Canadian HIV/AIDS Legal Network

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Bedford v. Canada: a paradigmatic case toward ensuring the human and health rights of sex workers

The *Criminal Code* of Canada prohibits certain aspects of sex work: the keeping of a common bawdy-house, living off the avails of prostitution and communicating for the purposes of prostitution in a public place. These legal constraints impede sex workers' ability to practise their profession safely and without risk to their bodily integrity; they also impair their personal autonomy and can lead to their stigmatization. *Bedford v. Canada* is a groundbreaking case, since the applicants and intervening organizations seek to overturn aspects of Canadian law that specifically put the health and human rights of sex workers at risk.

Sex work is not illegal in Canada. Contrary to what some people believe, it is legal for individuals to exchange money for sexual services. Sex work is a legitimate occupation that individuals voluntarily choose as a source of income. It is also a highly politicized form of work that necessarily engages one's bodily integrity. By placing criminal controls on the manner in which sex workers conduct their business, the Canadian state constrains sex workers' right to make fundamental decisions about their own bodies, their sexuality and their personal relationships.

cont'd on page 5

Inside

Special Section

3rd Symposium on HIV, Law and Human Rights

A summary of proceedings from "Litigating for Change," the 3rd Symposium on HIV, Law and Human Rights, which took place June 2011 in Toronto. See page 63.

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About the Canadian HIV/AIDS Legal Network
The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

Comments? ***We would like to hear your views and opinions. Letters to the editor, responses to specific articles, and comments on the format of the* Review *are welcome and encouraged.***

CONTENTS

cont'd

HIV/AIDS IN THE COURTS — INTERNATIONAL

THIRD SYMPOSIUM ON HIV/AIDS, LAW AND HUMAN RIGHTS

Bedford v. Canada: a paradigmatic case toward ensuring the human and health rights of sex workers

cont'd from page 1

Prostitutes of Ottawa/Gatineau Work Educate and Resist (POWER) and Maggie's: the Toronto Sex Workers' Action Project, decided to intervene in the *Bedford v. Canada*[1] appeal because they believe sex workers should enjoy the same human rights, labour rights, health rights as well as dignity and autonomy as other workers in Canada. In intervening, the organizations' aims were to raise the personal autonomy implications of the impugned *Criminal Code* provisions and the equality rights of the communities who engage in sex work.

The *Criminal Code* currently prohibits certain aspects of sex work: the keeping of a common bawdy-house (Section 210); living off the avails of prostitution (Section 212(1)(j)); and communicating for the purposes of prostitution in a public place (Section 213(1)(c)).[2] These provisions affect sex workers' ability to control their work environment, to conduct essential communications with potential and existing clients, and to be in relationships that are supportive of their sex work.

For example, Section 210 is directed at reducing supposed nuisances associated with indoor brothels, but the section as drafted captures any space in which one or more persons regularly engage in sex work.[3] It has been interpreted to include locations like parking garages, parking lots or hotel rooms to which a sex worker has returned twice for the purposes of work. To avoid liability under Section 210, most sex workers choose not to work in familiar locations, including their own homes, because those spaces can be characterized as a bawdy-house if used with any regularity.

Similarly, Section 212(1)(j) provides that anyone who lives wholly or in part on the avails of another person's prostitution is guilty of a criminal offence. The provision has been interpreted as applying to a variety of relationships in which someone is viewed as having a vested financial interest in someone else's sex work. As a result, anyone who is hired by a sex worker to assist them with their work runs the risk of being captured by the provision. This includes receptionists or managers who support sex workers by making appointments and screening clients, and bodyguards or drivers who accompany workers on out-calls. There is also a risk that a sex worker's live-in partner could be viewed as having a vested financial interest in their partner's work and thus charged for living off the avails of a prostitute.

Section 213(c) prohibits individuals from communicating with someone for the purposes of prostitution, through speech or "any other manner," in a public place or in a place open to public view. This provision could be interpreted as prohibiting sex workers from taking basic occupational safety measures, such as screening their clients to assess levels of intoxication or obtaining key personal information from clients. The prohibition against communicating in public view can lead outdoor sex workers to work in more isolated and dangerous spaces to avoid arrest. Indoor workers are also constrained by this provision because many of the places in which they interact initially with clients could be viewed as public, i.e., elevators, hallways and, arguably, the internet.

These *Criminal Code* provisions are currently being challenged for their harmful effects on sex workers' right to life and liberty of the person, as per Section 7 of the *Canadian Charter of Rights and Freedoms*. In addition, POWER and Maggie's believe that the personal autonomy interests of sex workers are harmed because the provisions prevent sex workers from talking about their sexual activities, exerting legitimate control over their bodies and making choices about their personal relationships. These same sex workers often belong to communities to whom the protections of Section 15 apply. Sex workers are women, men who have sex with men, gay or bisexual, racialized, of Aboriginal ancestry, and/or transsexual or transgendered.

The *Criminal Code* provisions subject sex workers to an adverse and differential treatment that exacerbates

the prejudice and disadvantage that sex workers otherwise face due to their membership in these communities. By criminalizing sex work and by exposing sex workers to further risk, the provisions convey the message that sex work has no value. Indeed, the message is that sex workers themselves — their dignity, their autonomy, their safety and even their lives — have no value.

History of the *Bedford* proceedings

In 2007, Terri Jean Bedford, Amy Lebovitch and Valerie Scott filed a constitutional challenge to the three *Criminal Code* provisions, arguing that the impugned sections violated their *Charter* right to life, liberty and security of the person, as per Section 7, because they prevent sex workers from taking any steps to protect themselves in their work. The Attorney General of Ontario and a coalition comprised of the Christian Legal Fellowship, REAL Women of Canada and the Catholic Civil Rights League intervened in support of the federal government, who argued that removing criminal prohibitions would not result in safer sex work because, it claimed, sex work is inherently risky and dangerous. The application involved over 25 000 pages of evidence in 88 volumes, and included witnesses who were past and present sex workers, police officers, social science experts, politicians, social workers and advocates. Justice Susan Himel presided over the hearing in October 2009.

On 28 September 2010, Justice Himel issued her decision in favour of the applicants. She determined that the three *Criminal Code* provisions violated sex workers' Section 7 rights by making safety-enhancing methods illegal. Specifically, she found that Section 210 prevents sex workers from working in their homes, which is the safest place to practise sex work; Section 212(1)(j) prevents sex workers from taking measures to protect themselves, such as hiring an assistant or a bodyguard; and Section 213(1)(c) prevents street-based sex workers from screening clients at an early stage, thus putting them at an increased risk of violence. As to whether the deprivations occurred in accordance with the principles of fundamental justice, Justice Himel found that the provisions were arbitrary, overly broad and disproportionate.

> Criminalizing sex work conveys the messages that it and sex workers themselves have no value.

The applicants had also challenged Section 213(1)(c) as a violation of the right to freedom of expression as guaranteed by Section 2(b) of the *Charter*. Justice Himel agreed, finding that "speech meant to safeguard the physical and psychological integrity of individuals is also at the core of the constitutional guarantee" (to freedom of expression).[4]

Due to the immense harm created to sex workers, Justice Himel declared that the impugned provisions would be invalid within 30 days of her judgment. The invalidity of the impugned provisions has been stayed pending the outcome of the appeal. This means that, despite their being found unconstitutional, the challenged laws remain on the books for the time being.

Both the federal and provincial Attorneys General appealed Justice Himel's decision, alleging, among other grounds, that there was no causal connection between the impugned provisions and the harm that sex workers experience from third parties in the course of their work. Rather, as argued by the Attorney General of Canada, the harms of sex work derive from "a prostitute's drug use, coping abilities, and the violence inherent in all prostitution."[5] Both governments argued in the alternative that any harms that may result from the laws are outweighed in significance by the purposes of the laws, which, according to the Attorney General of Canada, includes preventing the degradation of women and children.[6]

The two Attorneys General also argued that sex work falls outside the scope of the Section 7 guarantee because there is no constitutional protection for "economic" interests. In their view, the impugned *Criminal Code* provisions do not interfere with sex workers' rights to make fundamental life decisions, but with their choice to pursue a particular line of work.[7]

The appeal took place before a five-member panel of the Ontario Court of Appeal from 13 to 17 June 2011. A large number of interested groups participated as interveners on the appeal. The Christian Legal Fellowship, the Catholic Civil Rights League and REAL Women intervened in support of continued criminalization of sex work. A coalition of women's groups, referring to

themselves as the "Coalition for the Abolition of Prostitution," and which included the Canadian Association of Sexual Assault Centres, the Canadian Association of Elizabeth Fry Societies, the Vancouver Rape Relief Society and the Native Women's Association of Canada, intervened to argue that sex work should be criminalized on an asymmetrical basis: customers and managers of sex workers should face penal sanctions, but sex workers themselves should not.[8] The remaining interveners support the decriminalization of sex work: the PACE Society, the Downtown Eastside Sex Workers United Against Violence Society (SWUAV) and the Pivot Legal Society; the British Columbia Civil Liberties Association; the Canadian HIV/AIDS Legal Network and the B.C. Centre for Excellence on HIV/AIDS; the Canadian Civil Liberties Association; and POWER and Maggie's.

The POWER/Maggie's intervention

POWER and Maggie's are two sex worker-led organizations[9] that believe strongly that the criminalization of aspects of sex work leads to violence and stigmatization against the men and women in the occupation, and that there is nothing inherently degrading about sex work.

Both groups were granted intervener status in a motion before Justice O'Connor on 11 March 2011, due to their interest in the proceedings, their expertise and the important perspectives they proposed to raise.[10] Most notably, Maggie's and POWER were the only interveners to say that sex work is a valid and dignified occupation. They also alleged that the impugned provisions have a particularly adverse effect on sex workers who may face intersecting disadvantages based on sex, gender identity, sexual orientation, race, Aboriginal ancestry and/or class.

POWER and Maggie's believe that the impugned laws impair not only the safety of sex workers, but their personal autonomy. Their starting point is that many people choose to engage in sex work voluntarily. The decision to pursue sex work is a choice about one's body, one's sexuality and about whom to have sex with and on what terms. It is the position of POWER and Maggie's that these kinds of decisions are protected by the liberty and security of the person component of Section 7. As stated by the Supreme Court in *Rodriguez v. British Columbia (Attorney General)*, Section 7 protects "the right to make choices concerning one's body, control over one's physical and psychological integrity, and basic human dignity."[11]

At stake is nothing less than the right to decide the terms of one's sexual interactions.

The personal autonomy protected by the *Charter* does not encompass any and all decisions that an individual might make in the course of their life. Nevertheless, it does protect decisions that are "fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence."[12] POWER and Maggie's believe that this encompasses the decision to engage in sex work, as well as many of the decisions that sex workers make in the course of their occupation. At stake is nothing less than the right to decide and articulate the terms of one's sexual interactions.

Sex workers' personal autonomy interests are especially engaged by Section 213(1)(c), which prohibits sex workers from communicating for the purposes of sex work in a public space. This effectively prohibits sex workers from negotiating the terms of their interactions with clients in the relative safety of a public place. Sex workers cannot tell their clients which sexual services they are prepared or not prepared to provide until the sex worker and her client are out of public view, where the sex worker is most vulnerable to violence.

The two levels of governments and the Coalition for the Abolition of Prostitution characterized sex workers as coerced victims forced to engage in inherently violent and degrading behaviour. POWER and Maggie's believe that, far from being degrading, sex work can be an affirmative choice for those who engage in it. It can restore a sense of autonomy for those who have experienced certain forms of oppression. It can empower women by providing them with financial security and by allowing for "the development of alliances between women, bodily integrity and sexual self-determination."[13] As well, some members of the gay and transgendered communities, whose sexuality and gender expression is frequently marginalized, find that sex work provides acceptance of their

sexuality and gender expression.[14] To disregard these experiences displays a paternalistic attitude at odds with fundamental *Charter* values. Everybody's distinct experience contributes to their own sense of personal dignity.

POWER and Maggie's do acknowledge that some sex workers may be coerced, that some may choose sex work from a particularly restricted set of options and that some will change jobs given the opportunity. However, these experiences do not diminish the personal autonomy interest inherent in a person's decision to engage in sex work. Sex work is analogous to abortion in this respect. A woman's decision about whether or not to have an abortion is a fundamentally personal choice that engages the personal autonomy component of Section 7, even though some women may be coerced or pressured into having an abortion. Some women choose not to have an abortion for moral or religious reasons, and some women who choose to have an abortion later come to regret that choice.

What the abortion example highlights is that Section 7 protects the human capacity to make fundamental decisions about one's own body even — and, indeed, especially — where the choice in question is difficult or complex. As Justice Wilson wrote in *R. v. Morgentaler*:

> The question then becomes whether the decision of a woman to terminate her pregnancy falls within this class of protected decisions. I have no doubt that it does. This decision is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.[15]

POWER and Maggie's do not accept that the violence or degradation that some sex workers experience is inherent to sex work, as the Attorneys General argued. Rather, much of the violence and degradation that sex workers experience is attributable to the impugned laws, which criminalize the measures that sex workers could be taking to protect themselves, and perpetuate the very stigma that makes sex workers a target for predators.[16]

The impugned provisions also diminish sex workers' access to justice in respect of violent crimes. Sex workers are reluctant to go to the police to report crimes against themselves or other sex workers "out of fear they might be arrested and incur other consequences such as losing custody of their children, losing their lawful employment, and being stigmatized as a result of being found guilty of prostitution-related activity."[17] It is crucial to understand how stigma against sex workers exacerbates the violence and degradation that they experience in the course of their work, and that this stigma affects all sex workers, regardless of whether they work indoors in Toronto's upscale hotels or outdoors in Vancouver's Downtown Eastside.

Contrary to what the Attorneys General argue, sex work cannot simply be reduced to an "economic activity"[18] or "a choice of livelihood."[19] In the governments' view, sex workers should not be invoking *Charter* protections when they can simply choose another occupation to engage in. This perspective ignores the non-economic interests engaged by sex work. The fact that economic interests may be at stake does not mean that the personal autonomy interests also engaged by sex work can be disregarded.[20]

The impugned provisions of the Criminal Code diminish sex workers' access to justice.

The debate about sex work, both inside and outside the courtroom, demonstrates that people have mixed views about sex work. However, the autonomy protected by Section 7 does not differentiate between state-approved choices and those that may be unpopular. An individual has the freedom to make his or her own choices for good or ill.[21] As stated by Justice Wilson in *Morgentaler*, "liberty in a free and democratic society does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them."[22]

Personal relationships and well-being

The impugned laws also restrict sex workers from making fundamental personal decisions about their rela-

tionships, health and well-being. For example, a sex worker may think twice before entering into a personal relationship, or disclosing a personal relationship to family members, neighbours or service agencies, because of the prospect that his or her partner will be reported to the police as living off the avails, or as a "pimp" and prosecuted under Section 212(1)(j).[23] Supportive relationships that add to a sex worker's safety and dignity, like a fellow sex worker who might provide a safe working environment, support and mentorship, may also be caught by Section 212(1)(j).

