criminal law;
    - Some exposure cases involving intentional conduct may be more serious than transmission cases involving reckless conduct; for example, public health interventions are more likely to be effective where irresponsible conduct results from a need for assistance in managing HIV, rather than the desire for sexual gratification alone.

- Canada's criminal law approach to HIV transmission and exposure cases should reflect the varying levels of blameworthiness in these cases, for example:
    - In HIV cases that involve lower levels of blameworthiness, such as recklessness, as opposed to intention to transmit HIV, non-sexual offences may more appropriately reflect the wrongdoing committed. In such cases, intent to place others at risk purely for sexual gratification purposes is not at play;
    - HIV exposure cases may not have resulted in transmission because the person living with HIV has taken steps to prevent transmission (e.g., condom use and/or treatment). These

cases must be distinguished from those involving a pattern of high risk conduct that, only by chance, did not result in transmission;
    - Non-criminal responses should be considered in appropriate cases, in particular where high risk conduct is the result of lack of access to health care and other services.

- Collaboration between public health and criminal justice officials at all stages of the criminal justice process may assist in achieving appropriate outcomes in HIV non-disclosure cases. Public health authorities may have important information about whether a person who has come to the attention of law enforcement has been acting responsibly, which may affect law enforcement's determination of whether: the criminal justice system should be engaged at all; non-criminal responses should be pursued; or, the protection of the criminal law is required.

- Public education on HIV generally, and HIV transmission risks specifically, would assist in addressing the stigma experienced by persons living with HIV. Stigmatization is often the result of a lack of knowledge about HIV and the way it is transmitted.

All of these possible measures are capable of being implemented within the existing legal framework governing HIV non-disclosure cases and would assist in ensuring that, as the SCC called for, the criminal law is applied only to "conduct associated with serious wrong and harms."[148] In particular, the development of policy statements and/or prosecutorial guidelines across Canada that address these issues could further assist in achieving greater consistency in the application of the law. Alternatively, criminal law reform could result in greater legal certainty, in particular regarding the role of the most recent medical science. However, law reform impacts the scope of the criminal law, not decisions about how to address cases that fall within that scope. Moreover, law reform may require enacting HIV-specific provisions, which many stakeholders have opposed on the basis that this would increase the stigma experienced by persons living with HIV.

ANNEX 1: Statement from Minister Wilson-Raybould on World AIDS Day

Minister Wilson-Raybould Issues Statement on World AIDS Day

December 01, 2016 (Ottawa, ON) - Department of Justice Canada

The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada, today issued the following statement:

> World AIDS Day is a time to reflect on the impact that HIV/AIDS has had on Canadians, and to give thanks to the many dedicated people who work to prevent this disease and help people get the care and support they need.
>
> It is also a time to recognize the tremendous medical advances that have been made since the first World AIDS Day was held in 1988. HIV treatment has slowed disease progression to the point that, for many, HIV infection can now be regarded as a chronic, manageable condition.
>
> Still, the over-criminalization of HIV non-disclosure discourages many individuals from being tested and seeking treatment, and further stigmatizes those living with HIV or AIDS. Just as treatment has progressed, the criminal justice system must adapt to better reflect the current scientific evidence on the realities of this disease.
>
> Over the coming months, I intend to work with my provincial and territorial counterparts, affected communities and medical professionals to examine the criminal justice system's response to non-disclosure of HIV status. This could include a review of existing charging and prosecution practices, as well as the possible development of prosecutorial guidelines. I also look forward to working with Member of Parliament Randy Boissonnault, Special Advisor to the Prime Minister on LGBTQ2 issues, in his continued efforts to engage Canadians on important issues such as this one.
>
> On World AIDS Day, we should all share in the commitment to reduce stigma and discrimination against those living with HIV or AIDS.

[1] Viral load refers to how many copies of HIV are present in a milliliter sample of blood. Viral load testing is a way to estimate how much HIV is in the blood. It is used to monitor immune function and see how well HIV treatment is working.

[2] UNAIDS, *90-90-90 An ambitious treatment target to help end the AIDS epidemic*, JC2684, October 2014 at 1, available online.

[3] Canadian AIDS Society, "HIV Transmission: Factors that Affect Biological Risk" (11 February 2013) at 2, available online [Canadian AIDS Society, "HIV Transmission: Factors"].

[4] Public Health Agency of Canada, "Summary: Measuring Canada's Progress on the 90-90-90 HIV Targets", by Surveillance and Epidemiology Division Professional Guidelines and Public Health Practice Division Centre for Communicable Diseases and Infection Control (Ottawa: PHAC, 2017) at 3, available online.

[5] Public Health Agency of Canada, "HIV in Canada: Surveillance summary tables, 2014-2015" (Ottawa: PHAC, 2014-15), available online.

[6] Public Health Agency of Canada, "Summary: Estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014" (Ottawa: PHAC, 2014), available online.

[7] *Ibid*.

[8] Jacek Skarbinski et al, "Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States" (2015) 175:4 JAMA Intern Med 588 at 590, available online.

[9] Bluma G Brenner et al, "High rates of forward transmission events after acute/early HIV-1 infection" (2007) 195:7 J Infect Dis 951 at 957.

[10] Statistics Canada, *Table 102-0521 Deaths, by cause, Chapter I: Certain infectious and parasitic diseases (A00 to B99), age group and sex, Canada*, CANSIM, available online.

[11] Public Health Agency of Canada, "HIV and AIDS in Canada: Surveillance Report to December 31, 2014" (Ottawa: PHAC, 2014) at 95, available online.

[12] Transmission risks are frequently reported in studies as number of transmissions per number of person-years. A person-year is the equivalent of following one person for one year. Risk per 100 person-years represents the number of transmissions one would expect to see if they followed 100 couples for 1 year each, or 10 couples for 10 years each, for example.

[13] CC Cheung et al, "Reductions in all-cause and cause-specific mortality among HIV-infected individuals receiving antiretroviral therapy in British Columbia, Canada: 2001–2012" (2016) 17 HIV Medicine 694 at 694 [CC Cheung et al, "Reductions"].

[14] British Columbia Centre for Excellence in HIV/AIDS, "HIV Monitoring Quarterly Report for British Columbia" (2015) Third Quarter at 14, online.

[15] Saskatchewan, Ministry of Health Population Health Branch. *HIV Prevention and Control Program Report for 2015* (2015).

[16] Ontario HIV Epidemiologic Monitoring Unit, *Number of HIV tests and positivity rate by year of test, Ontario, 1996 to 2013*, available online.

[17] Institut National de Santé Publique du Québec, *Programme de surveillance de l'infection par le virus de l'immunodéficience humaine (VIH) au Québec RAPPORT ANNUEL 2014*, (2014) at p 6, available online.

[18] Public Health Agency of Canada, "Population-Specific HIV/AIDS Status Report: People Living with HIV/AIDS" (Ottawa: PHAC, 2013), available online.

[19] See also Judith G. Rabkin, "HIV and depression: 2008 review and update" (2008) 5:4 Behavioral Aspects of HIV Management 163; Maria Giulia Nanni et al., "Depression in HIV Infected Patients: a Review" (2015) 17 Complex Medical-Psychiatric Issues 530; Stylianos Arseniou, Aikaterini & Maria Samakouri, "HIV infection and depression" (2013) 68:2 Psychiatry and Clinical Neurosciences 96; Ellen M. Tedaldi, Nancy L Minniti & Tracy Fischer, "HIV-Associated Neurocognitive Disorders: The Relationship of HIV Infection with Physical and Social Comorbidities" (2015) 2015 BioMed Research International; David S. Bennett et al., "Shame among people living with HIV: a literature review" (2015) 28:1 AIDS Care 87; Keira Lowther et al., "Experience of persistent psychological symptoms and perceived stigma among people with HIV on antiretroviral therapy (ART): A systematic review" (2014) 51:8 International Journal of Nursing Studies 1171; Jeffrey S Gonzalez et al,, "Depression and HIV/AIDS Treatment Non-adherence: A Review and Meta-analysis" (2013) 58:2 J Acquir Immune Defic Syndr 10; P Bravo et al., "Tough decisions faced by people living with HIV: a literature review of psychosocial problems" (2010) 12:2 AIDS Rev 76; Roger C McIntosh & Monica Rosselli, "Stress and Coping in Women Living with HIV: A Meta-Analytic Review" (2012) 16:8 AIDS and Behaviour 2144; Alexandra Sawyer, Susan Ayers & Andy P Field, "Posttraumatic growth and adjustment among individuals with cancer or HIV/AIDS: A meta-analysis (2010) 30:4 Clinical Psychology Review 436; Ingrid T Katz et al., "Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis" (2013) 16:2 Journal of the International AIDS Society 1.

[20] Canadian AIDS Society, "HIV Transmission: Factors", *supra* note 3 at 22.

[21] CATIE, "HIV in Canada: A primer for service providers" (September 2017) at 68, available online.

[22] Sachin Jain & Kenneth H Mayer, "Practical guidance for nonoccupational postexposure prophylaxis to prevent HIV infection: an editorial review" (2014) 28:11 AIDS 1545 at 1545.

[23] An overview of systematic reviews was carried out, searching from 2007-March 2017 to identify 1,414 citations that were screened to identify 12 relevant systematic reviews. An update of primary literature based on previous systematic reviews was carried out for the effect of ART, which involved searches from November 2012 – April 2017. This search identified 7,266 citations which were screened to identify 7 studies, which were then combined with studies from previous systematic reviews, to give a final sample of 11 studies (encompassing literature searched back to prior to the advent of combination ART).

[24] Canadian AIDS Society, "HIV transmission: Guidelines for Assessing Risk" (2004) 5th ed, at 17, available online.

[25] *Ibid* at 18.

[26] CC Cheung et al, "Reductions", *supra* note 13.

[27] *Ibid*.

[28] *Ibid*.

[29] Pragna Patel et al., "Estimating per-act HIV transmission risk: A systematic review". (2014) AIDS 28:10 1509 at 1509.

[30] LF Wood et al., "The Oral Mucosa Immune Environment and Oral Transmission of HIV/SIV". (2013) 254:1 Immunological reviews 34.

[31] *Ibid*.

[32] J Montaner, S Guillemi & M Harris, on behalf of the Committee for Drug Evaluation and Therapy. *Therapeutic guidelines for antiretroviral (ARV) treatment of adult HIV infection*, (September 2015) British Columbia Centre for Excellence in HIV/AIDS; G Robbins et al., "Predicting virologic failure in an HIV clinic" (2010) 1:50 Clin Infect Dis 2010 779.

[33] Centers for Disease Control and Prevention, *Condom effectiveness - Fact sheet for public health personnel*, (2013) available online.

[34] Public Health Agency of Canada, *Summary: Estimates of HIV incidence, prevalence and proportion undiagnosed in Canada 2014* (2015).

[35] See e.g. *R v Iamkhong*, 2009 ONCA 478 [*Iamkhong*] & *R v Booth*, 2005 ABPC 137 [*Booth*], respectively.

[36] "No consent is obtained where the complainant submits or does not resist by reasons of… fraud" (paragraph 265(3)(c) of the *Criminal Code*).

[37] These factors reflect the test set out in *R v Cuerrier,* [1998] 2 SCR 371 [*Cuerrier*].

[38] See especially *R v Mabior*, 2012 SCC 47 at paras 2 & 92 [*Mabior*].

[39] *Ibid* at para 104.

[40] *Ibid* at para 105.

[41] *Ibid at* para 104.

[42] *R v Felix*, 2013 ONCA 415 at para 48 & 57 [*Felix*]; "In these circumstances, the issues of the appellant's exact viral load at the time of his sexual encounters with [the complainants], and the degree of risk of HIV transmission posed as a result of his viral load, are simply irrelevant. The nature of the appellant's viral load at the times in question cannot change the fact that, on the trial judge's findings, the appellant was HIV positive at the time of intercourse and failed to use a condom…. On the *Mabior* standard, even if the evidence had established that the appellant had a low viral load at the time of intercourse…, a realistic possibility of HIV transmission would not have been negated".

[43] *R v Murphy*, [2013] CarswellONT 11952 at para 70-71; the court cited the above passages in *Felix* as authorities.

[44] See *R v C. (J.T.)*, 2013 NSPC 105 at para 85 [*J.T.C.*]; "There must be a realistic possibility of transmission. It is negated by a low viral load and the use of a condom. The court does not state that that is the only way in which it can be negated. It does not state that an expert opinion which establishes that the risk of transmission in a particular case is effectively zero is irrelevant. That would be tantamount to saying that the facts just don't matter and that a person with HIV is presumed to be infectious despite the facts… [*Mabior* and *D.C.*] were, in my view, not intended to substitute scientific facts with legal conclusions".

[45] See *R v Thompson*, 2016 NSSC 257 at para 14; the court followed the ruling in *J.T.C.*: "Neither *JTC* nor *Felix* are binding on me. However, I prefer and accept the approach taken by Campbell, P.C.J. in *JTC*. In my view it is consistent with the interpretation of *Mabior* that a tactical burden may fall to the defence to raise a reasonable doubt once a *prima facie* case has been made out by the Crown. It also reflects the caveat in *Mabior* that other risk factors may result in a different conclusion than that which flowed from the evidence in *Mabior*. I agree with Campbell, P.C.J. that the Supreme Court of Canada was not instructing trial judges to ignore evidence and find a realistic possibility of transmission when such a risk was speculative or negligible".

[46] *Ibid*.

[47] See *R v Schenkels*, 2017 MBCA 62 [*Schenkels*]; In June of 2017, the Manitoba Court of Appeal upheld a conviction for aggravated sexual assault in an HIV transmission case.

[48] *R v C.B.*, 2017 ONCJ 545 at para 10.

[49] *Ibid* at paras 80-88.

[50] The *Cuerrier* and *R v Williams*, 2003 SCC 41 [*Williams* SCC], decisions involved aggravated assault charges, while *Mabior* and *D.C.* decisions involved aggravated sexual assault charges.

[51] *Mabior*, *supra* note 38 at para 2.

[52] See *Krieger v Law Society of Alberta*, 2002 SCC 65 at paras 44-47; The SCC has specified, in another context, that prosecutorial discretion, including in respect of which charge to pursue in criminal prosecutions, is not subject to interferences by other arms of government: "In our theory of government, it is the sovereign who holds the power to prosecute his or her subjects. A decision of the Attorney General, or of his or her agents, within the authority delegated to him or her by the sovereign is not subject to interference by other arms of government. An exercise of prosecutorial discretion will, therefore, be treated with deference by the courts… Significantly, what is common to the various elements of prosecutorial discretion is that they involve the ultimate decisions as to whether a prosecution should be brought, continued or ceased, and what the prosecution ought to be for. Put differently,

prosecutorial discretion refers to decisions regarding the nature and extent of the prosecution and the Attorney General's participation in it".

[53] *Cuerrier*, *supra* note 37 at para 141, cited in *R v Williams*, 2006 ONCJ 484 [*Williams*, 2006]; *R v McGregor*, 2008 ONCA 831 [*McGregor*]; *R v Ralph*, 2014 ONSC 2800 [*Ralph*]; *R v Kaotalok*, 2013 NWTSC 36 [*Kaotalok*]. See also *Cuerrier*, *supra* note 37 at para 142, cited in *R v Miron*, [2000] MJ No 500, 174 Man R (2d) 52 (Man Prov Ct) [*Miron*]; *R v Lamirande*, 2006 MBCA 71 [*Lamirande*]; *R v Kaonga*, [2008] CarswellMan 684 [*Kaonga*]; *R v Walkem*, [2007] CarswellOnt 247 [*Walkem*]; *R v Bruneau*, [2010] OJ No 4600 (ONCJ) [*Bruneau*]; *R v Williams*, 2001 NFCA 52 [*Williams*, 2001].

[54] *Mabior*, *supra* note 38 at para 45 & 48. See also *R v Hutchinson*, 2014 SCC 19 at para 19: "The need for restraint and certainty, which sometimes work at cross-purposes to absolute protection of sexual autonomy, has influenced the law's approach to consent, particularly where consent has been obtained by deception".

[55] *Mabior*, *supra* note 38 at para 89.

[56] *Ibid* at para 67.

[57] *Ibid* at para 87.

[58] A "case" was generally considered to be one accused and one set of circumstances. All judicial decisions relating to that accused and the circumstances leading to the charge(s) were counted under the same "case" (trial, sentencing and appeal decisions, evidentiary/procedural decisions, etc.). In some instances, the same accused is in more than one "case" because the circumstances leading to charges were distinct, or the charges were severed at the accused's request and adjudicated separately.

[59] Some cases involved multiple charges; each count for which a conviction was entered is counted.

[60] *R v J.U.*, 2011 ONCJ 457 [*J.U.*]; *R v Thomas*, 2012 ONSC 1201 [*Thomas*]; *R v Krouglov*, 2017 ONCA 197 [*Krouglov*]; *Mabior, supra* note 38; *Williams*, SCC, *supra* note 50; *R v Nduwayo*, 2010 BCSC 1277 [*Nduwayo*]; *R v Nyoni*, 2014 BCSC 1074 [*Nyoni*]; *McGregor*, *supra* note 53; *Cuerrier, supra* note 37*; Miron*, *supra* note 53; *Kaonga*, *supra* note 53; *R v Leone*, some information published at *Leone v Canada*, 2016 FC 980 [*Leone*]; *R v Aziga*, 2011 ONSC 4592 [*Aziga*]; *Felix*, *supra* note 42; *R v Ralph*, *supra* note 53; *R v DeBlois*, [2005] CarswellOnt 1551 [*DeBlois*]; *Walkem*, *supra* note 53.

[61] *R v Boone*, 2016 ONSC 1626 [*Boone*]; *Nduwayo*, *supra* note 60; *Nyoni*, *supra* note 60; *Miron*, *supra* note 53; *Kaonga*, *supra* note 53; *Aziga*, *supra* note 60.

[62] *Cuerrier, supra* note 37; *R v Smith*, 2004 BCPC 384 [*Smith*, 2004]; *Nduwayo*, *supra* note 60; *R v Mzite*, 2011 BCCA 267 [*Mzite*]; *Nyoni*, *supra* note 60 ; *R v Smith*, [2007] SJ No 150 [*Smith*, 2007]; *Miron*, *supra* note 53; *Williams, 2006*, *supra* note 53; *Walkem, supra* note 53; *Leone*, *supra* note 60; *Iamkhong*, *supra* note 35; *Bruneau*, *supra* note 53; *R v Tippeneskum*, 2011 ONCJ 219 [*Tippeneskum*]; *Thomas*, *supra* note 60; *Krouglov*, *supra* note 60; *R v Trott*, 2010 BCSC 766 [*JAT*]; *Ralph*, *supra* note 53; *R v Thery*, [2012] CarswellQue 9375 [*Thery*]; *McGregor*, *supra* note 53; *Williams*, 2001, *supra* note 53; *R v Courcy*, 2017 QCCQ 4348 [*Courcy*]; *Aziga*, *supra* note 60.

[63] *Boone*, *supra* note 61; *Nduwayo*, *supra* note 60.

[64] *Aziga, supra* note 60; *Nduwayo*, *supra* note 60; *Mzite*, *supra* note 62; *Nyoni*, *supra* note 60; *Booth*, *supra* note 35; *DeBlois*, *supra* note 60; *Walkem*, *supra* note 53; *Leone*, *supra* note 60; *Iamkhong, supra* note 35; *Tippeneskum*, *supra* note 62; *Boone*, *supra* note 61; *Ralph*, *supra* note 53; *R v Ngeruka*, 2015 YKTC 22 [*Ngeruka*]; *Krouglov*, *supra* note 60; *R c Tshibamba Muntu*, 2017 QCCQ 4299.

[65] *Nduwayo*, *supra* note 60; *Mzite*, *supra* note 62; *Leone*, *supra* note 60; *Aziga*, *supra* note 60; *Tippeneskum*, *supra* note 62; *R v L (J.M.)*, 2007 BCPC 341 [*JML*]; *Miron*, *supra* note 53; *Nyoni*, *supra* note 60; *Smith,* 2007, *supra* note 62; *Aziga*, *supra* note 60; *Bruneau*, *supra* note 53; *Ralph*, *supra* note 53; *Thery*, *supra* note 62; *Boone, supra* note 61.

[66] *Boone*, *supra* note 61; *Ralph*, *supra* note 53; *Krouglov*, *supra* note 60; *Smith*, 2004, *supra* note 62; *Nduwayo*, *supra* note 60; *JML*, *supra*; *Nyoni*, *supra* note 60; *Miron*, *supra* note 53; *Lamirande*, *supra* note 53; *Aziga, supra* note 60; *DeBlois*, *supra* note 60; *Williams*, 2006, *supra* note 53; *Walkem*, *supra* note 53; *Felix*, *supra* note 42; *Ralph*, *supra* note 53.