Sex workers' decision to access health and social services is hampered by their legitimate fear that they will be reported to the police or to child protective services for merely disclosing their occupation.[24] Despite the laws' purported objective of discouraging sex work, the impugned *Criminal Code* provisions make it more difficult for sex workers to make the decision to change jobs. Many sex workers have criminal records, serving as a barrier to re-employment in many fields.[25]

The impugned provisions cast a wide — and constrictive — net around the lives of all sex workers. However, questions have been raised throughout the proceedings about whether street-level sex workers will benefit from decriminalization to the same extent as sex workers who work inside. POWER and Maggie's believe that all sex workers, regardless of the circumstances in which they work, have their rights infringed by the impugned provisions. If Section 210 (the "bawdy-house" law) is struck down, not all street-level sex workers may want to work indoors. Some prefer the stroll as it is cheaper than paying for a hotel room and involves fewer interactions with third parties, while others may simply not have access to a home or a third-party location in which they could work. Those sex workers still benefit from the striking down of Section 213, as this will give them the ability to communicate lawfully with clients about the terms of their work in the relative safety of a public space.

The Coalition for the Abolition of Prostitution proposed an asymmetrical approach, in which the clients, employees and managers of sex workers would continue to be criminalized, but sex workers themselves — referred to by the Coalition as "prostituted persons" — would not.

POWER and Maggie's oppose an asymmetrical approach because it will not lessen or eliminate risks to sex workers: sex workers will still be prevented from screening their clients, since it will be illegal for clients to engage in these communications; sex workers will still be prevented from working indoors because the bawdy-house law will apply to clients and others found on the premises; and sex workers will still be prohibited from hiring a bodyguard or driver, since these persons would be caught by the living on the avails provision.

Criminalization of sex work and sexual health

The criminalization of certain aspects of sex work also engages the security of the person component of sex workers' Section 7 rights by hindering their ability to take certain measures to care for their sexual health and to prevent HIV transmission. Sex workers in all sectors of the industry are known to practise safer sex and are eager to protect themselves and their clients from sexually transmitted infections (STIs) and HIV infection.[26] The impugned provisions hinder sex workers' ability to reduce their risks related to HIV and STIs by criminalizing the ways in which sex workers can negotiate safer sex and effectively screen clients, and by inhibiting their access to sexual health services and their ability to carry condoms freely.

Section 213(1)(c) of the *Criminal Code,* which prohibits communication for the purposes of prostitution, captures communication necessary to negotiate, and agree upon, safer sex practices. Sex workers have expressed how, when rushed to move to a private location under the threat of the enforcement of Section 213(1)(c), they become hesitant to negotiate agreements around condom use.[27] Not only do sex workers not wish to be seen communicating about sex work in public, but talking about safer sex and condoms in itself could be characterized as a type of communication prohibited under Section 213.

Prohibiting sex workers from working in indoor locations also affects the ways in which they are able to care for their sexual health. Not only does working indoors provide sex workers with a safer environment and more time to negotiate safer sex, but brothels as organizations can establish and enforce procedural mechanisms around condom use and safer sex practices.[28] For instance, sex workers in brothels with firm policies relating to condom use are in a better position to turn away clients who refuse to use condoms because they have the support of the institution and others working within it. The brothel setting also allows for more time to screen the clients for sores or other indications of STIs.[29]

The Section 210 bawdy-house provisions push workers outside and

often result in sex workers working in isolation where they cannot benefit from established institutional practices around safer sex. Section 212(1)(j) (the living off the avails provision) is engaged when a third party, potentially also working out of a brothel, assists a sex worker in screening clients or promoting safer sex practices.

The criminalization of certain aspects of sex work hinders sex workers' ability to prevent HIV transmission.

The criminalization of sex work can also make the mere possession of condoms problematic for sex workers. In many instances, the police undermine a sex worker's ability to engage in safer sex practices by confiscating condoms or citing the possession of condoms as evidence of their engaging in an illegal activity.[30] Evidence before the court about the sex work trade in New Zealand included comments from sex workers that, since the decriminalization of sex work in that country, they can now carry condoms and lubrication, whereas previously they feared that these safer sex tools were being used as evidence for a conviction.[31]

Access to adequate and non-judgmental health-care services is essential for the health of any sexually active person. Access to HIV and STI testing and education programs, treatment and safer sex paraphernalia are particularly relevant to sex workers as a profession. Evidence before Justice Himel explained how the decriminalization of sex work would provide opportunities for sexual health providers to do outreach inside brothels or other indoor sex work locations.[32] As it stands, the illicit and underground nature of sex work creates a huge gap in the delivery of sexual health services to this target population.

The criminalization of sex work also severely hinders the ability of sex workers to access needed health services due to stigma. Due to well-founded fears of being judged, sex workers can be reluctant to disclose relevant information to their health-care providers, which in turn can preclude them from receiving appropriate health care.[33] The fear of being judged and mistreated by health-care professionals can result in sex workers not accessing sexual health services at all.

Sex work and equality

It has long been recognized that the rights protected by the *Charter* do not exist in isolation, but rather influence and reinforce one another.[34] POWER and Maggie's believe that the Section 15 principles of equality are imperative in interpreting the scope and content of the Section 7 violations. As Justice L'Heureux-Dubé wrote in *New Brunswick (Minister of Health and Community Services) v. G. (J.)*:

> All *Charter* rights strengthen and support each other (see, for example, *R. v. Lyons,* [1987] 2 S.C.R. 309 at p. 326; *R. v. Tran,* [1994] 2 S.C.R. 951 at p. 326) and s. 15 plays a particularly important role in that process. The interpretive lens of the equality guarantee should therefore influence the interpretation of other constitutional rights where applicable, and in my opinion, principles of equality, guaranteed by both s. 15 and s. 28, are a significant influence on interpreting the scope of protection offered by s. 7….
>
> …Thus, in considering the s. 7 rights at issue, and the principles of fundamental justice that apply in this situation, it is important to ensure that the analysis takes into account the principles and purposes of the equality guarantee in promoting the equal benefit of the law and ensuring that the law responds to the needs of those disadvantaged individuals and groups whose protection is at the heart of s. 15. The rights in s. 7 must be interpreted through the lens of ss. 15 and 28, to recognize the importance of ensuring that our interpretation of the Constitution responds to the realities and needs of all members of society.[35]

This case raises issues of equality, as most sex workers fall into the categories of disadvantage represented by the enumerated or analogous grounds under Section 15 of the *Charter*. In particular, the majority of sex workers are women,[36] and the majority of male sex workers identify as either gay or bisexual[37] or experience homophobia because they are assumed to be gay.[38] The evidence submitted at the Superior Court level indicates that a relatively large proportion of street-level sex workers are racialized,[39] of Aboriginal ancestry[40] and/or transsexual or transgendered.[41] POWER and Maggie's work with a diverse group of sex workers, and their members are those who confront discrimination based on these grounds. Moreover, sex workers face intersecting forms of disadvantage. That is to say, they are disadvantaged in more than one respect. Sex

workers struggle with the very forms of prejudice and disadvantage that Section 15 of the *Charter* was enacted to redress.

While the principles of equality should infuse all aspects of the Section 7 analysis, equality is itself a "principle of fundamental justice" to which any deprivation of life, liberty or security of the person must accord in order to comply with Section 7. As Justice Wilson wrote, "a deprivation of the s. 7 right which has the effect of infringing a right guaranteed elsewhere in the *Charter* cannot be in accordance with the principles of fundamental justice."[42] In this connection, the Ontario Court of Appeal has held that "the equality rights created by s. 15 are principles of fundamental justice."[43]

Sex workers struggle with the very forms of prejudice and disadvantage that the *Charter* was enacted to redress.

It is a basic principle of equality that governments should be prevented from making distinctions based on enumerated or analogous grounds that have the effect of perpetuating group disadvantage and prejudice. Perpetuation of disadvantage typically occurs when the law treats an historically disadvantaged group in a way that exacerbates their disadvantage.[44] The impugned laws violate this equality principle by singling out sex workers for adverse treatment that is not accorded to workers in other occupations, thereby exacerbating the various and intersecting disadvantages that sex workers otherwise face.

As Justice Himel found, while sex work carries the risk of violence towards sex workers, it could be made safer.[45] However, rather than enacting or supporting measures to protect sex workers, the government has criminalized the very activities that could improve sex workers' safety. To quote from the decision:

> With respect to s. 210, the evidence suggests that working in-call is the safest way to sell sex; yet, prostitutes who attempt to increase their level of safety by working in-call face criminal sanction. With respect to s. 212(1)(j), prostitution, including legal out-call work, may be made less dangerous if a prostitute is allowed to hire an assistant or a bodyguard; yet, such business relationships are illegal due to the living on the avails of prostitution provision. Finally, s. 213(1)(c) prohibits street prostitutes, who are largely the most vulnerable prostitutes and face an alarming amount of violence, from screening clients at an early, and crucial stage of a potential transaction, thereby putting them at an increased risk of violence.
>
> In conclusion, these three provisions prevent prostitutes from taking precautions, some extremely rudimentary, that can decrease the risk of violence towards them. Prostitutes are faced with deciding between their liberty and their security of the person. Thus, while it is ultimately the client who inflicts violence upon a prostitute, in my view the law plays a sufficient contributory role in preventing a prostitute from taking steps that could reduce the risk of such violence.[46]

Sex workers are uniquely singled out for criminalization as a legislated response to the risks of their occupation. No other lawful occupation that carries the risk of violence — such as professional sports, policing,[47] security and corrections, and hospital work[48] — is subject to government measures that increase the risks to the worker. To the contrary, these professions are regulated to protect the worker as much as possible within their chosen occupation.[49] The differential treatment accorded to sex workers in this regard was described by the Applicants' experts as follows:

> Sex Work is a job in which society recognizes its workers to be at risk. However, rather than implementing job security measures, as we might do for other industries, society's response is to do away with the profession.[50]
>
> It is my belief that we as a society should not tolerate anybody having to work in a workplace that is unregulated, out of sight, unplaced and completely unsafe, particularly when the demand for the service that they sell comes from mainstream society. We would not tolerate those conditions for any other group of workers except sex workers.[51]

The adverse and differential treatment of sex workers exacerbates the stigma, prejudice and disadvantages that sex workers otherwise face. Specifically, by criminalizing the measures that would help protect sex workers from violent crimes, the impugned laws heighten and compound sex workers' vulnerability to violence for reasons related to sex-

ism,[52] transphobia,[53] homophobia[54] and/or racism.[55] As one report puts it, "exploitation can happen across the spectrum of sex work, but it is more prevalent when individuals have fewer options and are more vulnerable. Race, gender, class, socio-economic status and culture are also very influential on an individual's experience."[56]

Instead of enacting measures to protect sex workers, the government has criminalized the very activities that could improve their safety.

As stated earlier, the impugned laws also diminish sex workers' access to justice in respect of violent crimes since they are reluctant to report crimes committed against themselves or other sex workers. This effect is particularly acute for racialized sex workers, notably Aboriginal women,[57] whose access to justice is already compromised due to systemic racism on the part of the police and who are notoriously and tragically overrepresented among sex workers who have been assaulted or murdered.[58]

The impugned laws also facilitate employment discrimination against sex workers. Although discriminatory practices in the sex trade are common,[59] the impugned laws discourage sex workers from accessing human rights protections "for fear that a complaint will turn into an investigation of procuring or bawdy-house offences."[60] This has an especially acute effect on sex workers struggling with intersecting forms of disadvantage, who are most likely to experience discrimination. By discouraging human rights complaints from sex workers, the impugned laws help perpetuate a climate in which discrimination against already-marginalized sex workers is permitted to continue with impunity.

POWER and Maggie's argued that the impugned laws violate the principles of equality and, thus, the principle of fundamental justice by subjecting sex workers to adverse and differential treatment. Where the equality provisions of the laws are concerned, the Section 7 deprivations are rendered all the more grave. The security of the person deprivations occasioned by the laws regulating sex work are experienced differently and more acutely by sex workers struggling with various and intersecting forms of disadvantage.

Conclusion

In intervening before the Court of Appeal, POWER and Maggie's sought to remind the court that sex workers are people just like everyone else. Sex workers deserve the same guarantees to equality, dignity, security of the person and personal autonomy as all other Canadians. The *Charter* challenge raised questions for POWER and Maggie's such as: what communities are most affected by these laws? How far-ranging are these effects? What does criminalization allow us to believe and practise towards sex workers? POWER and Maggie's envision a world where sex work is valued, rather than being an object of violence and shame. While striking down these particular criminal laws may not cure the stigma about sex work, it would at least provide sex workers with the types of protections afforded to other workers in Canada. Our *Charter* promises nothing less.

— Karin Galldin, Leslie Robertson and Charlene Wiseman

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[1] *Bedford v. Canada*, 2010 ONSC 4264 (Ontario Superior Court of Justice).

[2] The impugned provisions state as follows:

> 210. (1) Every one who keeps a common bawdy-house is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years.
>
> (2) Every one who
>
> (a) is an inmate of a common bawdy-house,
>
> (b) is found, without lawful excuse, in a common bawdy-house, or
>
> (c) as owner, landlord, lessor, tenant, occupier, agent or otherwise having charge or control of any place, knowingly permits the place or any part thereof to be let or used for the purposes of a common bawdy-house,
>
> is guilty of an offence punishable on summary conviction.
>
> (3) Where a person is convicted of an offence under subsection (1), the court shall cause a notice of the conviction to be served on the

owner, landlord or lessor of the place in respect of which the person is convicted or his agent, and the notice shall contain a statement to the effect that it is being served pursuant to this section.

(4) Where a person on whom a notice is served under subsection (3) fails forthwith to exercise any right he may have to determine the tenancy or right of occupation of the person so convicted, and thereafter any person is convicted of an offence under subsection (1) in respect of the same premises, the person on whom the notice was served shall be deemed to have committed an offence under subsection (1) unless he proves that he has taken all reasonable steps to prevent the recurrence of the offence.

212. (1) Every one who

...

(j) lives wholly or in part on the avails of prostitution of another person, is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

213. (1) Every person who in a public place or in any place open to public view

...

(c) stops or attempts to stop any person or in any manner communicates or attempts to communicate with any person for the purpose of engaging in prostitution or of obtaining the sexual services of a prostitute is guilty of an offence punishable on summary conviction.