[67] *Felix*, *supra*; *Boone*, *supra*; *Ralph*, *supra*; *Krouglov*, *supra*; *Lamirande*, *supra*; *Mabior*, *supra* note 38; *Nduwayo*, *supra*; *Leone*, supra note 60; *R v Biron,* 2014 QCCQ 8115 [*Biron*].

[68] *R v Rollo,* 2011 BCPC 283 [*ATR*]; *Schenkels*, *supra* note 47; *R v J.M.*, [2005] OJ No. 5649 (Ont Sup Ct J) [*JM*]; *J.U.*, *supra* note 60; *Ngeruka*, *supra* note 64; *Kaotalok*, *supra* note 53.

[69] *Bruneau*, *supra* note 53; *Tippeneskum*, *supra* note 62; *Kaotalok*, *supra*; *Ngeruka*, *supra*; *Schenkels*, *supra*; *Williams*, 2006, *supra* note 53; *Biron*, *supra* note 67.

[70] *Schenkels*, *supra* note 47; *JM*, *supra* note 68; *Williams*, 2006, *supra* note 53; *McGregor, supra* note 53; *JU*, *supra* note 60; *R v Washington,* [2016] OJ No 3253; *Kaotalok*, *supra* note 53; *R v D.C.,* 2012 SCC 48, aff'g, 2010 QCCA 2289 [*D.C.*].

[71] *ATR, supra* note 68; *Schenkels*, *supra* note 47; *JM, supra* note 68; *DeBlois*, *supra* note 60; *Williams*, 2006, *supra*; *Bruneau*, *supra* note 53; *Tippeneskum*, *supra* note 62; *Washington*, *supra*; *Biron*, *supra* note 67; *Kaotalok*, *supra*; *Courcy*, *supra* note 62.

[72] *ATR*, *supra* note 68; *Leone*, *supra* note 60.

[73] *JAT*, *supra* note 62.

[74] *D.C.*, *supra* note 70.

[75] See especially, *Mabior, supra* note 38; the applicable legal test establishing when HIV status must be disclosed prior to sexual activity.

[76] Canadian HIV/AIDS Legal Network, Information Sheet, "Criminal Law & HIV Non-Disclosure in Canada" (2014), available online [Canadian HIV/AIDS Legal Network, "Criminal Law & HIV"]; Positive Living Society of British Columbia, Position Paper, "The Need for New Charge Assessment Guidelines: HIV Non-Disclosure in British Columbia" (11 June 2014), available online [Positive Living, "The Need for New Charge Assessment Guidelines"]; HIV & AIDS Legal Clinic Ontario (HALCO) & Canadian HIV/AIDS Legal Network, "The criminalization of HIV non-disclosure: Recommendations for police", Submissions to the Ontario Association of Chiefs of Police Diversity Committee (February 2013), available online [HALCO & Canadian HIV/AIDS Legal Network. "Recommendations for police"]; Isabel Grant, "The Over-Criminalization of Persons with HIV" online: (2013) 63:3 UTLJ 475 at 479 [Grant, "Over-Criminalization"].

[77] Grant, "Over-Criminalization", *supra* note 76 at 478-480.

[78] Colin Hastings, Cécile Kazatchkine & Eric Mykhalovskiy, Information Sheet, *HIV Criminalization in Canada: Key Trends and Patterns* (Canadian HIV/AIDS Legal Network, 17 March 2017), at p. 8, available online.

[79] HIV&AIDS Legal Clinic Ontario & Canadian HIV/AIDS Legal Network, "Exploring Avenues to Address Problematic Prosecutions against People Living with HIV in Canada", (March 2017), at p 3, available online [HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues"]; Ontario Working Group on Criminal Law and HIV Exposure, "Ontario Ministers Roundtable: Exploring avenues to address problematic prosecutions against people living with HIV in Ontario", (5 December 2016) at p 2, available online; Cécile Kazatchkine, "HIV Non-Disclosure and the Criminal Law: An Analysis of two Recent Decisions of the Supreme Court of Canada" (2013) 60 Crim L Q 30 at 38.

[80] As reported in Eric Mykhalovskiy, "The public health implications of HIV criminalization: past, current, and future research directions", (2015) 25:4 Critical Public Health 373 at 375 [Mykhalovskiy, "Public health implications of HIV criminalization"]; see also Mona Loutfy et al., "Canadian consensus statement on HIV and its transmission in the context of criminal law" (2014) 25:3 Canadian J Infect Dis & Med Microbiol 135; UNAIDS, *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*, JC2351E, May 2013 [UNAIDS, "Ending overly broad criminalization"]; Erin Dej & Jennifer M. Kilty, "Criminalization Creep: A Brief Discussion of the Criminalization of HIV/AIDS Non-disclosure in Canada" (2012) 27:1 Can JL & Soc 55 [Dej, "Criminalization Creep"]; HALCO & Canadian HIV/AIDS Legal Network. "Recommendations for police", *supra* note 76; UNAIDS, *Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Background and Current Landscape, Background paper*, February 2012, at 27-28 [UNAIDS, *Criminalisation of HIV Non-Disclosure*].

[81] Grant, "Over-Criminalization", *supra* note 76; Kim Shayo Buchanan, "When is HIV a Crime? Sexuality, Gender and Consent" (2015) 99 Minn L Rev 1231 [Shayo Buchanan, "When is HIV a Crime?"]; HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues", *supra* note 79 at p 4; Positive Living, "The Need for New Charge Assessment Guidelines", *supra* note 76 at 12-13; Eric Mykhalovskiy, Glenn Betteridge & David McLay, "HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario" (2010) at 67, available online [Mykhalovskiy, Betteridge & McLay, "Establishing Policy Options for Ontario"].

[82] Positive Living, "The Need for New Charge Assessment Guidelines", *supra* note 76 at 13; Mykhalovskiy, Betteridge & McLay, "Establishing Policy Options for Ontario", *supra* note 81 at p 49.

[83] Canadian HIV/AIDS Legal Network, "Criminal Law & HIV", *supra* note 76; HALCO & Canadian HIV/AIDS Legal Network "Recommendations for police", *supra* note 76 at 12; Canadian HIV/AIDS Legal Network, Information Sheet, "Women and the Criminalization of HIV Non-Disclosure" (2017) at p 5, available online [Canadian HIV/AIDS Legal Network, "Women and Criminalization of HIV Non-Disclosure"]; Canadian HIV/AIDS Legal Network, Information Sheet, "HIV Criminalization in Canada: Current Context & Advocacy" (16 December 2016), available online.

[84] Canadian HIV/AIDS Legal Network, Information Sheet, "HIV Criminalization in Canada: Current Context & Advocacy" (16 December 2016), available online; Akim Adé Larcher & Alison Symington, *Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario* (November 2010) African and Caribbean Council on HIV/AIDS in Ontario, available online; Eric Mykhalovskiy & Glenn Betteridge, "Who? What? Where? When? And with What Consequences?: An Analysis of Criminal Cases of HIV Non-disclosure in Canada" (2012) 27 Canadian Journal of Law & Society 31, available online [Mykhalovskiy, "Who? What? Where?]; Cécile Kazatchkine & Sandra Ka Hon Chu, "We need to address the unique and complex issues of Indigenous people living with HIV", (10 April 2016) CATIE (Blog), available online; Judy Mill et al., "Challenging Lifestyles: Aboriginal Men and Women Living with HIV", (2008) 5:2 Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 151, available online.

[85] Meeting between representatives of the office of the Minister of Justice and stakeholders held on February 9, 2017; Mykhalovskiy, Betteridge & McLay, "Establishing Policy Options for Ontario", *supra* note 76 at 57; Alison Symington, "What Does Consent Really Mean? Rethinking HIV Non-Disclosure and Sexual Assault Law", (25 February 2016) at 9; Canadian HIV/AIDS Legal Network, *Responding to the Criminalization of HIV Transmission or Exposure: Resources for lawyers and advocates*, available online; Alexander McClelland, Concordia University "The Criminalization of HIV Non-Disclosure & Exposure: Impacts of Legal Violence on the Lives of People Living with HIV" (2017).

[86] Aziza Ahmed et al., "Criminalising consensual sexual behaviour in the context of HIV: Consequences, evidence, and leadership" (2011) 6:3 Global Public Health S357 at S362; Sarah L Drummond, "Criminalizing HIV Transmission and Exposure in Canada: A Public Health Evaluation" (2011) 19:2 Health Law Review 28 at 33; Martin French, "Counselling anomie: clashing governmentalities of HIV criminalisation and prevention" (2014) 25:4 Critical Public Health 427 at 432; C. L. Galletly & S.D. Pinkerton, "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV" (2006) 10:5 AIDS and Behavior 451; Ciann Wilson, "The Impact of the Criminalization of HIV Non-Disclosure on the Health and Human Rights of 'Black' Communities" (2013) 1 Health Tomorrow 109; Mykhalovskiy, "Public health implications of HIV criminalization", *supra* note 80 at 377; International Community of Women Living with HIV, Issue Paper, "Criminalization of Women Living with HIV: Non-Disclosure, Exposure, And Transmission" (May 2015) at 2, available online; Cécile Kazatchkine, "HIV Non-Disclosure and the Criminal Law: An Analysis of two Recent Decisions of the Supreme Court of Canada" (2013) 60 Crim L Q 30 at 40; Alison Symington, "Injustice Amplified by HIV Non-Disclosure Ruling" (2013) 63 UTLJ 485 at 486; public health critiques are summarized in Shayo Buchanan, "When is HIV a Crime?", *supra* note 81 at 1241-48; Mark A. Wainberg, "HIV transmission should be decriminalized: HIV prevention programs depend on it" (2008) 5 Retrovirology 108; HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues", *supra* note 79 at 4; Canadian HIV/AIDS Legal Network, "Women and Criminalization of HIV Non-Disclosure", *supra* note 83 at 2; HALCO & Canadian HIV/AIDS Legal Network. "Recommendations for police", *supra* note 76 at 6; Positive Living, "The Need for New Charge Assessment Guidelines", *supra* note 76; ATHENA Network, "10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women" (2009), available online; Inter-Parliamentary Union, *Effective Laws to*

End HIV and AIDS: Next Steps for Parliaments, (2013) at 6, 11 & 14 online; UNAIDS, *The Gap Report* (16 July 2014) at 137, available online; UNAIDS, *Criminalisation of HIV Non-Disclosure*, *supra* note 80 at 23 & 25; Richard Elliott, *Criminal Law Public Health and HIV Transmission: A Policy Options Paper* (2002: UNAIDS) at 5 & 7, available online [Richard Elliott, "UNAIDS Policy Options Paper"].