[3] To constitute a bawdy-house, premises must have been used "frequently or habitually" for the purposes of prostitution: *R v. Patterson,* [1968] S.C.R. 157 at paras. 162–63.

[4] *Bedford v. Canada, supra*, at para. 462.

[5] Factum of the Appellant, The Attorney General of Canada, 1 March 2011, at para. 166. On-line: http://mypage.uniserve.ca/~lowman/.

[6] Factum of the Appellant, The Attorney General of Ontario, 1 April 2011, at para. 67. On-line: http://mypage.uniserve.ca/~lowman/.

[7] See, for example, Factum of the Attorney General of Ontario, *supra*, at para. 49, and Factum of the Attorney General of Canada, *supra*, at para. 62. On-line: http://mypage.uniserve.ca/~lowman/.

[8] The Coalition also includes the Canadian Association of Sexual Assault Centres, Action ontarienne contre la violence faite aux femmes, La Concertation des luttes contre l'exploitation sexuelle, Le Regroupement québécois des Centres d'aide et de lutte contre les agressions à caractère sexuel and the Vancouver Rape Relief Society.

[9] POWER is an Ottawa-area advocacy organization comprised of past and current sex workers who are men, women, LGBT, Aboriginal and/or racialized, from the exotic dance, out-call, in-call, erotic massage, and street level sectors of the sex industry. Maggie's is a Toronto-based advocacy and service provision organization that works with about 1000 sex workers annually, including those working on- and off-street, the large majority of whom are women. Maggie's is also the first government-funded sex worker agency in the world.

[10] The intervener status of seven of the proposed interveners was granted on consent of the parties. However, Maggie's proposed intervention was opposed by the federal and Ontario Attorneys General because Maggie's had initially sought to raise a fresh Section 15 equality challenge to the impugned *Criminal Code* provisions before the Court of Appeal. Justice O'Connor denied Maggie's intervention on the basis that an intervener cannot raise new issues on appeal. However, recognizing Maggie's longstanding interest and expertise in the issues, Justice O'Connor allowed Maggie's to join one of the other intervener groups; hence, Maggie's and POWER intervened in the coalition.

[11] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at pp. 587–588, per Sopinka J.

[12] *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 at para. 66. See also: *R v. Morgentaler*, [1988] 1 S.C.R. 30 at p. 166; *R. v. Malmo-Levine*, [2003] 3 S.C.R. 571 at para. 85.

[13] "Making Work", Joint Application Record, Vol. 9, Tab 35D, p. 2239. On-line: http://mypage.uniserve.ca/~lowman/.

[14] *Street Prostitution: Assessing the Impact of the Law,* Joint Application Record, Vol. 8, Tab 34C, p. 2038. On-line: http://mypage.uniserve.ca/~lowman/.

[15] *R. v. Morgentaler, supra*, at para 239.

[16] Shaver Affidavit at para. 38, Joint Application Record, Vol. 24, Tab 55, p. 6819; Gillies, *Bound by Law*, Joint Application Record, Vol. 6, Tab 24A, p. 1141. On-line: http://mypage.uniserve.ca/~lowman/.

[17] Report of the Subcommittee on Solicitation Laws, Joint Application Record, Vol. 9, Tab 37F, p. 2472. On-line: http://mypage.uniserve.ca/~lowman/. See also *Bedford v. Canada*, 2010 ONSC 4264, *supra*, at para. 35: "She (Amy Lebovitch) experienced one notable instance of violence at this location, when she was tied up and raped by a client. Ms. Lebovitch did not report this incident to the police, out of fear of police scrutiny and the possibility of criminal charges."

[18] Factum of the Appellant, The Attorney General of Canada, *supra*, at para. 110.

[19] Factum of the Appellant, The Attorney General of Ontario, *supra*, at para 49.

[20] *Irwin Toy Ltd. v. Quebec (Attorney General),* [1989] 1 S.C.R. 927 at pp. 1003–4; *Godbout v. Longueuil (City),* [1997] 3 S.C.R. 844, at para 61.

[21] *R. v. Jones*, [1986] 2 S.C.R. 284 at pp. 318–9, as quoted in *Morgentaler, supra,* at p. 166, per Wilson J.

[22] *Morgentaler, supra,* at p. 167.

[23] Fraser Report, Volume 2, Joint Application Record, Vol. 71, Tab 154B, p. 20897. On-line: http://mypage.uniserve.ca/~lowman/.

[24] Report of the Subcommittee on Solicitation Laws, Joint Application Record, Vol. 9, Tab 37F, p. 2466. On-line: http://mypage.uniserve.ca/~lowman/.

[25] Ibid., at p. 2473.

[26] C. Bruckert and F. Chabot, *Challenges: Ottawa area sex-workers speak out,* POWER, 2010, p. 34. See also L. Shaver, *Safety, security and the well-being of sex workers: A report submitted to the House of Commons Subcommittee on Solicitation Laws*, Sex Trade Advocacy and Research, 2006; and L.A. Jeffrey and G. MacDonald, *Sex workers in the Maritimes talk back*, UBC Press, 2006.

[27] Maticka-Tyndale Affidavit, Joint Application Record, Vol. 12, Tab 45, at p. 3094. On-line: http://mypage.uniserve.ca/~lowman/.

[28] *Bedford v. Canada*, 2010 ONSC 4264, *supra*, at para 325. See also B. Brents and K. Hausbeck, "Violence and Legalized Brothel Prostitution in Nevada: Examining Safety, Risk, and Prostitution Policy," *Journal of Interpersonal Violence* 270 (2005).

[29] *Bedford v. Canada*, 2010 ONSC 4264, *supra*, at para 211. See also: "Violence and Legalized Brothel Prostitution in Nevada: Examining Safety, Risk, and Prostitution Policy," *supra*.

[30] *Challenges: Ottawa area sex-workers speak out, supra*, at p. 59.

[31] Justice Himel made reference to these comments made to the Prostitution Law Review Committee: see *Bedford v. Canada*, 2010 ONSC 4264, at para. 192.

[32] House of Commons Subcommitee on Solicitation Laws Evidence 2005-03-30, Testimony of Mandip Kharod, Joint Application Record, Vol. 84, Tab 164v at p. 25578. On-line: http://mypage.uniserve.ca/~lowman/.

[33] "Voices of Dignity: A call to End the Harms Caused by Canada's Sex Trade Laws," Joint Application Record, Vol. 24, Tab 55M, p. 7150. On-line: http://mypage.uniserve.ca/~lowman/. See also *Challenges: Ottawa area sex-workers speak out, supra*, at p. 86.

[34] *Morgentaler, supra,* at p.175.

[35] *New Brunswick (Minister of Health and Community Services) v. G. (J.),* [1999] 3 S.C.R. 46, at paras. 112 and 115, per L'Heureux-Dube (also see paras. 113–114, 117).

[36] Between 75 and 85 percent of individuals selling sexual services in Canada are women (*Bedford*, para. 165). See also: "Safety, Security, and the Well Being of Sex Workers", Exhibit "B" to the Affidavit of Dr. Eleanor Maticka-Tyndale, Joint Application Record, Vol. 12, Tab 45–46, p. 3132. On-line: http://mypage.uniserve.ca/~lowman/.). It is estimated that approximately 10–25 percent of those involved in street prostitution are men ("Traditional Data Distort our View of Prostitution", Exhibit "C" to Affidavit of Frances Shaver, Vol. 24, Tab 55, p. 6877. On-line: http://mypage.uniserve.ca/~lowman/.).

[37] "Respondents also differed from the general population in regard to sexual orientation: 60.7% classified themselves as heterosexual, 31.9% as bisexual, 5.5% as homosexual and 1.8% as two-spirited. Further, males were far more likely than their female counterparts to identify themselves as homosexual (19.4% versus 1.9%) or bisexual (47.2% versus 29.4%)." ("Dispelling Myths and Understanding Realities: Working Conditions, Health Status, and Exiting Experiences of Sex Workers", Exhibit B to the Affidavit of Cecilia Benoit, Application Record, Vol. 13, Tab 48, pp. 3504–05. On-line: http://mypage.uniserve.ca/~lowman/.)

[38] Balancing Perspectives, Joint Application Record, Vol. 5, Tab, 228, p.1076. On-line: http://mypage.uniserve.ca/~lowman/.

[39] "About 40% of all sex workers are women of colour" (Decriminalizing Sex work, Joint Application Record, Vol. 3, Tab 16, p. 476. On-line: http://mypage.uniserve.ca/~lowman/.)

[40] Surveys of sex workers in cities across Canada consistently establish that Aboriginal women are over-represented among sex workers relative to the numbers in the general population (e.g., Report of the Subcommittee on Solicitation Laws, Joint Application Record, Vol. 9, Tab 37F, p. 2420; Amnesty International, Stolen Sister, Joint Application Record, Vol. 7, Tab 29C, pp. 1771–72. On-line: http://mypage.uniserve.ca/~lowman/. See also *Bedford v. Canada,* 2010 ONSC 4264, at paras. 90 and 165.

[41] "20 per cent of those involved in street prostitution are transgendered or transvestites" (*Bedford v. Canada*, 2010 ONSC 4264, at para. 165)

[42] *Morgentaler, supra*, at p.175. See also *Reference re. ss. 193 and 195.1(1)(c) of the* Criminal Code *(Man.),* [1990] 1 S.C.R. 1123, at p. 1130 per Wilson K. (in dissent).

[43] *Pacificador v. Philippines* (1993), 14 O.R. (3d) 321 at p.337. See also: *R. v. Andrew,* 1986 CanLII 966 B.C S.C. at paras. 23–24.

[44] *R. v. Kapp*, [2008] 2 S.C.R. 383 ¶25; *Withler v. Canada (Attorney General),* 2011 SCC 12 (CanLII), at paras. 30 and 35.

[45] See *Bedford v. Canada*, 2010 ONSC 4264, at paras. 300–318, 421.

[46] *Bedford v. Canada*, 2010 ONSC 4264 at paras. 359–362. See also paras. 327–343, 385, 387, 421, 422, 427–428, 429–421, 432, 434.

[47] *Bedford v. Canada,* 2010 ONSC 4264, at para. 294.

[48] "Safety, Security and the Well-Being of Sex Workers", Joint Application Record, Vol. 24, p. 7100 (slide presentation). On-line: http://mypage.uniserve.ca/~lowman/.

[49] For example, a regulation under *Ontario's Health and Safety Act*, R.S.O. 1990, c.0.1 protects the health and safety of health-care workers and is tailored to the unique risks they face. See Health Care Residential Facilities, O. Reg 67/93. In the federal jurisdiction, there are specific regulations protecting workers in occupations where there is a high risk of physical injury, including: aviation (SOR/87); oil and gas work (SOR/87-612); and mining (SOR/90-97). Both the Ontario and federal health and safety statutes require employers to take various precautions to reduce the risk of violence to regulated workers. See OHSA Part III.0.1 and Canada OHS Regulations, SOR/86-304, Part XX.

[50] Shaver Affidavit at para. 38, Joint Application Record, Vol. 24, Tab 55, p. 6819.

[51] Patterson Affidavit at para. 18, Joint Application Record, Vol. 7, Tab 30, p. 1838.

[52] *R v. Ewanchuk*, [1991] 1 S.C.R. 330, at paras. 68–70.

[53] "Transsexuals…face very serious forms of discrimination within our society, including routine acts of violence and hatred" (*Hogan v. Ontario (Health and Long-Term Care),* [2006] O.H.R.T.D. No. 34, at para. 459. See also paras. 330, 331, 406)

[54] *Egan v. Canada,* [1995] 2 S.C.R. 513, at paras. 173–174.

[55] "Aboriginal women between the ages of 25 and 44, with status under the Indian Act, are five times more likely to die of violence than other women of the same age." (Mooney Affidavit at para 18, Joint Application Record, Volume 7, Tab 29, p. 1690. On-line: http://mypage.uniserve.ca/~lowman/.).

[56] *Balancing Perspectives,* Joint Application Record, Vol. 5, Tab 23B, p. 1070. On-line: http://mypage.uniserve.ca/~lowman/.

[57] Aboriginal women are subject to both over-policing due to racist stereotypes that "native women are immoral and sexually promiscuous," as well as under-policing because "aboriginal people are often seen as less worthy victims." Thus, "the problems which aboriginal women face in their interactions with police are magnified by the perception that sex workers are also less worthy victims." (Mooney Affidavit at paras. 20–21, Joint Application Record, Vol. 7, Tab 29, p. 1691.) See also: *Bedford* at para. 174; Comments from Kara Gillies, Joint Application Record, Vol. 6, Tab 24C, p. 1428; Report of the Subcommittee on Solicitation Laws, Joint Application Record, Vol. 9, Tab 37F, p. 2420. On-line: http://mypage.uniserve.ca/~lowman/.

[58] "Missing native women invisible," Joint Application Record, Vol. 7, Tab 29 D, p. 1821; "Creating Options", Joint Application Record, Vol. 38, Tab 96D, p. 11032; Report of the Sub-committee on Solicitation Laws, Joint Application Record, Vol. 9, Tab 37F, p. 2420. On-line: http://mypage.uniserve.ca/~lowman/.

[59] "Many women reported discriminatory and racist hiring or management practices on the part of employers. Racialized women described being outright denied employment, relegated to unpopular shifts or receiving a minimal number of clients. Many participants spoke of race-based quotas whereby management limits the number of women of colour, black women and Aboriginal women hired in general or assigned to each shift or location. All three transsexual women interviewed stated that the vast majority of escort agencies and massage parlous refuse to hire transsexual/transgendered women and that those that do frequently pay these workers a lower rate than genetic/biological women. These forms of discrimination are in clear breach of federal, provincial and territorial human rights codes" (Gillies, Bound by Law, Joint Application Record, Vol. 6, Tab, 24A, p. 1346).

[60] Ibid. For the same reasons, sex workers' access to other employment protections, such as employment standards, occupational health and safety and labour relations would likely be impeded, even to the extent that these protections apply to sex work.