[87] UNAIDS, *Criminalisation of HIV Non-Disclosure*, *supra* note 80 at 23.

[88] Mykhalovskiy, "Public health implications of HIV criminalization", *supra* note 80; Kyle Kirkup, "Releasing Stigma: Police, Journalists and Crimes of HIV Non-Disclosure" (2014) 46 Ottawa L Rev 127; A. Persson, "'I don't blame that guy that gave it to me': contested discourses of victimisation and culpability in the narratives of heterosexual women infected with HIV" (2014) 26:2 AIDS Care 233; A Persson & C Newman, "Making monsters: heterosexuality, crime and race in recent Western media coverage of HIV" (2008) 30:4 Sociology of Health & Illness 632; Patrick O'Byrne, "The potential effects of a police announcement about an HIV nondisclosure: a case analysis" (2011) 12:1 Policy, Politics and Nursing Practice 53; Patrick O'Byrne et al, "Nondisclosure prosecutions and population health outcomes: examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada" (2013) 13:94 BMC Public Health, available online; Barry D. Adam et al, "HIV positive people's perspectives on Canadian criminal law and non-disclosure" (2016) 31 Can JL & Society 1.

[89] Mykhalovskiy, "Public health implications of HIV criminalization", *supra* note 80 at 374; Isabel Grant, "The Boundaries of the Criminal Law: the Criminalization of the Non-disclosure of HIV", (2008) 31 Dalhousie LJ 123 [Grant, "Boundaries of Criminal Law"].

[90] Canadian HIV/AIDS Legal Network and Interagency Coalition on AIDS and Development, Briefing Papers, "Addressing HIV Risk Behaviours: A Role for Public Health Legislation and Policy" (September 2010), available online.

[91] Mykhalovskiy, Betteridge & McLay, "Establishing Policy Options for Ontario", *supra* note 81 at 58.

[92] The United Nations Committee on the Elimination of Discrimination against Women (CEDAW), consistent with recommendations of UNAIDS, recommends criminalizing only intentional transmission of HIV and welcomed Canada's intention to review the use and application of criminal law to HIV issues. United Nations, Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding Observations on the Combined Eighth and Ninth Periodic Reports of Canada* (2016) at 15, available online; Mykhalovskiy, "Who? What? Where?", *supra* note 84 at 50-51.

[93] Scott Burris, Edwin Cameron & Michaela Clayton, *The Criminalization of HIV: Time for an Unambiguous Rejection of the Use of Criminal Law to Regulate the Sexual Behavior of those with and at Risk of HIV* (2008) available online (published in shorter form in Scott Burris and Edwin Cameron, "The Case Against Criminalization of HIV Transmission" (2008) 300 JAMA); W Brown, J Hanefeld & J Welsh, "Criminalising HIV transmission: Punishment without protection" (2009) 17:34 Reproductive Health Matters 119; R Jurgens et al, "Ten reasons to oppose the criminalization of HIV exposure or transmission" (2009) 17:34 Reproductive Health Matters 163; Philip B Berger, "Prosecuting for knowingly transmitting HIV is warranted" (2009) 180:13 CMAJ 1368.

[94] UNAIDS, "Ending overly broad criminalization", *supra* note 80 at 22-23.

[95] *Ibid* at 3.

[96] Richard Elliott, "UNAIDS Policy Options Paper", *supra* note 86 at 5 online.

[97] UNAIDS, "Ending overly broad criminalization", *supra* note 94.

[98] Global Commission on HIV and the Law, *Risks Rights & Health*, 2012 at 24, available online [Global Commission on HIV and the Law, "Risks, Rights & Health"]; Richard Elliott, "UNAIDS Policy Options Paper", *supra* note 86 at 39.

[99] Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006 consolidated version, at 29.

[100] Sharon Cowan, "Offenses of Sex or Violence? Consent, Fraud, and HIV Transmission" (2014) 17:1 New Criminal L Rev 140.

[101] HALCO & Canadian HIV/AIDS Legal Network, "Recommendations for police", *supra* note 76; HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues", *supra* note 79; Ontario Working Group on Criminal Law and HIV Exposure, *Consultation on Prosecutorial Guidelines for Ontario Cases Involving Non-disclosure of Sexually Transmitted Infections: Community Report and Recommendations to the Attorney General of Ontario*, June 2011, available online [Ontario WG, "Consultation on Prosecutorial Guidelines"].

[102] Elaine Craig, "Personal *Stare Decisis*, HIV Non-Disclosure, and the Decision in *Mabior*" (2015) 53:1 Alberta L Rev 208; Grant, "Over-criminalization", *supra* note 76.

[103] Ontario WG, "Consultation on Prosecutorial Guidelines", *supra* note 101. Stakeholders who participated in the February 9, 2017 meeting with the office of the Minister of Justice recommended adopting a restorative justice lens to these cases.

[104] Canadian HIV/AIDS Legal Network, *Sex Offender Registries: Fact Sheet*, April 2017, available online.

[105] Grant, "Boundaries of Criminal Law", *supra* note 89; UNAIDS, "Ending overly broad criminalization", *supra* note 80 at 39; UNAIDS & UNDP, *International Consultation on the Criminalization of HIV Transmission, Summary of main issues and conclusions*, September 2008, available online [UNAIDS & UNDP, "International Consultation"].

[106] Barry D Adam et al, "Impacts of criminalization on the everyday lives of people living with HIV in Canada" (2014) 11 Sexuality Research and Social Policy 39; HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues" *supra* note 79 at 10; COCQ-SIDA, *Recommandation pour une directive sur la non-divulgation du VIH ou d'une autre ITSS*, January 2013; Positive Living, "The Need for New Charge Assessment Guidelines", *supra* note 76; Mykhalovskiy, Betteridge & McLay, "Establishing Policy Options for Ontario", *supra* note 81.

[107] Yusef Azad, "Developing guidance for HIV prosecutions: an example of harm reduction?" (2008) 13:1 HIV AIDS Policy L Rev 13.

[108] Ontario Working Group on Criminal Law and HIV Exposure, *Latest News*, online; Ontario WG, "Consultation on Prosecutorial Guidelines", *supra* note 101; UNAIDS, "Ending overly broad criminalization", *supra* note 80 at 44.

[109] David Hughes, "Condom Use, Viral Load and the Type of Sexual Activity as Defences to the Transmission of HIV" (2013) 77 J Crim L 136; UNAIDS, "Ending overly broad criminalization", *supra* note 80 at 29; UNAIDS & UNDP, "International Consultation", *supra* note 105 at 18; Richard Elliott, "UNAIDS Policy Options Paper", *supra* note 86 at 39-40.

[110] HALCO & Canadian HIV/AIDS Legal Network, "Recommendations for police", *supra* note 76 at pp 8, 9 and 14; HALCO & Canadian HIV/AIDS Legal Network, "Exploring Avenues", *supra* note 79 at pp 8 and 12; COCQ-SIDA, *Position de la COCQ-SIDA sur la criminalisation de l'exposition au VIH*, April 2013 at p 8, available online; the CLHE also recommends training for Crown counsel specifically: Ontario Working Group on Criminal Law and HIV Exposure, Ontario WG, "Consultation on Prosecutorial Guidelines", *supra* note 101 at 25; UNAIDS, "Ending overly broad criminalization", *supra* note 80; Richard Elliott, "UNAIDS Policy Options Paper", *supra* note 86 at 40.

[111] Wilson, "Health and Human Rights of 'Black' Communities", *supra* note 86 at 137-38.

[112] Mykhalovskiy, "Public health implications of HIV criminalization", *supra* note 80; Dej, "Criminalization Creep", *supra* note 80 at 64-65.

[113] EJ Bernard, *The evolution of global criminalisation norms: the role of the United States*, HIV and the Criminal Law, London, NAM, 2010 online.

[114] Global Commission on HIV and the Law, "Risks, Rights & Health", *supra* note 98 at 22.

[115] UNAIDS, *Criminalisation of HIV Non-Disclosure*, *supra* note 80 at 6.

[116] *Ibid*.

[117] Crown Prosecution Service, *Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection*, updated July 2011, available online [England and Wales Crown Prosecution Service, "Policy Statement on Intentional or Reckless Sexual Transmission of Infection"]; see also, Crown Prosecution Service, *Intentional or*

Reckless Sexual Transmission of Infection, available online [England and Wales Crown Prosecution Service, "Legal Guidance on Intention or Reckless Sexual Transmission of Infection"].

[118] Crown Office and Procurator Fiscal Service, *Prosecution policy on the sexual transmission of infection*, May 2012, available online: [Scotland Prosecution Service, "Prosecution Policy on sexual transmission of infection"].

[119] *Ibid.*

[120] *Ibid*.

[121] This information was requested and received through the FPT Council of Chief Medical Officers of Health.

[122] However, the First Nations and Inuit Health Branch (FNHIB) supports the delivery of public health and health promotion services on-reserve and in Inuit communities. FNHIB also provides primary care services on-reserve in remote and isolated areas, where there are no provincial services readily available. For more information, see Health Canada, First Nations and Inuit Health Branch, online.

[123] HIV testing can be nominal (name-based), non-nominal (non-identifying) or anonymous. Anonymous testing is not available in all jurisdictions. The type of information collected from the individual participating in HIV testing and subsequently reported to public health authorities varies according to the type of test and province and territory. For more information, see Public Health Agency of Canada (PHAC), HIV/AIDS Epi Updates, Chapter 3, *HIV Testing and Surveillance Systems in Canada*, July 2010, available online [PHAC, "HIV/AIDS Epi Updates"]. For examples of HIV reporting and data collection regulations, see Nova Scotia's *Reporting Requirements for HIV Positive Persons Regulations*, NS Reg 197/2005 [Nova Scotia *Reporting Requirements for HIV Positive Persons*]; and Québec's *Minister's Regulation under the Public Health Act*, CQLR c S-2.2, r 2, ss 10-13.

[124] For example, in Saskatchewan it is physicians, nurse practitioners or clinic nurses who are responsible to notify the local medical health officer of persons diagnosed with HIV (or upon forming the opinion that a person is infected) under the *Public Health Act, 1994*, SS 1994, c P-37.1, s 34 [Saskatchewan, *Public Health Act*] and the *Disease Control Regulations*, RRS, c P-37.1, Reg 11, s 14.

[125] PHAC, "HIV/AIDS Epi Updates", *supra* note 123.