A tale of two cases: urging caution in the prosecution of HIV non-disclosure

Two provincial Courts of Appeal have recently released unanimous decisions that clarify the law regarding the obligation imposed upon people living with HIV to disclose their HIV status prior to sexual relations. The decision of the Manitoba Court of Appeal in *R v. Mabior*[1] and of the Quebec Court of Appeal in *R c. D.C.*[2] must be seen against a background of increasing criminal prosecutions in Canada of people with HIV who allegedly do not disclose their HIV status to sexual partners. Since the first HIV non-disclosure prosecution in 1989, there have been over 120 prosecutions. A high proportion of accused has either pleaded guilty to, or been convicted at trial, of serious criminal offences, often resulting in harsh sentences and sex offender registration.[3] In the majority of convictions, there was no transmission of HIV to the complainant.[4]

Despite the significant number of prosecutions, it is arguable that people living with HIV who know of their infection, of whom there were an estimated 48 100 in Canada in 2008,[5] cannot ascertain their criminal law disclosure obligation. The test set out by the Supreme Court of Canada in *R v. Cuerrier*,[6] requiring significant risk of serious bodily harm, has not provided adequate guidance to people living with HIV, police, Crown counsel or lower courts. The Supreme Court will soon have an opportunity to revisit *Cuerrier*. It has granted leave to appeal in Mabior and D.C.,[7] which will be heard together. In both cases, the Crown is arguing for a doctrine of informed consent in sexual assault such that non-disclosure accompanied by *any* risk of HIV transmission, regardless of condom use or the amount of HIV in the infected person's blood (known as viral load), would attract criminal liability.[8] This comment begins with a review of each case, focusing on the analysis of the appellate courts, and then discusses three issues that the Supreme Court of Canada must confront when it hears the appeals.

The *Mabior* case

The accused was diagnosed as HIV-positive in January 2004, and placed on antiretroviral therapy in April 2004. Between February 2004 and January 2006, the accused had sexual relations with nine female complainants, several of them teenagers, sometimes with condoms and sometimes without, and often the relations involved use of alcohol and illicit drugs supplied by the accused. There was evidence that he had not been using condoms properly during this time, because he was infected twice with gonorrhoea and was listed as a contact for chlamydia. To date, none of the complainants has tested positive for HIV.

At trial, the accused was convicted of six counts of aggravated sexual assault and one count each of invitation to sexual touching and sexual interference, and was sentenced to a total of 14 years' incarceration.[9] The trial judge found that five of these six complainants would not have had sex with Mabior if they had known of his HIV-positive status. The sixth, who was 14 years of age, learned of his status during the course of their sexual relationship. The trial judge stated several times in her reasons that condom usage only resulted in an 80 percent reduction of the risk of transmission of HIV, but she did not clearly apply this level of risk reduction to the already low rates of sexual transmission. In essence, she found that *any* risk of transmission was sufficient to meet the *Cuerrier* test — only when use of a condom and an undetectable viral load are *both* present would the risk be reduced sufficiently to negate the significant risk of serious bodily harm.

The Manitoba Court of Appeal, in a cautious and well-reasoned judgment, attempted to put some limits on the criminalization of non-disclosure. The Court sought to achieve a balance between competing interests:

> In this context, no one, including the intervener, the Canadian HIV/AIDS Legal Network, disagrees with charging individuals who intentionally or recklessly infect their partners with a serious disease. The criminal law has a role to play in protecting the public from irresponsible individuals. Nor is there any disagreement that, from an ethical and public health perspective,

> disclosure is necessary. However, between those two poles, policy considerations should impact on the law so as to produce a more nuanced view of when failure to disclose warrants criminal sanctions. There are other mechanisms for the state to intervene, short of criminalizing the act. Criminal sanctions should be reserved for those deliberate, irresponsible or reckless individuals who do not respond to public health directives and who are truly blameworthy.[10]

The Court held that the trial judge made two errors. First, even though the test requires that there be a significant risk, the trial judge required that, to avoid conviction, there must be virtually no risk of harm, requiring both the use of condoms *and* an undetectable viral load. Instead, the Court held that, if either of these factors was present, HIV non-disclosure was not subject to criminal liability because the risk would be reduced below what is considered significant.

Second, the Court held that the trial judge had erred in her focus on the finding that condoms reduce the risk of sexual transmission by 80 percent. The Court clarified that 80 percent relates to an 80 percent reduction of an already low rate of sexual transmission. The risk of transmission the trial judge should have considered was 20 percent of "an already small baseline figure."[11] The Court found that "consistent and careful use of condoms"[12] or "reasonably proper condom use"[13] reduces the risk below significance. The Court explicitly rejected the Crown's argument that, because the potential harm involved was so serious, virtually any possibility of that harm occurring was significant.

The Court elaborated on the careful use of condoms by listing 10 factors provided by an expert witness that would represent "an ideal situation."[14] In addition, the Court made clear that, when a condom breaks, the accused must immediately disclose his or her HIV status to a non-HIV-positive partner so that the partner may seek prophylactic measures. Non-disclosure in this context would be equated with unprotected sex.[15]

The Court noted the significance of the scientific developments post-*Cuerrier,* including the successful use of antiretroviral therapy, which can dramatically reduce viral load and subsequent risk of transmission. The Court held that the application of *Cuerrier* must "evolve to account appropriately for the development of the science of HIV treatment."[16]

People living with HIV who know of their infection cannot ascertain with certainty their criminal law disclosure obligation.

However, the Court was not willing to make definitive statements on viral load and instead held that each case will depend on the evidence presented, while also urging the Supreme Court of Canada to provide more guidance.[17] On the facts, the Court of Appeal found that the standard of "significant risk of serious bodily harm" was met with respect to only two of the accused's six aggravated sexual assault convictions.

The *D.C.* case

In the summer of 2000, D.C. met a man at a soccer pitch, where each had a son playing soccer. Thus began a four-year relationship. The trial judge found one incident of unprotected sexual intercourse prior to HIV disclosure, which took place early in the relationship. The relationship came to a tumultuous end in November 2004 when D.C. called police alleging that her partner had physically assaulted her and her son. Her partner was charged with, and convicted at trial of, assault. In February 2005, he contacted the police and complained of the one earlier incident of unprotected intercourse prior to HIV disclosure. D.C. was charged with one count each of aggravated assault and sexual assault.

At trial, expert medical testimony established that the risk of HIV transmission during unprotected sexual intercourse between an HIV-infected female and a male is 1 in 1000, irrespective of HIV viral load.[18] Where the female's HIV viral load is "undetectable" (below 50 copies of HIV per millilitre of blood), the risk of transmission is 1 in 10 000, which risk decreases to 1 in 50 000 where a condom is used. Citing *Cuerrier* and *Williams*,[19] the trial judge found D.C. guilty of aggravated assault because her failure to disclose her HIV status prior to unprotected sexual intercourse exposed her partner to a significant risk of serious bodily harm. The trial judge also found D.C. guilty of sexual assault, since her partner's consent to sex had been vitiated by the HIV non-disclosure.

D.C. appealed her convictions to the Quebec Court of Appeal. She argued that the trial judgment represented an unwarranted and overly expansive interpretation of the criminal obligations placed upon HIV-positive people, and erred in rejecting the uncontradicted expert evidence of the extremely minimal risk of HIV transmission in the circumstances of the case, thereby ignoring the significant risk standard established in *Cuerrier*. The Crown argued that the failure by an HIV-positive person to disclose his or her HIV status prior to unprotected sexual intercourse carried sufficient risk to vitiate his or her partner's consent to intercourse.

A unanimous Court of Appeal addressed the "heart of the appeal":[20] the relationship between the disclosure obligation, the significance of the risk of bodily harm and the medical evidence. The Court reviewed the essential elements of fraud in sexual relations — dishonesty and the risk of deprivation — established by the Supreme Court in *Cuerrier*. Its analysis highlighted those parts of Justice Cory's judgment that tie the HIV disclosure obligation to the risk posed to the sexual partner's health: the disclosure obligation increases with the risk associated with the sexual act.[21] The Court found that the trial judge had erred in the application of the test to the evidence. There was uncontradicted evidence that the accused had an undetectable viral load. The Court reviewed the expert testimony and found that, as a result of effective medications, D.C.'s HIV viral load became undetectable at the end of June 2000 and stayed undetectable until spring of 2001. The Court found that, in the circumstances of the case, the risk of transmission was so small as not to constitute a "significant risk of serious bodily harm," such that D.C.'s failure to disclose her HIV status to the complainant did not vitiate his consent to unprotected sexual intercourse as required under *Cuerrier*.[22] In the Court's view, the terms used by the medical experts ("very weak," "very minimal" and "very, very low") were incompatible with the existence of any significant risk whatsoever.[23] Thus, the trial judge had erred in finding that the Crown had proven the offences of sexual assault and aggravated assault.

The Court quotes favourably from Justice Steel's reasons in *Mabior*, including the invitation to the Supreme Court to revisit and clarify the inherent uncertainty in the significant risk test.[24] In conclusion, the Court suggests that the question of the use of the criminal law to address the transmission of serious communicable infections might be one most appropriately left to Parliament, given the issue's numerous social, ethical and moral ramifications.[25]

Analysis and comment

These cases could not be more different on their facts and demonstrate the wide range of complex and diverse circumstances that lead to HIV non-disclosure prosecutions. What these cases share, however, is that the trial judges held that *any* risk of transmission of HIV was sufficient to satisfy the "significant risk of serious bodily harm" test from *Cuerrier.* Both appeal courts disagreed, holding that the requirement from *Cuerrier* that the risk be significant must be given some meaning and that not all risks will vitiate consent to sex. These cases provide the opportunity for the Supreme Court of Canada to examine how our increased knowledge of HIV transmission risk, and our ability to greatly reduce that already low risk through condoms and antiretroviral medication, should affect a legal test developed at a time when HIV almost always led to AIDS and death. We discuss three issues that merit consideration by the Supreme Court.

The requirement from *Cuerrier* that the risk be significant must be given some meaning — not all risks will vitiate consent to sex.

The significant risk test: an evidence-informed approach

The Supreme Court will soon have the opportunity to clarify the significant risk of serious bodily harm test. If the Supreme Court follows its *Cuerrier* analysis, the Court of Appeal's reasoning in *Mabior* is an excellent, evidence-informed starting point. The latter Court provides overall guidance as to the appropriate function of the criminal law in the context of HIV non-disclosure, fundamentally distinguishing between what the majority of people would consider moral or ethical sexual conduct, and conduct that should be subject to criminal sanction: "[e]veryone would want to be told that a potential partner was HIV-positive. Most people would agree that there was a moral and ethical obligation to disclose that information."[26] Yet the Court explicitly

recognized that criminal sanctions should only be imposed where the risk of bodily harm resulting from the non-disclosure is significant.[27]

The Court articulated the following principles for determining whether the sexual act put the complainant at a "significant risk of serious bodily harm": (i) at present, being infected with HIV subjects an individual to serious bodily harm;[28] (ii) the Crown will bear the burden of proving that there was a significant risk of HIV transmission given the HIV viral load of the accused at the relevant time(s);[29] (iii) the determination of risk should be consistent with medical science related to HIV/AIDS, which will develop over time;[30] (iv) the risk of sexual transmission is cumulative, increasing with each risk-presenting act; (v) reasonably proper condom use, as opposed to perfect condom use, reduces the risk of sexual transmission to below the level of significance;[31] and (vi) where a condom breaks, immediate disclosure by the HIV-positive partner could suffice to reduce the risk of harm.[32] Non-disclosure after a condom breaks is only criminalized where there is a detectable viral load.

Significantly, the Court recognizes the significant legal relevance of condoms in determining HIV transmission risk and the criminal law duty of disclosure. The Court accepts that even reasonably proper condom use, as opposed to perfect condom use, for sexual intercourse reduces the risk of HIV transmission to below the level of significance.[33] This position is consistent with the Supreme Court of Canada's decision in *Cuerrier* and encourages mutually responsible sexual behaviour that will ultimately reduce the risk of HIV transmission more than disclosure.

By contrast, the Court's equivocal approach to the impact of HIV viral load on the risk of transmission represents a missed opportunity to clarify the law further:

> It is true that the test for a viral load is done for "a moment in time." … Common infections, STDs and treatment issues can lead to fluctuations in a person's viral load. HIV-positive people with apparently undetectable viral loads can experience occasional spikes in viral load or may develop viral resistance. *Consequently, no comprehensive statement can be made about the impact of low viral loads on the question of risk*. Each case will depend on the facts regarding the particular accused, and each case will depend on the state of the medical evidence at the time and the manner in which it is presented in that particular case.[34] [Emphasis added.]

This approach is unfortunate given the large body of recent scientific literature suggesting that effective antiretroviral therapy offers more significant protection against HIV transmission during sex than does condom use.[35] It also stands in contrast to the Court's findings on the facts of the case. It posed the following question in relation to each complainant where it found that a condom was not properly used: "[w]as the accused's viral load undetectable at the time of sexual intercourse?" If so, there was no significant risk of HIV transmission, no duty to disclose on the part of Mabior and no criminalization of non-disclosure.

One issue that must be addressed in the context of viral load is burden of proof. We suggest that the burden be on the Crown to prove all elements of the assault offence beyond a reasonable doubt, which includes leading evidence to establish that, *in the circumstances of the case*, the sexual act presented a significant risk of serious bodily harm to the complainant. This approach is preferable to the one set out by the British Columbia Court of Appeal in *Wright*,[36] whereby the Crown can establish a significant risk based on average risk as set out in the literature. The approach from *Wright* is based on the heavily stigmatizing presumption that sexual intercourse with a person living with HIV *per se* presents a significant risk of HIV transmission, which reflects an outdated, inaccurate view of HIV. Moreover, the courts of appeal in *Mabior* and *D.C.* soundly reject this presumption in favour of a case-specific, expert-informed assessment of risk, which takes into account the factors that decrease and increase transmission risk. Such an approach avoids placing on the accused the tactical burden of proof to introduce case-specific evidence regarding HIV transmission risk in response to the general evidence of risk introduced by the Crown. It properly places the initial tactical decision on the Crown whether to introduce medical and scientific evidence of HIV transmission risk in the circumstances of the case, readily obtained by the Crown through search warrant, subpoena and expert testimony.

Is aggravated (sexual) assault the appropriate offence?

Currently, prosecutions for non-disclosure to one's sexual partner involve almost exclusively charges of aggravated assault or aggravated sexual assault.[37] The latter is the most serious sexual offence in the *Criminal Code* and is punishable by a maximum life sentence. These offences are used whether or not HIV is transmitted. In fact, prosecution

will be easier where the virus is not transmitted because where the complainant is HIV-positive the Crown will need to prove that she was not infected with HIV at the time of sexual relations with the accused.[38] We argue that both aggravated sexual assault and aggravated assault result in over-criminalization where the virus is not transmitted to the complainant, and such serious offences should be limited to cases where HIV was transmitted with the result that the complainant's life was actually endangered as opposed to the potential risk of endangerment.[39]

What makes an assault or sexual assault "aggravated" is the additional harm caused to the complainant through wounding, maiming, disfiguring or endangering life.[40] We would argue that, where the virus is not transmitted, life has not been endangered. As mentioned earlier, the presumption that sex with an HIV-positive person is always life-endangering is not accurate. Where the virus is not transmitted, the fact that it could have been is not sufficient to warrant the degree of criminal responsibility attached to an aggravated (sexual) assault conviction. New Zealand and several Australian jurisdictions rely on different offences based on whether the virus was transmitted.[41]

This raises the question of what offence is most appropriate where transmission has not taken place despite the fact that the complainant has been exposed to a significant risk of acquiring HIV. We would argue that, at most, the lesser included offences of assault or sexual assault be employed where the virus has not been transmitted. This would be most consistent with treating transmission cases as aggravated (sexual) assault and the idea that non-disclosure, in the context of a significant risk of serious bodily harm, vitiates consent to the touching involved. However, assault-based offences leave courts in the conundrum of applying probabilities in individual cases to determine whether the risk of an event that did not happen was significant.

Where the virus is not transmitted, the fact that it could have been is not sufficient to warrant the degree of criminal responsibility attached to an aggravated (sexual) assault conviction.

We suggest that the Supreme Court has a more radical option open to it, that is, to reject the assault-based analysis of *Cuerrier* as unworkable and to shift the focus to the harm caused by transmission. The Court could re-think the question of whether failure to disclose actually vitiates consent to sexual activity. What kind of deceptions constitute fraud? On the one hand, one could take a very broad approach such as was done by Justice L'Heureux-Dubé in *Cuerrier*, whereby any deception that induces consent constitutes fraud and vitiates consent. Under such an approach, if a man told a woman he was single when in fact he was married and his assertion induced consent, his lie would constitute fraud vitiating consent. A broad approach might be desirable in sexual assault generally to protect women from sexual violence and coercion.

On the other hand, one could apply a narrower approach that only limits consent in cases where the fraud goes to precisely what the complainant consented to. For example, in *R v. Crangle*,[42] the accused was the identical twin brother of the complainant's boyfriend. When he started having sex with her, she thought she was having sex with her boyfriend. This deception went to the very essence of the sexual activity — she consented to have sex with A and not to have sex with B. The kind of deception involved in non-disclosure is subtly different from most of the other fraud cases that arise. In the HIV non-disclosure cases, the complainant wanted the sexual activity to take place with the accused, but not necessarily with a person who was HIV-positive. The assumption is that if the accused is HIV-positive, he or she will disclose and sex will either not take place or protective measures will be taken.

We would argue, however, that one can never presume one is having sex with a person who is HIV-negative. HIV is most transmissible when one's viral load is highest, such as during the early stages of infection, often before the person knows they are HIV-positive[43] — and an alarmingly high proportion of persons with HIV do not know their status.[44] Nor can one make reasonable assessments about who is likely to be HIV-positive based on assumptions about who gets HIV and who does not. Thus, while the suggestion that everyone needs to protect themselves appears trite, it remains the best way to prevent transmission of the virus.

We do recognize that some people are not in a position to insist on condom use or to understand the risks involved in sexual activity generally. In this latter category, it may be possible to argue that someone who does not understand the risks involved in sexual activity is not capable of giving meaningful consent to sex.[45] With respect to someone who cannot safely insist on condom use to protect herself, we question the voluntariness of consent in this context.[46]

If the Court were to reject the fraud-based approach as unworkable, criminal negligence causing bodily harm would be a possible charge in cases of HIV transmission. The *mens rea* is well-suited to the HIV non-disclosure cases where, in the vast majority of cases, the accused does not intend to transmit the virus and rather hopes that no transmission takes place.[47] In such a case, criminal negligence, which speaks of wanton or reckless disregard for the safety of others, seems well-suited to the risk-taking nature of the activity. This offence would only apply where the virus has been transmitted because Canadian criminal law does not punish criminal negligence in and of itself without proof of bodily harm or death. This offence would take the focus off the sexual nature of the harm and shift it to the deliberate risk-taking activity on the part of the accused. The more difficult question is what offence might be appropriate where the virus is not transmitted. In our view, such cases should only be prosecuted where there is a pattern of non-disclosure in the context of unprotected sex. Common nuisance is one option that could be applied, an offence that criminalizes the endangering of "lives, safety or health of the public" through an unlawful act or failure to discharge a duty.[48] This offence is not without its problems and courts would still have to draw limits about what level of risk is sufficient to constitute that endangerment to the public.[49]

It is imperative that provincial and territorial Attorneys General seriously consider developing comprehensive prosecutorial guidelines.

We are not suggesting we can resolve this difficult issue in a case comment. Rather, we seek merely to raise the possibility that the sexual assault approach is not the only approach to this issue. What is clear from examining various *Criminal Code* provisions is that none of the offences in the current *Criminal Code* were designed to cover the non-disclosure of a sexually transmitted infection. The *Criminal Code* used to have a specific provision, enacted in 1919,[50] making it an offence, punishable on summary conviction, to communicate a venereal disease, knowingly or by culpable negligence, to another person. This provision was, somewhat ironically, repealed in 1985, just a few years before the first HIV non-disclosure prosecution in Canada. In 1984, the federal Badgely Committee had recommended, instead of the provision, strengthening provincial health regulations, more effective diagnostic criteria, research and public education.[51] In 1985, the Fraser Committee concluded again that the provision was "hopelessly outdated in the etiological assumptions it makes" and "clearly does not reflect modern knowledge on, or practice in relation to, sexually transmitted diseases."[52] We are concerned that HIV has been singled out for special treatment when other sexually transmitted infections may be even more easily transmissible. Why are HIV prosecutions increasing in frequency and severity at the same time that our ability to clinically manage HIV, and to prevent transmission through antiretroviral medication, has improved so dramatically?

Whatever crime(s) the Supreme Court of Canada decides should apply in this context, it is imperative that provincial and territorial Attorneys General seriously consider developing comprehensive prosecutorial guidelines, as has been done in England and Wales.[53] Given the dangers of over-criminalizing non-disclosure — such as discouraging HIV testing, driving people living with HIV away from health care and social services out of fears of criminal prosecution — and the dangers of further marginalizing people living with HIV, guidelines should strive to limit prosecutions to those cases where the blunt force of the criminal law is absolutely necessary to deter or incapacitate the individual.

The need for caution in the unique context of non-disclosure prosecutions

Our final point is that the political and social dynamics of HIV non-disclosure prosecutions mitigate in favour of caution. The Crown, in the documents filed with the Supreme

Court in *Mabior* and *D.C.*, argues that *R v. Ewanchuk*[54] be used to modify the rule in *Cuerrier* so as to require fully informed consent, the absence of which would render any non-disclosures an aggravated sexual assault.

The Supreme Court of Canada decision in *Ewanchuk* was an important victory for women in the context of sexual assault, reaffirming the importance of consent being assessed from the perspective of the complainant and the importance of autonomy in sexual decision-making. We are concerned that an expansion of *Ewanchuk* in the HIV context ignores the unique context of HIV non-disclosure prosecutions and the stigma and prejudice resulting from over-criminalization of persons living with HIV. The criminal law must be used with particular caution where it is being applied only against members of a marginalized group and we must ask whether other mechanisms, such as public health legislation, are better suited for dealing with this complex social problem. We urge the courts to deal with non-disclosure cases as a unique context and not as an opportunity to expand the crime of sexual assault generally.

As the Supreme Court of Canada has recognized, sexual assault generally is a highly gendered crime. Over 97 percent of those accused of sexual assault are men,[55] and roughly 85 percent of all complainants are women.[56] Certain groups of women are at a higher risk of sexual assault, such as women involved in prostitution,[57] women with disabilities[58] and Aboriginal women.[59] Conviction rates for sexual assault generally are also very low in part due to the fact that women's allegations of sexual violence are often disbelieved.[60]

The gendered nature of non-disclosure prosecutions is less clear and something we are only beginning to understand. Overwhelmingly, in Canada,[61] the accused in non-disclosure cases are men. A recent study found that 91 percent of those charged in Canada for failing to disclose their HIV status are men.[62] Overall, 65 percent of all Canadians charged are men who fail to disclose their status to women, although we may be seeing an increase in the number of charges against men who have sex with men.[63] However, this does not appear to be an accurate reflection of non-disclosure rates in the community. There is some evidence that men withhold their HIV status more often than do women, but this evidence is far from unambiguous and does not explain the preponderance of female complainants:

> Variations in disclosure based on race, gender and age yield controversial findings. White and Hispanic individuals have been found to be more likely to disclose to partners than African-Americans, yet other research suggests that race and ethnicity do not play a role. Although Stein and colleagues found that women are more likely to disclose than men, most existing research suggests that gender is not associated with partner disclosure. Younger age has also been associated with higher disclosure. Other researchers, however, have documented a relationship between youth and non-disclosure.[64]

The criminalization of non-disclosure may make non-disclosure more likely, as persons with HIV may fear the consequences of their status becoming known to previous or current partners.

We would argue that the prosecutions for non-disclosure in the HIV context are disproportionately for non-disclosure in the heterosexual context. This may say more about the value we put on potential complainants of non-disclosure than the potential accused. Police and prosecutors may be more likely to see women as victims of sexual assault (as compared to gay men). Similarly, there may be a different ethic in the gay community around laying complaints for non-disclosure because of attitudes towards police and the criminal justice system, or because there may be a higher level of acceptance of mutual responsibility for preventing HIV transmission in the gay community. Conviction rates in the non-disclosure context are much higher than in sexual assault generally,[65] perhaps because persons with HIV are even less likely to be believed than sexual assault complainants and guilty pleas are common, possibly due to the publicity and resultant stigma associated with these trials.

The impact of over criminalization of non-disclosure of HIV status has implications for women both as potential complainants and as potential accused.[66] The cases to date highlight women as HIV-negative complainants who face the potential of acquiring the virus from their

non-disclosing partners. But issues of non-disclosure also arise for HIV-positive women. *D.C.* demonstrates the complexity of this issue: charges were not laid against D.C. until over four years after the complainant learned of the non-disclosure and only after D.C. laid charges of domestic assault. Women in relationships of heightened inequality, such as women in abusive relationships or women with disabilities, may have particular barriers to disclosing their status to sexual partners or in insisting on condom use. There is also the alarming potential for charging women for passing on the virus to their children during childbirth or breastfeeding.[67]

Perhaps the biggest difference between the non-disclosure context and other sexual assault offences is that *every* accused person in the non-disclosure context is grappling with HIV and thus is a member of a highly stigmatized group in Canadian society. The charges in question relate directly to their status as HIV-positive individuals. They may have acquired the virus through the non-disclosure of their partners or through some other means. Regardless, they are likely to have experienced discrimination and rejection when others have learned of their HIV status. Many will have experienced the loss of a job, the loss of friends and the loss of a partner on disclosing their HIV-positive status.[68] Over-criminalization of persons with HIV runs the risk of further marginalization and stigmatization. Marginalization contributes to non-disclosure; it does not prevent it. The more negative the social consequences of disclosure, the less likely it is to take place. Until we give people the necessary physical, economic and social supports to enable them to disclose their status safely, non-disclosure is likely to continue at a high rate. In fact, the criminalization of non-disclosure may make non-disclosure more likely, as persons with HIV may fear the consequences of their status becoming known to previous or current partners.

Conclusion

At a minimum, with the upcoming appeals the Supreme Court should address the need for clarity among the range of people affected by the criminal law related to HIV non-disclosure: people living with HIV/AIDS, police, Crown counsel and the judiciary. These people need to know whether there is a duty to disclose prior to oral sex, prior to protected sexual intercourse, or prior to unprotected sexual intercourse where an HIV-positive person has an undetectable viral load. The appeals will also present the Supreme Court with the opportunity to further refine the criminalization of HIV non-disclosure in ways that will preserve the integrity of sexual assault law by restricting the circumstances in which HIV non-disclosure calls for criminal prosecution and identifying the *Criminal Code* offences most appropriate to those circumstances.

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[1] *R v. Mabior (C.L.)*, 2010 MBCA 93.

[2] *R c. D.C.*, 2010 QCCA 2289.

[3] Eric Mykhalovskiy, Glenn Betteridge and David McLay, *HIV Non-disclosure and the Criminal Law: Establishing Policy Options for Ontario* (Toronto: Ontario HIV Treatment Network, 2010), at 12, on-line at http://library.catie.ca/pdf/ATI-20000s/26343.pdf [forthcoming update on file with author].

[4] Ibid., at 13.

[5] Public Health Agency of Canada, *HIV/AIDS Epi Updates, July 2010* (Ottawa: Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada, 2010) [Public Health Agency of Canada, *HIV/AIDS Epi Updates*], on-line at www.phac-aspc.gc.ca.

[6] *R v. Cuerrier*, [1998] 2 SCR 371.

[7] *R v. Mabior*, [2010] SCCA No 492 ; *R v. D.C.*, [2011] SCCA No. 137.

[8] Crown Memorandum of Argument in the SCC application for leave to appeal in *Mabior*, at para. 10.

[9] *R v. Mabior*, 2008 MBQB 201.

[10] Ibid., at para. 55.

[11] *Mabior, supra* note 1, at para. 88.

[12] Ibid., at para. 87.

[13] Ibid., at para. 92.

[14] Ibid., at para. 92.

[15] Ibid., at para. 97.

[16] Ibid., at para. 104.

[17] Ibid., at para. 152. The Quebec Court of Appeal in *D.C.* echoed this request (*D.C., supra* note 2, at para. 121).

[18] *R c. D.C.,* 2008 QCCQ 629.

[19] *R v. Williams,* 2003 SCC 41.

[20] *D.C., supra* note 2, at para. 76.

[21] Ibid., at para. 78, citing *Cuerrier, supra* note 6 at para. 127.

[22] Ibid., at paras. 100, 115–117.

[23] Ibid., at para. 118.

[24] Ibid., at paras. 102–114.

[25] Ibid., at para. 120.

[26] *Mabior, supra* note 1 at para. 156.

[27] Ibid., at para. 154.

[28] Ibid., at para. 64.

[29] Ibid., at para. 151.

[30] Ibid., at para. 59.

[31] Ibid., at para. 92.

[32] Ibid., at para. 97.

[33] Ibid., at para. 92.

[34] Ibid., at paras. 112–113.

[35] See, for example, HIV Prevention Trials Network, Press Release, "Initiation of Antiretroviral Treatment Protects Uninfected Sexual Partners from HIV Infection (HPTN Study 052)," (12 May 2011) on-line at www.hptn.org; "HIV treatment as prevention — it works," Editorial, *Lancet* (21 May 2011) 377:9779, p. 1719; J. Del Romero, et al.,

"Combined Antiretroviral Treatment and Heterosexual Transmission of HIV-1: Cross Sectional and Prospective Cohort Study," (2010) 340 *British Medical Journal* c2205; D. Donnell, et al., "Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: A Prospective Cohort Analysis," (2010) 375 *Lancet* 2092.