[126] As examples, see Government of Ontario, *Guidelines for HIV Counselling and Testing*, March 2008 at 15-18, available online; Government of Québec, *Guide québécois de dépistage des infections transmissibles sexuellement et par le sang*, updated June 2017, available online; eHealth Saskatchewan, *Communicable Disease Control Manual, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV)*, October 2015, section 6-40 available online; Manitoba Communicable Disease Control Branch, *Communicable Disease Management Protocol, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)*, February 2010 at 14-16, available online; Alberta Health Services, *The Blue Book: Standards for the Management and Evaluation of STI Clinic Clients*, July 2014 at 142-143, available online [Alberta, "*Blue Book*"]; BC Centre for Disease Control, *Communicable Disease Control Manual, Chapter 5 – Sexually Transmitted Infections, HIV Pre and Post Test Guidelines*, September 2011 at 10, available online.

[127] For example, under Saskatchewan's *Public Health Act*, *supra* note 124, a physician, nurse practitioner or clinic nurse is required to counsel an affected individual and obtain information on the individual's contacts no later than 72 hours after forming the opinion that a person is infected with or a carrier of HIV.

[128] For example, Ontario's *Health Protection and Promotion Act*, RSO 1990, c H.7, s 39 [*Health Protection Act]* includes a confidentiality provision which guards against the disclosure of identifying information of individuals affected by a communicable or reportable disease, there are however exceptions which may apply in certain cases. In guidelines used in British Columbia, the importance of contact notification and anonymity is explained; see BC Centre for Disease Control, *Communicable Disease Control Manual, Chapter 5 – Sexually Transmitted Infections, Guidelines for Testing, Follow up, and Prevention of HIV*, October 2016 at 25, available online.

[129] In Alberta, there are guidelines on contact management and the recommended processes for identifying and notifying an affected individual's sexual and needle-sharing partners. See Alberta Health and Wellness, *Public Health Notifiable Disease Management Guidelines, Human Immunodeficiency Virus (HIV)*, January 2011 at 9-10 available online; Alberta, "Blue Book", *supra* note 126.

[130] Provincial Infectious Disease Advisory Committee, *Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations*, April 2009 at 51-52, available online.

[131] Public Health Agency of Canada, *Canadian Guidelines on Sexually Transmitted Infections*, 2006, available online.

[132] For example, in the Northwest Territories' *Reportable Disease Control Regulations*, NWT Reg 128-2009, s 4(1), healthcare professionals shall within 24 hours of making a reportable disease diagnosis counsel the affected individual and make reasonable efforts to carry out contact tracing, among other things. See also Nova Scotia's *Reporting Requirements for HIV Positive Persons*, *supra* note 123, ss 12-14, which sets out partner notification responsibilities for affected individuals, physicians, and public health authorities.

[133] For example, Prince Edward Island's *Public Health Act*, RSPEI 1988, c P-30.1, s 39(4)(e) [PEI *Public Health Act*] provides that an order may be made "requiring the person to whom the order is directed to provide information respecting the person's contacts related to a communicable disease to the Chief Public Health Officer." See also Alberta's *Public Health Act*, RSA 2000, c P-37, s 56 [Alberta *Public Health Act*], which requires an individual to provide on request "the names of all persons with whom the person has had sexual contact." Similarly, see Saskatchewan's *Public Health Act*, *supra* note 124, s 38(2)(k.1); and Manitoba's *Reporting of Diseases and Conditions Regulation*, Man Reg 37/2009, s 20.

[134] For example, the Office of the Chief Medical Officer of Health in Alberta recently released a report that: addresses the needs of individuals who are unwilling or unable to prevent the spread of HIV; outlines the existing areas of services and supports for these individuals in Alberta; and describes the legal tools that may be used when deemed necessary to protect the public. See the Government of Alberta, Report by Alberta's Chief Medical Officer of Health, *HIV positive Individuals Who are Unwilling or Unable to Prevent the Spread of HIV in Alberta*, February 2015, available online; See also Manitoba's Winnipeg Regional Health Authority, *Managing HIV Non-Disclosure in Refusing (Unable or Unwilling) Clients*, 2014, available online [Winnipeg Health Authority, "Managing HIV Non-Disclosure"].

[135] See for example British Columbia's *Public Health Act*, SBC 2008, c 28, ss 27-29 [BC *Public Health Act*]; Ontario's *Health Protection Act*, *supra* note 127, ss 22-24; Saskatchewan's *Public Health Act*, *supra* note 124, s 38; New Brunswick's *Public Health Act*, SNB 1998, c P-22.4, ss 33-35 [New Brunswick's *Public Health Act*]; Newfoundland's *Communicable Diseases Act*, RSNL 1990, c C-26, s 15; Northwest Territories' *Public Health Act*, SNWT 2007, c 17, s 25 [Northwest Territories' *Public Health Act*]; Nova Scotia's *Health Protection Act*, SNS 2004 [Nova Scotia's *Health Protection Act*], c 4, s 32; and Québec's *Public Health Act*, SQ 2001, c 60, ss 100, 103, 106 [Québec's *Public Health Act*].

[136] For example, Alberta's *Public Health Act*, *supra* note 133, ss 39-40; and Northwest Territories' *Public Health Act*, *supra* note 135, s 28.

[137] See for example, British Columbia's *Public Health Act*, *supra* note 135, s 49; Ontario's *Health Protection Act*, *supra* note 127, s 35; Prince Edward Island's *Public Health Act*, *supra* note 133, s 42; Manitoba's *The Public Health Act*, CCSM c P210, ss 47, 49 [*The Public Health Act*]; and Québec's *Public Health Act*, *supra* note 135, s 105.

[138] For example, Ontario's *Health Protection Act, supra* note 127, s 100; New Brunswick's *Public Health Act*, *supra* note 135, ss 52-53; Nova Scotia's *Health Protection Act*, *supra* note 135, s 71; and Manitoba's *The Public Health Act*, *supra* note 137, s 90.

[139] For example, in Northwest Territories, the Chief Public Health Officer may provide notice to the public of the name of a person who has a reportable disease if the Chief Public Health Officer considers that the notice is necessary to protect the public and that the protection cannot reasonably be achieved by less intrusive means, pursuant to the *Public Health Act*, *supra* note 135, s 27. See also the release of information provisions in New Brunswick's *Public Health Act*, *supra* note 135, s 66.

[140] Several jurisdictions noted the application of privacy and information laws when disclosing any information.

[141] See for example Government of Northwest Territories, *NWT HIV/AIDS Manual for Health Professionals*, appendix 1, (Northwest Territories: March 2006); and Manitoba's Winnipeg Health Authority, "Managing HIV Non-Disclosure", *supra* note 134.

[142] See, for examples, Alberta's *Public Health Act*, *supra* note 133, s 40; and Saskatchewan's *Public Health Act*, *supra* note 124, s 55.

[143] Some guidelines cite domestic and international support (e.g., from UNAIDS and the Canadian HIV/AIDS Legal Network) for non-criminal responses to HIV and emphasize that public health measures are most appropriate in reducing the risk of transmission to others and less likely to stigmatize individuals with HIV. See for examples Manitoba's Winnipeg Regional Health Authority, *Position Statement on Harm Reduction*, December 2016 at 12-13, available online; and British Columbia's British Columbia Centre for Disease Control, *Guidelines for Medical Health Officers: Frequently Asked Questions*, January 2011 at 4-5, available online.

[144] The following jurisdictions provided information on charging and prosecutorial practices in their respective jurisdictions: Northwest Territories, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Nova Scotia.

[145] Victim impact statements in over 50 cases were reviewed. To protect complainants' privacy case names are not provided.

[146] Government of Canada, *The Criminal Law in Canadian Society*, (Ottawa: 1982).

[147] *Ibid*.

[148] *Mabior*, *supra* note 38 at para 89.

Bibliography

LEGISLATION

Communicable Diseases Act, RSNL 1990, c C-26.

Health Protection Act, SNS 2004, c 4.

Health Protection and Promotion Act, RSO 1990, c H.7, s 39.

Public Health Act, RSA 2000, c P-37.

Public Health Act, SBC 2008, c 28.

Public Health Act, RSPEI 1988, c P-30.1.

Public Health Act, SNB 1998, c P-22.4

Public Health Act, SQ 2001, c 60.

Public Health Act, RSS 1994, c P-37.

Reporting of Diseases and Conditions Regulation, Man Reg 37/2009.

Reportable Disease Control Regulations, NWT Reg 128-2009.

JURISPRUDENCE

Krieger v Law Society of Alberta, 2002 SCC 65.

R v Agnatuk-Mercier, [2001] OJ No 4729 (QL).

R v Allen, 2012 BCSC 215; 2012 BCCA 377.

R v Antonius, 2000 BCSC 429.

R v Aziga, [2008] OJ no 4669 (QL); 2011 ONSC 4592.

R v Beaudoin, 2016 ONCJ 803.

R v Bear, 2011 MBQB 191; 2013 MBCA 96.

R v Biron, [2014] QCCQ 8115.

R v Bissette, [2017] ONCJ 545.

R v Bitterman, 2005 ABPC 165.

R v Boone, 2012 ONSC 441; 2016 ONCA 227.

R v Boone, 2013 ONSC 79.

R v Boone, 2016 ONSC 1626.

R v Booth, [2005] ABPC 137.

R v Brooks, [2006] AJ No 245 (QL).

R v Bruneau, [2010] OJ No 4600 (QL).

R v C.B., 2017 ONCJ 545.

R v C. (J.T.), [2013] NSPC 105.

R v Clarke, 2013 ONSC 3232.

R v Courcy, [2017] QCCQ 4348.

R v Cuerrier, [1998] 2 SCR 371.

R v D.C., 2012 SCC 48.

R v DeBlois, [2005] Carswell Ont 1551 (WL Can).

R v Debnam, 2002 ABCA 222.

R v Dionne, 2012 ABPC 261.

R v Dowholis, 2016 ONCA 801.

R v Dufresne, 2009 QCCQ 16249; 2010 QCCA 2212.

R v Edwards, 2001 NSSC 80.

R v F.S., 2004 ONCJ 230.

R v Felix, 2010 ONCJ 322; 2010 ONCJ 654; 2013 ONCA 415.

R v Flowers, [2014] ORBD No 3101 (QL); [2016] ORBD No 229 (QL); [2016] ORBD No 3096 (QL).

R v Gowdy, 2014 ONCJ 592; 2014 ONCJ 696; 2016 ONCA 989.

R v Hutchinson, 2014 SCC 19.

R v Iamkhong, [2007] OJ No 3252 (QL); 2009 ONCA 478.

R v Ifejika, 2006 ONCJ 356; C*atholic Children's Aid Society of Hamilton c I. (J.)*, [2006] OJ no 2299 (QL).

R v Jacko, 2013 QCCQ 931.

R v J.M., [2005] OJ No 5649 (QL); 2005 CarswellOnt 8297 (QL).

R v JTC, 2013 NSPC 88; 2013 NSPC 105.

R v Jackson, 2003 YKTC 32.

R v Kaonga, [2008] CarswellMan 684 (WL Can).

R v Kaotalok, 2013 NWTSC 36.

R v Kidane Gebrejohannes, 2016 ABCA 205.

R v Krouglov, 2017 ONCA 197.

R v L (J.M.), 2007 BCPC 341.

R v L (M), 2006 QCCQ 11242; 2010 QCCA 395.

R v Lamirande, [2006] MJ No 223 (QL); 2006 MBCA 71.

R v Leahy, 2006 BCPC 179.

R v Leone, 2016 FC 980.

R v Lesage, 2013 QCCQ 1951.

R v Levac, 2009 QCCQ 4533.

R v M (RP), [2000] MJ No 500 (QL).

R v Mabior, 2012 SCC 47.

R v McGregor, 2008 ONCA 831.
R v Mekonnen, 2009 ONCJ 643; 2013 ONCA 414.
R v Mercier, 2011 QCCQ 198.
R v Miron, [2000] MJ no 500 (QL).
R v Mumford, [2009] OJ no 1637 (QL); 2010 ONSC 5624.
R v Murphy, [2013] CarswellOnt 11952 (WL Can).
R v Murray, 2002 BCPC 203.
R v Mzite, 2011 BCCA 267.
R v N.D., 2006 QCCA 14; 2006 QCCA 15.
R v Nduwayo, 2010 BCSC 1277; 2010 BCSC 1467; 2012 BCCA 281.
R v Nelson, 2012 BCPC 348.
R v Ngeruka, 2015 YKTC 10; 2015 YKTC 22.
R v Nyandwi, 2014 ABPC 186.
R v Nyoni, 2014 BCSC 1074; 2014 BCCA 106.
R v P (J.D.), 2001 BCCA 341.
R v Parenteau, 2010 ONSC 1500.
R v Pelletier, 2011 SKQB 7; 2013 SKCA 107.
R v Pottelberg, 2010 ONSC 5756.
R v Ralph, 2014 ONSC 1376; 2014 ONSC 2800; 2014 ONSC 1072.
R v Rollo, 2011 BCPC 283.
R v S (KA), 2007 NSCA 119.
R v Schenkels, 2016 MBQB 44; 2017 MBCA 62.
R v Smith, 2004 BCPC 384; 2004 BCCA 657.
R v Smith, [2007] SJ No 150 (QL); 2008 SKCA 61.
R v Spooner, 2014 ONSC 7420.
R v Thery, [2012] CarswellQue 9375 (WL Can).
R v Thomas, 2011 ONSC 7136; 2012 ONSC 1201; 2015 ONCA 221.
R v Thompson, 2016 NSSC 134; 2016 NSSC 257.
R v Thompson, 2007 BCPC 192; 2008 BCCA 350.
R v Tippeneskum, 2011 ONCJ 219.
R v Trott, 2010 BCSC 766.
R v Tshibamba Muntu, 2017 QCCQ 4299.
R v U (J), 2011 ONCJ 457.
R v WH, 2015 ONSC 6121; 2015 ONSC 3087.
R v Washington, [2016] OJ no 3253 (QL).

R v Walford, 2016 ONCA 355.

R v Walkem, [2007] CarswellOnt 247 (WL Can).

R v Ward, 2005 BCPC 630; 2006 BCCA 153.

R v Wilcox, 2011 QCCQ 11007; 2014 QCCA 321; 2014 CSC 75.

R v Williams, 2000 CarswellNfld 130 (WL Can); [2000] NJ no 166 (QL); 2001 NFCA 52; 2003 CSC 41.

R v Williams, [2001] NJ no 169 (QL) (C Sup TNL); 2004 NLCA 24.

R v Williams, 2006 ONCJ 484.

R v Wright, 2009 BCCA 514.

Re Mitchell, 2016 CarswellOnt 10925 (QL).

SECONDARY MATERIAL: ARTICLES

Adam, Barry *et al,* "Effects of the Criminalization of HIV Transmission in Cuerrier on Men Reporting Unprotected Sex with Men" (2008) 23:1-2 Canadian Journal of Law and Society 143.

———. "HIV positive people's perspectives on Canadian criminal law and non-disclosure" (2016) 21:1 Canadian Journal of Law and Society 1.

———. "Impacts of criminalization on the everyday lives of people living with HIV in Canada" (2014) 11 Sexuality Research and Social Policy 39.

Ahmed, Aziza *et al*., "Criminalising consensual sexual behaviour in the context of HIV: Consequences, evidence, and leadership" (2011) 6:3 Global Public Health 357.

Arseniou, Stylianos, Aikaterini Arvaniti & Maria Samakouri. "HIV infection and depression" (2013) 68:2 Psychiatry and Clinical Neurosciences 96;

Azad, Y. "Developing guidance for HIV prosecutions: an example of harm reduction?" (2008) 13:1 HIV AIDS Policy L Rev 13.

Becker *et al*, Association of Medical Microbiology and Infectious Disease Canada Position Statement, "The Use of Early Antiretroviral Therapy in HIV-infected Persons" (2015).

Berger, Philip B. "Prosecuting for knowingly transmitting HIV is warranted" (2009) 180:13 CMAJ 1368.

Bennett, David S. *et al*., "Shame among people living with HIV: a literature review" (2015) 28:1 AIDS Care 87.

Bravo, P. *et al*., "Tough decisions faced by people living with HIV: a literature review of psychosocial problems" (2010) 12:2 AIDS Rev 76.

Brenner, Bluma G *et al*, "High rates of forward transmission events after acute/early HIV-1 infection" (2007) 195:7 J Infect Dis 951.

Brown, W, J Hanefeld & J Welsh. "Criminalising HIV transmission: Punishment without protection" (2009) 17: 34 Reproductive Health Matters 119.

Buchanan, Kim Shayo. "When is HIV a Crime? Sexuality, Gender and Consent" (2014) 99 Minnesota Law

Review 14.

Burris, Scott, Edwin Cameron & Michaela Clayton. *The Criminalization of HIV: Time for an Unambiguous Rejection of the Use of Criminal Law to Regulate the Sexual Behavior of those with and at Risk of HIV* (2008).

Burris, Scott *et al*., "Do criminal laws influence HIV risk behavior?" (2007) 39 Arizona State Law Journal 467.

Canadian AIDS Society. "HIV Transmission: Factors that Affect Biological Risk" (11 February 2013).

———. "HIV transmission: Guidelines for Assessing Risk" (2004) 5th ed.

Canadian HIV/AIDS Legal Network. "Addressing HIV Risk Behaviors: A role for Public Health Legislation Policy" (2013).

———. "Criminal Law & HIV Non-Disclosure in Canada" (2014).

———. "HIV non-disclosure and the criminal law: An analysis of two recent decisions of the Supreme Court of Canada R. v. Mabior, 2012 SCC 47 R. v. D.C., 2012 SCC 48" (2012).

———. "Responding to the criminalization of HIV transmission or exposure" (2015).

Cheung, CC *et al*, "Reductions in all-cause and cause-specific mortality among HIV-infected individuals receiving antiretroviral therapy in British Columbia, Canada: 2001–2012" (2016) 17 HIV Medicine 694.

Cowan, Sharon. "Offenses of Sex or Violence? Consent, Fraud, and HIV Transmission" (2014) 17:1 New Criminal Law Review 135.

Craig, Elaine. "Personal Stare Decisis, HIV Non-disclosure, and the decision in Mabior" (2015) 53:1 Alberta Law Review 208.

Daar, Eric & Katya Corado. "Condomless Sex with Virologically Suppressed HIV-Infected Individuals: How Safe is it?" (2016) 316:2 JAMA 149.

Dej, Erin & Jennifer M. Kilty. "Criminalization Creep": A Brief Discussion of the Criminalization of HIV/AIDS Nondisclosure in Canada" (2012) 27:1 Canadian Journal of Law and Society 55.

Drummond, Sarah L. "Criminalizing HIV Transmission and Exposure in Canada: A Public Health Evaluation" (2011) 19:2 Health Law Review 28.

Flaherty, John. "Clarifying the Duty to Warn in HIV Transference Cases" (2008) 54 Crim. L.Q. 61.

French, Martin. "Counselling anomie: clashing governmentalities of HIV criminalisation and prevention". (2014) 25:4 Critical Public Health 373.

Galletly, Carol L. & Steven D. Pinkerton. "Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV" (2006) 10:5 AIDS and Behavior 451;

———. "Preventing HIV Transmission via HIV Exposure Laws: Applying Logic and Mathematical Modeling to Compare Statutory Approaches to Penalizing Undisclosed Exposure to HIV" (2008) 36:3 J Law Med Ethics 577.

Grant, Isabel. “Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions” (2009) 54 McGill LJ 389.

———. “The Boundaries of the Criminal Law: The Criminalization of the Non-Disclosure of HIV” (2008) 31 Dal LJ 123.

———. “The Over-Criminalization of Persons with HIV" online: (2013) 63:3 UTLJ 475.

Grant, Isabel, Martha Shaffer & Alison Symington. “Focus: R v Mabior and R v DC” (2013) 63 UTLJ 462.

Gonzalez, Jeffrey S *et al*., “Depression and HIV/AIDS Treatment Non-adherence: A Review and Meta-analysis” (2013) 58:2 J Acquir Immune Defic Syndr 10.

Harsono, Dini *et al*., “Criminalization of HIV Exposure: A Review of Empirical Studies in the United States” (2017) 21:1 AIDS and Behaviour 27.

Hastings, Colin, Cécile Kazatchkine & Eric Mykhalovskiy, Information Sheet, *HIV Criminalization in Canada: Key Trends and Patterns* (17 March 2017), Canadian HIV/AIDS Legal Network.

Hughes, David. “Condom Use, Viral Load and the Type of Sexual Activity as Defences to the Sexual Transmission of HIV” (2013) 77:2 The Journal of Criminal Law 136.

Jain, Sachin & Kenneth H Mayer. “Practical guidance for nonoccupational postexposure prophylaxis to prevent HIV infection: an editorial review” (2014) 28:11 AIDS 1545.

Jurgens, R *et al.*, “Ten reasons to oppose the criminalization of HIV exposure or transmission” (2009) 17:34 Reproductive Health Matters 163.