[36] *R v. Wright,* 2009 BCCA 514.

[37] Attempted murder charges are sometimes laid but they require an intent to cause death, which may be difficult to prove in the non-disclosure context.

[38] *Williams, supra* note 19. Where the Crown is unable to prove this fact, the verdict will be attempted aggravated (sexual) assault. See also Isabel Grant, "The Prosecution of Non-Disclosure of HIV in Canada: Time to Rethink *Cuerrier*," (2011) 5:1 *McGill Journal of Law and Health* 7, at 48.

[39] Grant, "Time to Rethink *Cuerrier*."

[40] One of us has argued elsewhere that where there is no disclosure, the accused should bear the risk that transmission takes place: see Grant, "Time to Rethink *Cuerrier*," at 49, 58–59.

[41] For instance, in New Zealand, there are three potential levels of liability: section 201 of the *Crimes Act* applies if the virus is intentionally transmitted; section 188 if the virus is recklessly transmitted; and section 145 if the virus is not transmitted (*Crimes Act* (NZ), 1961/43). Only three of the nine Australian jurisdictions criminalize exposure without transmission, and of those jurisdictions, two states apply different criminal offences for exposure and for transmission (*Crimes Act 1958* (Vic), ss 22–23; *Criminal Law Consolidation Act 1935* (SA) s 29; *Criminal Code* (NT), ss 174C, 174D). The remaining six jurisdictions do not prosecute exposure where no transmission has occurred. See Grant, "Time to Rethink *Cuerrier*," *supra* note 38. at 36–42, for details.

[42] *R v. Crangle*, 2010 ONCA 451.

[43] See e.g., Maria J. Wawer, et al., "Rates of HIV-1 Transmission per Coital Act, by Stage of HIV-1 Infection, in Rakai, Uganda," (2005) 191:9 *Journal of Infectious Diseases* 1403, at 1408; Gary Marks, Nicole Crepaz and Robert S. Janssen, "Estimating Sexual Transmission of HIV from Persons Aware and Unaware That They are Infected with the Virus in the USA," (2006) 20:10 *AIDS* 1447; Bluma G. Brenner, et al., "High Rates of Forward Transmission Events After Acute/Early HIV-1 Infection," (2007) 195:7 *Journal of Infectious Diseases* 951. Marks and his colleagues found that, adjusting for population size differences in the groups, the rate of transmission of HIV was 3.5 times higher in the group that was unaware of their HIV status than in the group that knew they had HIV.

[44] At the end of 2008, an estimated 65 000 people were living with HIV (including AIDS) in Canada. Of these, approximately 16 900, or 26 percent, were not aware of their infection. See Public Health Agency of Canada, *HIV/AIDS Epi Updates, supra* note 5.

[45] Janine Benedet and Isabel Grant, "Hearing the Sexual Assault Complaints of Women with Mental Disabilities: Consent, Capacity and Mistaken Belief," (2007) 52 *McGill Law Journal* 243; Janine Benedet and Isabel Grant, "Sexual Assault of Women with Mental Disabilities: A Canadian Perspective," in Claire McGlynn and Vanessa Munro, eds., *Rethinking Rape Law: International and Comparative Perspectives* (London: Routledge, 2010) 322.

[46] See e.g., *R v. Stender*, (2004) 188 CCC (3d) 514 (Ont CA), aff'd 2005 SCC 36.

[47] Where there is intent to transmit the virus, a more serious offence is appropriate.

[48] *Criminal Code*, RSC 1985, c C-46 s 180(1).

[49] Courts have disagreed as to whether creating a risk of HIV transmission to one person suffices to meet the requirement of endangering the public. See *R v. Ssenyonga*, (1992) 73 CCC (3d) 216, at para. 42, holding that this test is not met, and *R v. Williams,* (2000) 189 Nfld and PEIR 156 (Nfld Sup Ct); *R v. Williams*, 2001 NFCA 52, at paras. 88–89, holding that non-disclosure to an individual could be said to endanger the public. This issue was not addressed by the Supreme Court of Canada in *Williams, supra* note 19.

[50] *Criminal Code,* SC 1919, c 46, s 316A, as repealed by *Criminal Law Amendment Act,* SC 1985, c 19, s 42.

[51] Committee on Sexual Offences against Children and Youth, *Sexual Offences against Children: Report of the Committee on Sexual Offences against Children and Youth* (Ottawa: Department of Supply and Services, 1984), at 25.

[52] Special Committee on Pornography and Prostitution, *Pornography and Prostitution in Canada* (Ottawa: Minister of Supply and Services Canada, 1985), at 556.

[53] While British Columbia does have a section of its Crown Policy dedicated to sexually transmitted diseases, it focuses on information sharing and case reporting between the criminal justice and public health systems. See Criminal Justice Branch, Minister of Attorney General, *Crown Counsel Policy Manual* (2007), on-line at www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/SEX2-SexuallyTransmittedDiseases-16May2007.pdf. In contrast, the England and Wales legal guidance is wide-ranging. In addition to setting out the overall approach and policy consideration to be taken into account by Crown prosecutors, it includes specific guidance regarding the types of evidence the Crown will need to take into account at the charge screening stage, complainant and witness issues, and internal procedures for decision-making in individual cases.

[54] *R v. Ewanchuk*, [1999] 1 SCR 330.

[55] Shannon Brennan and Andrea Taylor-Butts, *Sexual Assault in Canada: 2004 and 2007* (Ottawa: Canadian Centre for Justice Statistics, 2008).

[56] Ibid.

[57] For recent discussions, see Janice Du Mont and Margaret J. McGregor, "Sexual Assault in the Lives of Urban Sex Workers: A Descriptive and Comparative Analysis," (2004) 39 *Women* and *Health* 79; Christine M. Sloss and Gary M. Harper, "Legal Service Needs and Utilization of Women Who Trade Sex," (2010) 7 *Sexuality Research* and *Social Policy* 229.

[58] Benedet and Grant, "Consent, Capacity and Mistaken Belief", *supra* note 45.

[59] For example, see Diane K. Bohn, "Lifetime Physical and Sexual Abuse, Substance Abuse, Depression, and Suicide Attempts Among Native American Women," (2003) 24 *Issues in Mental Health Nursing* 333. Aboriginal women in Canada report being victims of violent crime (sexual assault, robbery, or physical assault) at a rate nearly three times that of non-Aboriginal women: Shannon Brennan, "Violent Victimization of Aboriginal Women in the Canadian Provinces, 2009," (Ottawa: Canadian Centre for Justice Statistics, 2011), on-line at www.statcan.gc.ca.

[60] Alison Symington, "HIV Exposure as Assault: Progressive development or misplaced focus?" in Elizabeth Sheehy, ed., *Sexual Assault Law, Practice* and *Activism in a Post-Jane Doe Era* (Ottawa: University of Ottawa Press, 2011) [forthcoming, see on-line at www.ruor.uottawa.ca/en/handle/10393/19876], at 24.

[61] Grant, "Time to Rethink *Cuerrier*," *supra* note 38.

[62] Mykhalovskiy, Betteridge and McLay, *HIV Non-disclosure and the Criminal Law, supra* note 3 at 10.

[63] Ibid., at 11.

[64] E. Mayfield Arnold, et al., "HIV Disclosure Among Adults Living with HIV" (2008) 20 *AIDS Care* 80, citations omitted. This study discusses disclosure in several contexts — not just to sexual partners.

[65] Sixty-eight percent of HIV non-disclosure cases in Canada result in convictions: Mykhalovskiy, Betteridge and McLay, *HIV Non-disclosure and the Criminal Law, supra* note 3 at 13. This is two to three times higher than the conviction rates for sexual offences more generally: Kong, et al., *Sexual Offences in Canada* (Ottawa: Canadian Centre for Justice Statistics, 2003), on-line at www.statcan.gc.ca.

[66] See Patricia Allard, Cécile Kazatchkine and Alison Symington, "Criminal Prosecutions for HIV Non-disclosure: Protecting Women from Infection or Threatening Prevention Efforts?" in Jacqueline Gahagan, ed., *Women and HIV Prevention in Canada: The Past, The Present and the Future — Implications for Research, Policy and Practice* (Toronto: Canadian Scholars' Press, 2012) [forthcoming, copy on file with authors].

[67] See e.g., *R v. Ifejika,* 2006 ONCJ 356, a case in Hamilton in which a woman had her children permanently removed from her care and was convicted of failing to provide the necessities of life to her newborn child on the basis that, having followed medical advice during her first pregnancy, she failed to tell her doctors during her second delivery that she was HIV-positive. She was sentenced to a six-month conditional sentence and three years' probation.

[68] Arnold, et al., "HIV Disclosure," *supra* note 64.

CANADIAN DEVELOPMENTS

This section provides brief reports of developments in legislation, policy and advocacy related to HIV/AIDS in Canada. (Cases before the courts or human rights tribunals in Canada are covered in the section on HIV in the Courts — Canada.) The coverage is based on information provided by Canadian correspondents or obtained through scans of Canadian media. Readers are invited to bring stories to the attention of Alison Symington (asymington@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Unless indicated otherwise, all articles for this issue were written by Ms. Symington.

Senate stalling derails bill to fix Canada's law on affordable generic medicines for developing countries

On 26 March 2011, when Parliament was dissolved for a federal election, Bill C-393 died on the Order Paper. The bill addressed flaws in Canada's Access to Medicines Regime (CAMR), which is supposed to facilitate the export of lower-cost medications, including HIV treatments, to developing countries.

CAMR was created unanimously by Parliament in 2004. It permits compulsory licensing of pharmaceutical products patented in Canada for the purpose of exporting lower-cost, generic versions of those products to eligible developing countries. A compulsory licence is a legal authorization for someone other than the

pharmaceutical company holding the patent on a product to manufacture and, in the case of CAMR, to export that product to specific countries. In exchange, the company holding the patent must be paid a royalty. By counterbalancing the monopoly of the patent-holder, compulsory licensing helps create more competition in the marketplace, which brings the prices of medicines down.

Where it has been possible, this kind of global competition has led to a dramatic reduction in the price of AIDS drugs for developing countries. Yet, more than seven years after it was created, CAMR has been used only once, by a single generic manufacturer for authorization to produce one order of fixed-dose combination antiretroviral (ARV) drug for export to one country, Rwanda.

The current CAMR has been criticized by many observers as imposing a number of unnecessary requirements on both importing countries and Canadian generic manufacturers. These requirements hinder its ability to provide an expeditious and efficient solution to public health crises in the developing world.

Recommendations for reform have come not only from a wide range of civil society organizations and international legal experts, but also from within Parliament itself. In 2007, the Senate Standing Committee on Foreign Affairs and International Trade recommended that Canada should "amend Canada's Access to Medicines Regime, including its underlying legislation, to make it more effective in prompting shipments of medications for HIV/AIDS sufferers in Africa."[1]

Many of CAMR's current limitations are not required by the World Trade Organization's (WTO) *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS) and the subsequent 30 August 2003 General Council Decision, upon which CAMR is based.

In 2009, Bills S-232 and C-393 were introduced in the Canadian Senate and House of Commons, respectively, each proposing identical reforms to streamline CAMR.[2] The objective of Bills S-232 and C-393 was to simplify the compulsory licensing process by removing many of CAMR's limitations. Central to the proposed amendments was the introduction of a "one-licence solution" so that a generic manufacturer would need to obtain only a single licence for a given pharmaceutical product. Under this approach, a licence would not be limited to exporting a fixed "maximum" quantity of the product (specified in advance in the application for a licence) and only exporting to a single eligible country. Instead, the licence would authorize the generic manufacturer to export to any of the countries already listed in the law as eligible recipients and to supply them with the quantities that they request as their needs evolve over time.

Reforms proposed in Bills S-232 and C-393 also would have meant that generic manufacturers would not be required first to try to obtain a voluntary licence from the patent-holder, but could instead apply directly to the Commissioner of Patents for a compulsory licence to export a specific product. Any licence granted would continue to be non-transferable (i.e., it would only authorize exports by the generic company that obtained the licence) and non-exclusive (i.e., other generic manufacturers could also seek their own licences). The patent-holding pharmaceutical company would still maintain the right to manufacture its original product; however, it would face competition from manufacturers who obtain licences to produce lower-cost, generic versions.

Proposed CAMR reforms would also have expanded the definition of a "pharmaceutical product" that could be exported to eligible countries, so that it more closely reflects what has already been negotiated at the WTO.[3] The proposed reforms would also eliminate CAMR's arbitrary limit of two years on the duration of a licence. The reforms proposed were in keeping with Canada's obligations under the WTO and are fully compliant with the TRIPS Agreement.[4]

Senators Yoine Goldstein and Sharon Carstairs sponsored Bill S-232 in March 2009, which passed second reading and was sent to the Senate Standing Committee on Banking, Trade and Commerce for review in October 2009. However, the review was cut short when the Government of Canada prorogued Parliament in December 2009, and Bill S-232 died on the Order Paper.

In May 2009, Bill C-393 was introduced in the House of Commons by former Member of Parliament (MP) Judy Wasylycia-Leis and narrowly passed second reading in December that same year. As a private member's bill in the House of Commons, Bill C-393 survived the prorogation of Parliament and was sent on for review by the House of Commons Standing Committee on Industry, Science and Technology, which began in October 2010. A slim majority (of one) of MPs on the committee voted to strip many of the key amendments from the bill, including the "one-licence solution"

and the amended definition of "pharmaceutical product."

By this time, Wasylycia-Leis had left Parliament and the bill required a new sponsor to move forward in the House. In January 2011, 25 000 Canadians signed a petition circulated by the Canadian HIV/AIDS Legal Network and global advocacy organization Avaaz, calling for Parliament to grant the bill new sponsorship. On 2 February, Parliament allowed MP Paul Dewar to become the new sponsor of Bill C-393. The bill's final hour of debate took place on 3 March, during which a majority of the House of Commons re-instated the "one-licence solution" and the broader definition of "pharmaceutical product." On 9 March 2011, Bill C-393 was passed at third reading by a strong majority — 172 to 111 — with support from all parties in the House of Commons.

Bill C-393 was immediately transferred to the Senate under the sponsorship of Senator Carstairs. With agreement in the Senate, the bill could have been passed quickly. However, a group of Senators proceeded to stall the bill's progress for four consecutive days, reiterating talking points from a memo circulated to all Conservative Party Senators by Minister of Industry Tony Clement, which outlined the Government's opposition to the bill. On 26 March 2011, Parliament dissolved for a federal election and Bill C-393 died on the Order Paper.