Kaplan, Margo. “Rethinking HIV-Exposure Crimes” (2012) 87:4 Indiana Law Journal 1517.

Katz, Ingrid T *et al*., “Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis” (2013) 16:2 Journal of the International AIDS Society 1.

Kazatchkine, Cécile. "HIV Non-Disclosure and the Criminal Law: An Analysis of two Recent Decisions of the Supreme Court of Canada" (2013) 60 Crim L Q 30.

Kazatchkine, Cécile & Sandra Ka Hon Chu. “We need to address the unique and complex issues of Indigenous people living with HIV”, (10 April 2016) CATIE (Blog).

Larcher, Akim Adé & Alison Symington. Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario (November 2010), online: Toronto: African and Caribbean Council on HIV/AIDS in Ontario.

Lee, Sun Goo. “Criminal Law and HIV Testing: Empirical Analysis of How At-Risk Individuals Respond to the Law” (2015) 14:1 Yale Journal of Health Policy, law and Ethics 194.

Loutfy, Mona *et al*, “Canadian consensus statement on HIV and its transmission in the context of criminal law” (2014) 25:3 Can J Infect Dis Med Microbiol 135.

———. “Systematic Review of HIV Transmission between Heterosexual Serodiscordant Couples where the HIV-Positive Partner Is Fully Suppressed on Antiretroviral Therapy” (2013) 8:12 PLOS ONE 1.

Lowther, Keira *et al*., “Experience of persistent psychological symptoms and perceived stigma among

people with HIV on antiretroviral therapy (ART): A systematic review" (2014) 51:8 International Journal of Nursing Studies 1171.

MacKinnon, Emily & Constance Crompton. "The Gender of Lying: Feminist Perspectives on the Non-Disclosure of HIV Status" (2012) 45:2 UBC L Rev 407.

McClelland, Alexander. *Criminal Charges & Prosecutions Related to HIV Non-Disclosure, Transmission & Exposure: Impacts on The Lives of People Living with HIV*. Doctorate Thesis, Concordia University, (2017) [unpublished and dissertation under development].

McIntosh, Roger C & Monica Rosselli. "Stress and Coping in Women Living with HIV: A Meta-Analytic Review" (2012) 16:8 AIDS and Behaviour 2144.

Miller, James. "African immigrant damnation syndrome: The case of Charles Ssenyonga" (2005) 2:31 Sexuality Research & Social Policy 31.

Eric Mykhalovskiy. ''The problem of 'significant risk': Exploring the public health impact of criminalizing HIV non-disclosure'' (2011) 73:5 Social Science & Medicine 668.

———. "The public health implications of HIV criminalization: past, current, and future research directions", (2015) 25:4 Critical Public Health 373.

Mykhalovskiy, Eric & Glenn Betteridge. "Who? What? Where? When? And with What Consequences? An Analysis of Criminal Cases of HIV Non-disclosure in Canada" (2012) 27:1 Canadian Journal of Law and Society 31.

Mykhalovskiy, Eric *et al.*, "'Callous, Cold and Deliberately Duplicitous': Racialization, Immigration and the Representation of HIV Criminalization in Canadian Mainstream Newspapers" (2016).

Mykhalovskiy, Eric, Glenn Betteridge & David McLay. "HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario", (2010) at 52 CATIE.

Nanni, Maria Giulia *et al*., "Depression in HIV Infected Patients: a Review" (2015) 17 Complex Medical-Psychiatric Issues 530.

O'Byrne, Patrick. "The potential effects of a police announcement about an HIV nondisclosure: a case analysis" (2011) 12:1 Policy, Politics and Nursing Practice 53.

O'Byrne, Patrick, Alyssa Bryan & Marie Roy. "HIV criminal prosecutions and public health: an examination of the empirical research" (2013) 39:2 Medical Humanities 1.

Patrick O'Byrne *et al.*, "Nondisclosure prosecutions and population health outcomes: examining HIV testing, HIV diagnoses, and the attitudes of men who have sex with men following nondisclosure prosecution media releases in Ottawa, Canada" (2013) 13 BMC Public Health 94.

Patel, Pragna *et al*., "Estimating per-act HIV transmission risk: A systematic review". (2014) AIDS 28:10 1509 at 1509.

Persson, A. "I don't blame that guy that gave it to me: contested discourses of victimisation and

culpability in the narratives of heterosexual women infected with HIV" (2014) 26:2 AIDS Care 233.

Persson A & C Newman. "Making monsters: heterosexuality, crime and race in recent Western media coverage of HIV" (2008) 30:4 Sociology of Health & Illness 632.

Rabkin, Judith G. "HIV and depression: 2008 review and update" (2008) 5:4 Behavioral Aspects of HIV Management 163.

Rawluk, Kevin. "HIV and Shared Responsibility: A Critical Evaluation of Mabior and DC" (2013) 22 Dalhousie Journal of Legal Studies 21.

Robbins, G *et al*., "Predicting virologic failure in an HIV clinic" (2010) 1:50 Clin Infect Dis 2010 779.

Rodger, J. Alison *et al*, "Sexual Activity without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy" (2016) 316:2 JAMA 171.

Sawyer, Alexandra, Susan Ayers & Andy P Field. "Posttraumatic growth and adjustment among individuals with cancer or HIV/AIDS: A meta-analysis (2010) 30:4 Clinical Psychology Review 436.

Skarbinski, Jacek *et al*, "Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States" online: (2015) 175:4 JAMA Intern Med 588.

Stewart, Hamish. "When Does Fraud Vitiate Consent? A Comment on R v Williams" (2005) 49 Criminal Law Quarterly 144.

Symington, Alison. "Injustice Amplified by HIV Non-Disclosure Ruling" (2013) 63 UTLJ 485.

———. "What Does Consent Really Mean? Rethinking HIV Non-Disclosure and Sexual Assault Law", (25 February 2016), Canadian HIV/AIDS Legal Network.

Tedaldi, Ellen M., Nancy L Minniti & Tracy Fischer. "HIV-Associated Neurocognitive Disorders: The Relationship of HIV Infection with Physical and Social Comorbidities" (2015) 2015 BioMed Research International.

Vandervort, Lucinda. "HIV, Fraud, Non-Disclosure, Consent and a Stark Choice: Mabior or Sexual Autonomy?" (2013) 60:2 Criminal Law Quarterly 301.

Wainberg, M.A. "HIV transmission should be decriminalized: HIV prevention programs depend on it". (2008) 5 Retrovirology 108.

Waldman, Ari Ezra. "Exceptions: The Criminal Law's Illogical Approach to HIV-Related Aggravated Assaults" (2010) 18:3 Virginia Journal of Social Policy and the Law 550.

Wilson, Ciann. "The Impact of the Criminalization of HIV Non-Disclosure on the Health and Human Rights of 'Black' Communities" (2015) 1 Health Tomorrow 109.

Wood, LF *et al*., "The Oral Mucosa Immune Environment and Oral Transmission of HIV/SIV". (2013) 254:1 Immunological reviews 34.

GOVERNMENT AND PUBLIC HEALTH DOCUMENTS

Alberta. Alberta Health Services, *The Blue Book*: *Standards for the Management and Evaluation of STI Clinic Clients*, (July 2014).

———. Alberta Health and Wellness, *Public Health Notifiable Disease Management Guidelines, Human Immunodeficiency Virus (HIV)*, (January 2011).

———. Report by Alberta's Chief Medical Officer of Health, *HIV positive Individuals Who are Unwilling or Unable to Prevent the Spread of HIV in Alberta*, (February 2015).

British Columbia. BC Centre for Disease Control, Communicable Disease Control Manual, Chapter 5 – Sexually Transmitted Infections, HIV Pre and Post Test Guidelines, (September 2011).

———. BC Centre for Disease Control, "Condom effectiveness - Fact sheet for public health personal" (2013).

———. BC Centre for Disease Control, "Frequently Asked Questions: Topic: Guidelines for Medical Health Officers: Approach to persons with HIV/AIDS who may pose a risk of harm to others", (BC: BC

———. BC Centre for Disease Control, *"Guidelines for Medical Health Officers: Approach to people with HIV/AIDS who may pose a risk of harm to others", (BC: BC Centre for Disease Control, 2010).* Centre for Disease Control, January 24, 2011).

———. British Columbia Centre for Excellence in HIV/AIDS, "HIV Monitoring Quarterly Report for British Columbia" (2015) Third Quarter.

———. British Columbia Centre for Excellence in HIV/AIDS, "Therapeutic Guidelines for Antiretroviral (ARV) Treatment of Adult HIV Infection Canada" (September 2015).

Canada. Department of Justice Canada, "Restorative Justice Program Guidelines", (Ottawa: Department of Justice, 2003).

———. Department of Justice Canada, "Values and Principles of Restorative Justice in Criminal Matters", (Ottawa: Department of Justice, 2003).

———. Government of Canada, *The Criminal Law in Canadian Society*, (Ottawa: 1982).

———. Public Health Agency of Canada, *Canadian Guidelines on Sexually Transmitted Infections*, (2006).

———. Public Health Agency of Canada, "HIV and AIDS in Canada: Surveillance Report to December 31, 2014" (Ottawa: PHAC, 2014).

———. Public Health Agency of Canada, "HIV in Canada: Surveillance summary tables, 2014-2015" (Ottawa: PHAC, 2014-15).

———. Public Health Agency of Canada, HIV/AIDS Epi Updates, Chapter 3, *HIV Testing and Surveillance Systems in Canada*, (July 2010).

———. Public Health Agency of Canada, "HIV Transmission Risk: A Summary of Evidence", (Ottawa: Public Health Agency of Canada, 2013).

———. Public Health Agency of Canada, "Persons who fail to disclose their HIV/AIDS status:

Conclusions reached by an Expert Working Group" (2005) 31(5) Canada Communicable Disease Report.

———. Public Health Agency of Canada, "Population-Specific HIV/AIDS Status Report: People Living with HIV/AIDS" (Ottawa: PHAC, 2013).

———. Public Health Agency of Canada, "Summary: Estimates of HIV incidence, prevalence and proportion undiagnosed in Canada, 2014" (Ottawa: PHAC, 2014).

———. Public Health Agency of Canada, "Summary: Measuring Canada's Progress on the 90-90-90 HIV Targets", by Surveillance and Epidemiology Division Professional Guidelines and Public Health Practice Division Centre for Communicable Diseases and Infection Control (Ottawa: PHAC, 2017).

———. Statistics Canada, *Table 102-0521 Deaths, by cause, Chapter I: Certain infectious and parasitic diseases (A00 to B99), age group and sex, Canada*, CANSIM.