Commentary

An overwhelming need still exists in the developing world for affordable medicines to treat HIV and AIDS and many other diseases. Yet, in the years since it was created, CAMR has done little to address this need and is unlikely to do so in the future without substantial reforms. A more streamlined process under CAMR would provide a strong incentive for generic manufacturers to participate in the Regime, enabling them to use economies of scale and ultimately lower the price of a given product, thereby making limited aid resources benefit even more people in the developing world.

The progress achieved with Bills S-232 and C-393 was due in large part to the sustained grassroots advocacy initiatives spearheaded by the Canadian HIV/AIDS Legal Network and its partners, including the National Advocacy Committee of the Grandmothers to Grandmothers Campaign, Universities Allied for Essential Medicines, RESULTS Canada, the Interagency Coalition on AIDS and Development, the member organizations of the Global Treatment Access Group, and thousands of concerned Canadians. The campaign to fix CAMR is expected to continue with the introduction of very similar reform legislation in the latter part of 2011 in both the Senate and House of Commons.

— Lindsey Amèrica-Simms and Richard Elliott

Lindsey Amèrica-Simms (lsimms@aidslaw.ca) and Richard Elliott (relliott@aidslaw.ca) are, respectively, outreach coordinator and executive director at the Canadian HIV/AIDS Legal Network.

[1] Senate Standing Committee on Foreign Affairs and International Trade, "Overcoming 40 Years of Failure: A New Road Map for Sub-Saharan Africa", February 2007, p. 117, on-line: www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/fore-e/rep-e/repafrifeb07-e.pdf. It is important to note that, consistent with the outcome of WTO negotiations on which it is based, CAMR has never been, and should not be, limited to simply responding to the need for AIDS drugs in African countries, but is more broadly applicable to address public health problems in a wide range of eligible countries.

[2] See briefs to Parliamentary committees and other materials by Canadian HIV/AIDS Legal Network on Bills S-232 and C-393 on-line via www.aidslaw.ca/camr.

[3] Paragraph 1(a) of the 2003 WTO Decision, August 2003. On-line: www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm.

[4] *Reforming Canada's Access to Medicines Regime (CAMR): Bill C-393 — Finding the Expeditious Solution*, Conclusions of an International Expert Consultation convened by the UN Development Programme and the Canadian HIV/AIDS Legal Network (New York, February 2010). On-line: www.aidslaw.ca/publications/publicationsdocEN.php?ref=1109.

Ontario: study documents access and quality of care issues for women living with or vulnerable to HIV

A health study by researchers from Toronto's St. Michael's Hospital and the Institute for Clinical Evaluative Sciences demonstrates that, while considerable progress has been made in preventing and treating HIV infection, disparities continue to exist in terms of access to and quality of care for women across Ontario.[1] Targeted responses are needed in order to deliver universal, high-quality care throughout the province, particularly for older women, Aboriginal women and women who have emigrated from countries where HIV is endemic.

The POWER Study (Project for an Ontario Women's Health Evidence-Based Report) is a multi-year project funded by Echo: Improving Women's Health in Ontario, an agency of the Ontario Ministry of Health and Long-Term Care. It is producing a comprehensive provincial report on women's health, examining gender differences on a broad set of evidence-based indicators as well as differences among women associated with socioeconomic status, ethnicity and geography.

The "HIV Infection" chapter was released in June 2011[2] and looks at both patterns of illness and outcomes of care for HIV-positive women and among specific groups of women with HIV or at risk for HIV infection. The first section looks at incidence, prevalence and risk behaviours of Ontario women and men. The second section reports on indicators of community services for HIV, including government funding and measures of service delivery and utilization. The next section focuses on clinical care, including indicators of HIV prenatal screening and treatment of HIV-positive pregnant women, measures of quality of life, symptom burden, CD4 count and viral load. The final section on health outcomes reports on HIV-related hospitalizations and mortality.

Some of the key findings are as follows:

- Over 4700 women are living with HIV in Ontario (approximately 18 percent of people living with HIV in Ontario), most of whom acquired HIV through sexual contact. While only 13 percent of HIV infections among women were attributed to injection drug use (IDU), this represents an HIV prevalence of 5 percent among female injection drug users.
- Women who emigrated from a country where HIV is endemic account for more than half of all new infections among women in Ontario.
- Women reported lower condom use than men. Younger men and women were more likely to report condom use at their last sexual intercourse than older adults.
- Women who inject drugs report riskier injection behaviours than men, including injecting with previously used syringes.
- Approximately one third of the users of community-based HIV services are women. Women accounted for almost 40 percent of users of IDU-related services.
- Health-related quality of life among adults living with HIV is worse than for the general populations, especially for mental health status.
- Women living with HIV reported higher symptom burden than men, including symptoms such as fatigue, nervousness, pain and sadness.
- A significant proportion of patients do not receive a viral load test soon after being diagnosed with HIV, and about 1 out of every 5 HIV-positive individuals in HIV care in Ontario did not undergo viral load testing according to clinical care guidelines.
- Women were less likely than men to have undetectable viral loads.
- The HIV-related mortality rate is highest among men and women born in sub-Saharan Africa.[3]

One of the issues examined in the clinical care section is prenatal screening for HIV and treatment for HIV-positive pregnant women. The data revealed that 95 percent of pregnant women in Ontario were screened

for HIV in 2009 and that, of those, 28 women tested positive.[4] This high screening rate and the dramatic fall in the number of infants born with HIV in Ontario demonstrate the success of the coordinated intervention and clinical practice guidelines to prevent vertical transmission. It is noted, however, that there is no systematic data regarding the number of women who were tested without fully informed consent nor is there data on HIV prevalence among pregnant women who do not receive prenatal care.[5]

The authors of the "HIV Infection" chapter provide six key messages, each with suggested actions to help accelerate progress in reducing the burden of HIV infection, improve health outcomes among women and men living with HIV, and reduce health inequities related to HIV:

- More comprehensive data and better linkages are required to measure important quality indicators.
- Targeted prevention efforts are needed for some groups, including Aboriginal people and older women.
- HIV testing in pregnancy is high among women receiving prenatal care. Questions remain about women not receiving care and about the quality of consent.
- Prevention efforts among people who inject drugs seem to be effective but targeted interventions for women who inject drugs are needed.
- Important gaps in access to and quality of HIV care should be investigated.
- Despite effective treatment, some people living with HIV experience many symptoms and reduced quality of life, particularly women, injection drug users and people with lower education attainment.[6]

Commentary

The "HIV Infection" chapter documents critical inequities in access to treatment, quality of care and prevention efforts, differences that are often related to social determinants of health. It also reveals geographic differences in the nature of the epidemic across Ontario and the different needs of and impacts on distinct population groups, including Aboriginal people, older people, recent immigrants from HIV-endemic countries, and people who inject drugs. As clearly illustrated by this report, significant health differences exist between women and men, as well as between specific groups of women. This study therefore provides important policy and programmatic guidance in order to respond effectively to HIV in Ontario and ensure that the health rights of all people living with or vulnerable to HIV in the province are addressed.

— Eli Arkin and Alison Symington

[1] A.M. Bayoumi, et al., "HIV Infection," in A.S. Bierman (ed.), *Project for an Ontario Women's Evidence-Based Report*, Volume 2. 2011.

[2] See www.powerstudy.ca.

[3] "HIV Infection Highlights Document," available on-line: www.powerstudy.ca/the-power-report/hiv-infection.

[4] A.M. Bayoumi, et al., p.50.

[5] "HIV Infection Highlights Document," *supra*.

[6] A.M. Bayoumi, et al., "HIV Infection," pp. 102–104.

Studies confirm effectiveness of harm reduction for people who inject drugs

Three recent studies have provided further evidence that harm reduction initiatives are effective tools for reducing HIV incidence among people who inject drugs (IDUs).

A report from the office of the Provincial Health Officer of British Columbia, *Decreasing HIV Infections among People Who Use Drugs by Injection in British Columbia*, explored the substantial reduction in the number of new cases of HIV among IDUs in the province since mid-2007.[1] The report summarizes the discussion of an expert working group that included medical health officers, public health staff, representatives from the IDU community and experts in the fields of substance use, harm reduction and HIV treatment.

Among the reasons advanced for the decrease was the increased uptake of Highly Active Antiretroviral Therapy (HAART), which reduces viral load in individuals and thereby reduces the risk of HIV transmission. Another reason may be changing patterns of drug use, including an increase in crack cocaine smoking (which carries less risk of HIV transmission than injection). A third factor that may have contributed to the decrease is the impact of HIV prevention programs, including harm reduction programs such as needle exchange and methadone maintenance therapy.[2]

In Quebec, another study led by Dr. Julie Bruneau examined HIV incidence and risk behaviours, and the association between needle exchange programs and seroconversion among IDUs in the St. Luc area of Montréal. The prospective cohort study followed 2137 HIV-negative IDUs from 1992–2008.[3] The results of the study showed a decline in the incidence of HIV in IDUs in the period, including a decline that was four times faster after 2000 — the year that needle exchange programs were scaled up in the area — suggesting that the enhancement of HIV-prevention strategies may have played a significant role.[4]

The study results confirm the importance of intravenous cocaine use, unsafe injection practices and unstable housing conditions as the main drivers of the HIV epidemic among IDUs.[5] Significant reductions in the proportion of IDUs reporting syringe-sharing or sharing with a person known to be HIV-positive were observed.[6]

Finally, a study conducted by the Urban Health Research Initiative of the BC Centre for Excellence in HIV/AIDS showed that the number of deaths from drug overdoses declined by 35 percent in the area within 500 metres of Vancouver's supervised injection facility, Insite, since it opened in 2003.[7] By comparison, the rest of the City of Vancouver showed only a 9 percent decrease in deaths from drug overdoses.[8] Insite has not recorded a single death by drug overdose at the facility itself.

With the assistance of the British Columbia Coroners Service, the researchers collected information on every drug-related overdose death that occurred in Vancouver between 2001 and 2005. The study suggests that supervised injection facilities are effective at reducing overdose deaths in communities with high levels of injection drug use and that closing Insite would likely lead to unnecessary and preventable deaths due to overdose.[9]

— Eli Arkin

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[1] M. Gilbert et al., *Decreasing HIV infections among people who use drugs by injection in British Columbia: Potential explanations and recommendations for further action,* Office of the Provincial Health Officer, British Columbia, March 2011.

[2] Ibid. The report also posited three other factors that could explain the trends: decreased testing for HIV among IDUs, changes in the population of IDUs and decreased sexual transmission of HIV among IDUs.

[3] J. Bruneau, et al., "Trends in Human Immunodeficiency Virus Incidence and Risk Behaviour among Injection Drug Users in Montreal, Canada: A 16-Year Longitudinal Study," *American Journal of Epidemiology*, Vol. 173 No. 9 (2011): pp. 1049–58.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] B.D.L. Marshall, et al. "Reduction in overdose mortality after the opening of North America's first medically supervised safer injection facility: A retrospective population-based study," *The Lancet*, Volume 377, Issue 9775, Pages 1429–1437, doi:10.1016/S0140-6736(10)62353-7, 23 April 2011.

[8] Urban Health Research Initiative, *Vancouver's Supervised Injection Facility Reduces Overdose Deaths,* Research to Community document. April 2011. On-line: http://uhri.cfenet.ubc.ca/images/Documents/fewer-od-deaths.pdf.

[9] Ibid.

In Brief

British Columbia: forced testing legislation introduced

The *Emergency Intervention Disclosure Act*, introduced in the British Columbia Legislative Assembly on 31 May 2011, would permit emergency workers and victims of crime to apply for a blood testing order if they come into contact with the bodily fluid of another person.[1] Under such an order, the source person of the fluid would be compelled to provide test results for communicable diseases such as HIV and hepatitis C.

The bill sets out procedures for obtaining expedited testing orders and standard testing orders as well as procedures to object to or appeal a testing order. A person who fails to comply with a testing order can be fined up to $10,000 per day and/or imprisoned for up to six months.[2]

Norm Letnick, who introduced the legislation as a private member's bill, indicated that he did so at the urging of local firefighters.[3] The Ambulance Paramedics of B.C. union has also indicated its support for the legislation.[4]

Similar legislation exists in several other Canadian provinces.[5] It has been criticized as unnecessary, unjustified and an ineffective response to the risk of occupational exposure to HIV.

Special Diet Allowance changes in Ontario

Recent changes have raised the threshold people living with HIV (PLHIV) would need to meet to qualify for the Special Diet Allowance (SDA) in Ontario. As a result of the changes to the nutritional benefit program, some PLHIV could have their SDA decrease or end.

The SDA is a supplemental benefit intended to provide healthier food and other forms of nutrition for people receiving benefits through the Ontario Disability Support Program (ODSP) and Ontario Works (OW).[6] The new SDA, which began on 1 April 2011, is available to people living with 29 medical conditions, including HIV.

To qualify, the applicant must fall within one of the following categories related to weight loss: (1) weight loss of 5 percent to 10 percent of usual body weight (eligible for $191 per month); and (2) weight loss of more than 10 percent of usual body weight (eligible for $242 per month). In contrast, the former SDA allowed all people living with HIV and receiving OSDP or OW to receive a SDA. The weight loss/wasting categories were: 0 to 2 percent ($75 per month), 2 to 5 percent ($150), 5 to 10 percent ($180) and greater than 10 percent ($240). The maximum SDA an individual can receive is still $250 per month.[7]

There is also a Pregnancy/Breastfeeding Nutritional Allowance (PBNFA), in addition to any other SDA. The PBNFA is $40 per month for lactose-tolerant women and $50 if lactose-intolerant. Finally, for mothers who cannot or should not breastfeed, there is a SDA for infants (for the first 12 months of the child's life). The amount is $145 per month for lactose-tolerant infants or $162 if lactose-intolerant.[8]

To receive the new SDA, individuals must submit a signed copy of the new application, completed by their health-care provider. There is a separate form for the PBNFA. Applicants have the right to an Internal Review if they do not agree with the decision. Requests must be made in writing within 30 days of the decision being made.[9]

— Shalini Thomas

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[1] Bill M 210 — 2011. For analysis on a similar piece of legislation passed in Manitoba in June 2008, see "Manitoba legislation would authorize testing for HIV without informed consent," *HIV/AIDS Policy & Law Review* 13(1), July 2008, pp. 27–8.

[2] Bill M 210 — 2011, Sections 6(1) & (2).

[3] T. Sherlock, "Blood test bill introduced to protect emergency workers," *Times Colonist (Victoria)*, 2 June 2011, p. A4.

[4] Ibid.