Manitoba Communicable Disease Control Branch, *Communicable Disease Management Protocol, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)*, (February 2010).

Manitoba's Winnipeg Regional Health Authority, *Managing HIV Non-Disclosure in Refusing (Unable or Unwilling) Clients*, (2014).

———. *Position Statement on Harm Reduction*, (December 2016).

National Collaborating Centre for Infectious Diseases. "Review of Provincial and Territorial Partner Notification Guidelines and Legislation for Sexually Transmitted and Blood Borne Infections", (Winnipeg: National Collaborating Centre for Infectious Diseases, 2013).

Ontario Advisory Committee on HIV and AIDS. "Reducing HIV Transmission by People With HIV Who Are Unwilling or Unable to Take Appropriate Precautions: An Update" (May 2002).

Ontario. Ontario HIV Epidemiologic Monitoring Unit, *Number of HIV tests and positivity rate by year of test*, *Ontario*, 1996 to 2013.

———. *Guidelines for HIV Counselling and Testing*, (March 2008).

Ontario Working Group on Criminal Law and HIV Exposure. "Ontario Minister's Round Table: Exploring avenues to address problematic prosecutions against people living with HIV in Ontario" (5 December 2016).

———. Consultation on Prosecutorial Guidelines for Ontario Cases Involving Non-disclosure of Sexually Transmitted Infections: Community Report and Recommendations to the Attorney General of Ontario, June 2011.

———. News Release, "Latest News" (December 2016).

Provincial Infectious Disease Advisory Committee, *Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations*, (April 2009).

Québec. Institut National de Santé Publique du Québec. "Expert Consensus: Viral Load and the Risk of HIV Transmission", (Québec: Institut National de Santé Publique du Québec, 2014).

———. *Guide québécois de dépistage des infections transmissibles sexuellement et par le sang*, (April 2016).

Saskatchewan. Ministry of Health Population Health Branch. *HIV Prevention and Control Program Report for 2015* (Saskatchewan: Ministry of Health, 2015).

———. eHealth Saskatchewan, *Communicable Disease Control Manual*, *Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV)*, (October 2015).

Winnipeg. Winnipeg Regional Health Authority, "Position Statement on Harm Reduction" (Winnipeg: WRHA, December 2016).

FOREIGN SOURCES

UK. England and Wales, Crown Prosecution Service, *The Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection*, (July 2011).

———. Crown Prosecution Service, *Intentional or Reckless Sexual Transmission of Infection*.

UK. Scotland, Crown Office and Procurator Fiscal Service, *Prosecution policy on the sexual transmission of infection,* (May 2012).

INTERNATIONAL MATERIALS

Committee on the Elimination of Discretion against Women. *Concluding observations on the combined eighth and ninth periodic reports of Canada*, CEDAW/C/CAN/CO/8-9, 2016.

Elliot, Richard. *Criminal Law Public Health and HIV Transmission: A Policy Options Paper* (2002) UNAIDS.

Global Commission on HIV and the Law, *Risks, Rights & Health*, (2012).

International Advisory Panel on HIV Care Continuum Optimization. IAPAC Guideline for Optimizing the HIV Care Continuum for Adults and Adolescents

Inter-Parliamentary Union. *Effective Laws to End HIV and AIDS: Next Steps for Parliaments*, (2013).

Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights,* (2006).

UNAIDS. *Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Background and Current Landscape*, Background paper, February 2012.

———. *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*, JC2351E, May 2013.

UNAIDS & UNDP. *Summary of Main Issues and Conclusions: International Consultations on the Criminalization of HIV Tranmisssion,* (31 October – 2 November 2007).

———. *The Gap Report* (16 July 2014).

———. *90-90-90 An ambitious treatment target to help end the AIDS epidemic*, JC2684, October 2014.

United Nations, Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding Observations on the Combined Eighth and Ninth Periodic Reports of Canada* (2016).

World Health Organization. *Draft global health sector strategies HIV, 2016-2021*, WHO Doc A69/31 of 22 April 2016.

———. *Draft global health sector strategies viral hepatitis, 2016-2021,* WHO Doc A69/32 of 22 April 2016.

———. *Draft global health sector strategies sexually transmitted infections, 2016-2021,* WHO Doc A69/33 of 16 May 2016.

OTHER MATERIALS

Aids Action Now. Website. "Open Letter to Jane Philpott Minister of Health from AIDS ACTION NOW!" (11 October 2016).

———. Website, "Banner drop! Stop criminalizing people living with HIV!" (3 July 2016).

Aids Community Care Montreal. Website. "Home Page" (August 2017).

———. Trailer, "HIV is not a crime: Training Academy Video Documentary" (ACCM, 2017).

Arkell, C. Fact Sheet. "HIV treatment and an undetectable viral load to prevent HIV transmission" (CATIE, 2017).

———. Fact Sheet, "Oral pre-exposure prophylaxis (PrEP)" (CATIE, 2017).

Association of Iroquois & Allied Indians. Website. "Policy Areas" (August 2017).

ATHENA. Online Release, "10 Reasons Why Criminalization of HIV Transmission Harms Women".

Bernard, EJ. "The evolution of global criminalisation norms: the role of the United States, HIV and the Criminal Law", (2010) NAM.

British Columbia. BC Centre for Disease Control. Website. "Programs: Chee Mamuk (Aboriginal Health)" (August 2017).

Canadian Aboriginal AIDS Network. "Aboriginal Strategy on HIV/AIDS in Canada II: for First Nations, Inuit and Metis Peoples from 2009 to 2014" (March 2009).

Canadian HIV/AIDS Legal Network. "Consent: HIV Non-disclosure and sexual assault law" Online Documentary (Goldelox Production, 2016).

———. Fact Sheet, "Sex Offender Registries: Facts Sheet" (April 2017).

———. Information Sheet, "HIV Criminalization in Canada: Current Context & Advocacy" (16 December 2016).

———. "Positive Women: Exposing Injustice: What if you knew you could go to prison for something you couldn't change?" Online Documentary (Goldelox Production, 2012).

———. News Release, “New Canadian Coalition to Reform HIV Criminalization Launched” (2 November 2016).

———. News Release, “UN Experts Make Historic Recommendations to Canada: End unjust HIV criminalization, repeal law restricting supervised consumption services, and implement needle and syringe programmes in prison” (18 November 2016).

———. Information Sheet, “Women and the Criminalization of HIV Non-Disclosure” (16 February 2017).

Canadian Positive People Network. Website. “Resources” (August 2017).

Carrier Sekani Family Services. Website. “Services” (August 2017).

CATIE. Prevention Statement, “CATIE Statement on the use of oral pre-exposure prophylaxis (PrEP) as a highly effective strategy to prevent the sexual transmission of HIV” (March 2017).

———. Prevention Statement, “CATIE STATEMENT on the use of antiretroviral treatment (ART) to maintain an undetectable viral load as a highly effective strategy to prevent the sexual transmission of HIV” (March 2017).

———. “HIV in Canada: A primer for service providers” (April 2015).

Coalition des Organismes Communautaires Québécois de Lutte Contre le SIDA. “Criminalisation de l'exposition au VIH” VIH Info droits”.

———. “Position de la COCQ-SIIDA sur la criminalisation de l’exposition au VIH” (April, 2013).

———. “VIH/sida et Maladies à déclaration obligatoire (MADO)” VIH Info droits.

Elliott, Richard. “How everyone living with HIV in Canada became a potential criminal” (8 August 2017), XtraSpark.

File Hills Qu’Appelle Tribal Council. Website. “Home”. (August 2017).

Hastings, Colin, Cécile Kazatchkine & Eric Mykhalovskiy. Info Sheet, “HIV Criminalization in Canada: Key Trends and Patterns” Canadian HIV/AIDS Legal Network (17 March 2017).

HIV & AIDS Legal Clinic Ontario & Canadian HIV/AIDS Legal Network. “The criminalization of HIV non-disclosure: Recommendations for police”, Submissions to the Ontario Association of Chiefs of Police Diversity Committee (February 2013).

———. “Exploring Avenues to Address Problematic Prosecutions against People Living with HIV in Canada” (March 2017).

HIV & AIDS Legal Clinic Ontario. “HIV and Criminal Law” (2014).

International Community of Women Living with HIV (ICW). Position Paper, “Criminalization of Women Living with HIV: Non-Disclosure, Exposure, And Transmission” (May 2015).

———. Website. “10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women” (1 December 2009).

Ka Ni Kanichihk Inc. Website. “Programs” (August 2017).

Mill, Judy E *et al,* “Aborginal Women Living with HIV” (2008) 5:2 Pimatisiwin: A Journal of Aboriginal and

Indigenous Community Health 151.

———. “Challenging Lifestyles: Aboriginal Men and Women Living with HIV”, online: (2008) 5:2 Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 151.

Native Women’s Shelter of Montreal. Website. “Projects & Programs” (August 2017).

Nine Circle Community Health Centre. Website. “Programmes and Services” (August 2017).

Ontario Aboriginal HIV/AIDS Strategy. “A Strategic Plan for the Years 2010 -2015” (July 2010).

PARN. Website. “About PARN” (August 2017).

PASAN. Website. “Home Page” (August 2017).

Pauktuutit Inuit Women of Canada. “Inuit Five-Year Strategic Plan on Sexual Health 2010-2015” (2009).

Positive Living North. Website. “Resources” (August 2017).

Positive Living Society of British Columbia. Website. “Home” (August 2017).

———. Position Paper, “The Need for New Charge Assessment Guideline: HIV Non-Disclosure in British Columbia” (11 June 2014).

———. “Notice: HIV Disclosure and Criminalization” (2012).

Prevention Access Campaign, Consensus Statement, “Risk of Sexual Transmission of HIV from a person living with HIV Who has an undetectable viral load (6 July 2017).

Red Rose HIV/AIDS Network. Website. “Publications” (August 2017).

Shining Mountains Living Community Services. Website. “Programs & Funders” (August 2017).

Tk’emlúps te Secwėpemc. Website. “Medical” (August 2017).

Ts'ewulhtun Health Centre. Website. “Home” (August 2017).

Two-Spirited People of the First Nations. Website. (August 2017).

Two-Spirited People of Manitoba Inc. Website. “Home” (August 2017).

Vancouver Native Health Society. Website. “Research” (August 2017).

Wabano Centre for Aboriginal Health. Website. “Programs” (August 2017).

Women’s Health in Women’s Hands. Website. “Research: Chronic Illnesses/Diseases: HIV/AIDS” (August 2017).