[5] See Canadian HIV/AIDS Legal Network, *Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV,* 2007.

[6] ODSP and OW are income support programs provided by the government of Ontario.

[7] HIV & AIDS Legal Clinic — (Ontario), "Special Diet Allowance Changes — Information Sheet," revised 2 March 2011.

[8] Ibid.

[9] Ibid.

INTERNATIONAL DEVELOPMENTS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. (Cases before the courts or human rights tribunals are covered in the section on HIV in the Courts — International.) We welcome information about new developments for future issues of the *Review*. Readers are invited to bring cases to the attention of Cécile Kazatchkine (ckazatchkine@aidslaw.ca), policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Unless indicated otherwise, all articles for this issue were written by Ms. Kazatchkine.

Global: clinical trial shows dramatic reduction in transmission of HIV as a result of treatment

A groundbreaking trial has confirmed that HIV treatment can greatly reduce the transmission of HIV, prompting discussion on next steps and possible human rights implications.

In May 2011, the National Institutes of Health in the United States of America published the results of the trial, which was carried out by the HIV Prevention Trials Network. They showed that, when an HIV-positive individual adhered to an effective antiretroviral (ARV) therapy regimen, the risk of transmitting the virus to his or her uninfected partner was reduced by 96 percent.[1] These results were so significant that the trial was stopped four years ahead of schedule.

The trial enrolled more that 1700 sero-discordant couples (in which

only one partner is HIV-positive) from Africa, Asia, Latin America and the U.S. It was also required that the HIV-positive partner have a CD4 cell count of between 350 and 550, and therefore be not yet eligible for treatment for their own health according to World Health Organization guidelines.[2]

UNAIDS was quick to hail the results. "This breakthrough is a serious game changer and will drive the prevention revolution forward," said Executive Director Michel Sidibé. "People living with HIV can now, with dignity and confidence, take additional steps to protect their loved one from HIV."[3]

Only about one half of the 33 million people living with HIV (PLHIV) know their serostatus.[4] An increase in the uptake of testing for HIV would have a significant impact on the response to the disease, especially if more people gain access to treatment. Indeed, the medical journal *The Lancet* commented in an editorial that "treatment as prevention" could improve uptake in testing because there would be an increased incentive for people to know their status "with the reassurance of knowing that if treated early they are unlikely to infect others."[5]

An initial challenge for launching "treatment as prevention" efforts will be in terms of cost. International organizations like the Global Fund to Fight AIDS, Tuberculosis and Malaria lack sufficient money to treat all those who qualify for ARV therapy under current guidelines. It will be even more difficult to locate additional funds to treat millions more to help slow down the spread of HIV, especially at a time of worldwide economic uncertainty when many governments appear disinclined to increase their aid budgets.

Commentary

The results of the trial do not come without concerns about the legal and ethical implications of "treatment as prevention." During the 6th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, which took place in Rome, in July 2011, part of the discussion focused on the ethics of not providing treatment unless the PLHIV is in a sero-discordant relationship. Questions were raised about whether the emphasis should not instead be on making treatment available to all PLHIV who need it. Wafaa El-Sadr of the International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University in New York City for example, which provides treatment to over one million people, said that HIV-positive individuals who form part of a sero-discordant couple may comprise a very small part of the total population of PLHIV in some of the 21 countries in which ICAP works.[6]

A larger issue is one of consent to treatment. As Eric Fleutelot of the French organization Sidaction pointed out at the IAS conference, "Every individual with HIV should decide for themselves when and how to start treatment. No one should be forced or coerced into treatment primarily for the benefit of the public health rather than the health or the well-being of the individual."[7]

However, for treatment as prevention to achieve its goal, a vast majority of HIV-positive people would have to be receiving ARV therapy. *The Economist* notes that "people do not like taking medicine, particularly if they have no symptoms." Noting that almost one in five HIV-positive people stop taking ARVs within one year of initiation, the magazine posits that it "will be even harder to persuade the asymptomatic to pop a daily pill or two for the public good."[8]

Where "treatment as prevention" strategies are implemented in order to protect public health, another concern is that PLHIV who do not consent to treatment may face repercussions if authorities deem them to be a sufficient danger to public health. Should a PLHIV decline treatment — including those with a high CD4 count for whom there may be no clinical reason to commence ARV treatment — will he or she be treated as a criminal? Such measures could reinforce the belief that the responsibility for prevention lies solely with PLHIV. This is especially problematic in countries where there is willingness to resort to the criminal law to prosecute PLHIV for transmitting HIV or failing to disclose their HIV status.[9]

— David Cozac

David Cozac (dcozac@aidslaw.ca) is the managing editor of the *HIV/AIDS Policy & Law Review*.

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[1] World Health Organization and UNAIDS, "Groundbreaking trial results confirm HIV treatment prevents transmission of HIV," news release, Geneva, 12 May 2011. On-line: www.who.int/hiv/mediacentre/trial_results/en/index.html.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] "HIV treatment as prevention — it works," *The Lancet* Vol. 377, Issue 9779, 21 May 2011: p. 1719. On-line: www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960713-7/fulltext?rss=yes.

[6] K. Alcorn, "Treatment as prevention: what are the next steps?" Aidsmap, 20 July 2011. On-line: www.aidsmap.com/page/1881842/.

[7] Ibid.

[8] "The 30 years war," *The Economist*, 2 June 2011. On-line: http://stage.economist.com/node/18772276.

[9] K. Alcorn and T. Smart, "What do treatment as prevention study results mean for treatment?" Aidsmap, 2 June 2011. On-line: www.aidsmap.com/What-do-treatment-as-prevention-study-results-mean-for-treatment/page/1825240/.

Global: commission on drug policy declares drug war a failure, urges reforms

The Global Commission on Drug Policy recently declared in a report that the global "war on drugs" has failed. The report calls for a new approach to reduce drug abuse by replacing the current strategy of criminalization and incarceration of people who use drugs with the adoption of drug policies based on sound scientific evidence as well as on human rights and public health principles.[1]

The report states that, over the course of the 40-year war on drugs, money spent on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs has failed to eliminate the global supply or consumption of illicit drugs.

"Repressive efforts directed at consumers impede public health measures to reduce HIV/AIDS, overdose fatalities and other harmful consequences of drug use," the report concludes, adding that current reduction strategies and incarceration policies "displace more cost-effective and evidence-based investments in demand and harm reduction."[2]

United Nations estimates reveal marked increases in annual drug consumption, with worldwide opiate consumption increasing by 34.5 percent from 1998 to 2008, cocaine by 27 percent and cannabis by 8 percent.[3] There are approximately 250 million users of illicit drugs worldwide, with millions more involved in cultivation, production and distribution.[4]

The report outlines several examples of the widespread negative consequences of the drug war on producer, consumer and transit countries, including:

- the growth of a criminal black market financed by profits from supplying international demand for illicit drugs;
- substantial policy displacement where scarce resources are used to fund massive and largely symbolic law enforcement efforts;
- geographical displacement of illicit drug production; and
- the stigmatization, exclusion and marginalization of people who use drugs.[5]

Making a number of recommendations centred on a public health approach to manage drug use and addiction, the report urges increased investment in the health and social well-being of affected individuals and communities. Specifically, it calls on governments to:

- end the stigmatization, marginalization and criminalization of people who use drugs but do not harm others;
- respect the human rights of people who use drugs;
- experiment with alternative models of legal regulation of currently prohibited drugs, especially cannabis; and
- provide a wide range of comprehensive health and treatment services to those in need.[6]

The report also calls for the establishment of a new set of indicators to demonstrate the outcomes of drug policies according to the harms or benefits for individuals and affected communities. It furthermore calls on the UN to provide leadership in the reform of global drug policy by promoting an evidence-based approach; to support countries' ability to develop drug policies that meet their regional and specific needs; and to ensure coherence among UN policies, conventions and agencies.

The 19-member commission includes former UN Secretary-General Kofi Annan, former U.S. Secretary of State George Schultz, former chairman of the U.S. Federal Reserve Paul Volcker, former Mexican President Ernesto Zedillo, former Brazilian President Fernando Henrique Cardoso, former Colombian President Cesar Gaviria, authors Carlos Fuentes and Mario Vargas Llosa, businessman Sir Richard Branson and current Greek Prime Minister George Papandreou.

— Lindsey Amèrica-Simms

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[1] Global Commission on Drug Policy, *War on Drugs: Report of the Global Commission on Drug Policy.* 2011. On-line: www.globalcommissionondrugs.org/Report.

[2] Ibid. at p. 2.

[3] Ibid. at p. 4.

[4] Ibid. at p. 13.

[5] Ibid. at p. 9.

[6] Ibid, at pp. 10–17.

UN: Political Declaration on HIV and AIDS aims to intensify efforts to combat the epidemic

In June 2011, the United Nations General Assembly issued a Political Declaration on HIV and AIDS as a means to reaffirm its support for human rights and to call for the removal of barriers to treatment. The Declaration also explicitly recognizes key affected groups such as men who have sex with men (MSM), injection drug users (IDUs), and sex workers.[1]

The *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* (the Declaration) emerged from the High Level Meeting on HIV and AIDS, which took place at the UN General Assembly from 8–10 June. This document follows the Assembly's first *Political Declaration on HIV and AIDS* in 2006 and complements the 2001 *Declaration of Commitment on HIV/AIDS and the Millennium Development Goals*.

For the first time, key populations were mentioned in the 2011 Declaration, by recognizing people who are more vulnerable to contracting HIV. Such acknowledgment legitimizes long-standing calls for measures to protect these specific populations against HIV and guarantee their access to prevention, treatment and care without discrimination. The Declaration even goes as far as calling for the provision of sterile injection equipment as a means of prevention.[2]

The Declaration also addresses the disparities in access to antiretroviral (ARV) treatment, and encourages national legislation to be amended to remove barriers to such treatment.[3] The promotion of generic competition is explicitly mentioned, as are the use of existing flexibilities under Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the use of voluntary patent pools, such as the Medicines Patent Pool under UNITAID.[4] This is a welcome move, given that there are millions of people without access to treatment simply because it is unaffordable.[5]

Although many observers applaud the Declaration for specifically addressing key affected populations, some said that the UN did not go far enough. The International HIV/AIDS Alliance criticized the Declaration's assertion that harm reduction must be implemented "in accordance with national legislation."[6] Indeed, the Declaration appears to contradict itself, given the fact that many UN member states have harsh penalties for drug use, in addition to a lack of harm reduction services for IDUs. This inconsistency is compounded by certain governments criminalizing members of the key affected populations.

For its part, Médecins Sans Frontières accused governments who signed the Declaration of a double standard. The organization claimed that some governments give the impression that they are committed to fighting the spread of HIV/AIDS while, at the same time, actively pursue trade agreements that would block the production, export and importation of generic medicines.[7] MSF made specific reference to a trade agreement currently under negotiation between India and the European Union.[8]

In addition to drafting the Declaration, the High Level Meeting also set several key targets aimed at halting the spread of HIV. Among them is a commitment to reduce, by 2015, the sexual transmission of HIV by 50 percent; halve the incidence of HIV infection among IDUs; and eliminate mother-to-child transmission of HIV. The General Assembly also seeks to have 15 million people on ARV treatment by the same deadline.[9]

— Eli Arkin

Eli Arkin (earkin@aidslaw.ca) is a research and program support officer at the Canadian HIV/AIDS Legal Network.

[1] United Nations General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, Sixty-fifth session, Agenda item 10, A/RES/65/277, June 2011, para. 29.

[2] Ibid. at para. 59 (d).

[3] Ibid. at para. 36 and 71.

[4] Ibid. at para. 71.

[5] It is worth noting that the Political Declaration of 2006 also called for the removal of barriers to treatment access. See United Nations General Assembly, *Political Declaration on HIV/AIDS*, Sixtieth Session, Agenda item 45, A/RES/60/262, 87th Plenary Session, 2 June 2006, at para. 42.

[6] International HIV/AIDS Alliance, "UN Political Declaration to shape HIV response," 17 June 2011, online: www.aidsalliance.org/newsdetails.aspx?id=290951.

[7] Médecins Sans Frontières, "Governments to decide fate of nine million lives before AIDS summit," press release, New York, 6 June 2011.

[8] Ibid.

[9] United Nations General Assembly, *supra*, at paras. 62–64.

USA: alliance of AIDS directors criticizes punitive laws against people living with HIV

In an unprecedented statement, the National Alliance of State and Territorial AIDS Directors (NASTAD) denounced the criminalization of HIV transmission and non-disclosure in the United States of America and called for the expansion of programs to reduce HIV transmission while protecting the rights of people living with HIV (PLHIV).[1]

The organization, which represents public health officials that administer nationwide state and territorial HIV/AIDS and adult viral hepatitis prevention and care programs, expressed concern that "HIV criminalization undercuts our most basic HIV prevention and sexual health messages, and breeds ignorance, fear and discrimination against people living with HIV."[2]

The NASTAD membership pledged "to identify and share best practices related to successes in repeal of policies and/or laws and statutes in jurisdictions that are not grounded in public health science" as well as to "promote public education and understanding of the stigmatizing impact and negative public health consequences of criminalization statutes and prosecutions."[3]

With more than 300 convictions for HIV exposure and transmission, the U.S. is known to be the world leader in prosecutions against PLHIV for non-disclosure.[4] Today, 34 states and two territories explicitly criminalize HIV exposure through sex, shared needles or, in some states, through "bodily fluids" such as saliva and urine, which cannot transmit HIV.[5]

As revealed by the Positive Justice Project, a coordinated national effort to address statutes criminalizing HIV led by the Center for HIV Law & Policy, most prosecutions in the U.S. are not for transmission, and sentences for HIV-positive individuals convicted of HIV exposure are typically overly harsh and disproportionate to the actual or potential harm presented.[6] For example, in 2008, a 42-year-old HIV-positive homeless man in Texas who spat on a police officer during his arrest for public intoxication was sentenced to 35 years in prison.[7]

The NASTAD statement also comes at a time when more states in the U.S. continue to draft legislation that would target PLHIV for exposure to HIV. In May 2011, the Nebraska legislature passed the *Assault with Bodily Fluids Bill*, which ignores the National HIV/AIDS Strategy and the science related to HIV.[8] The legislation creates a misdemeanour crime for a person who strikes a public safety officer with bodily fluids that are identified as "any naturally produced secretion or waste product generated by the human body and shall include, but not be limited to, any quantity of human blood, urine, saliva, mucus, vomitus, seminal fluid or feces."[9] Individuals who know they are HIV-positive or carry hepatitis B or C would be subjected to a felony for striking a public safety officer with any of the identified body fluids in the eyes, mouth or skin.[10]

In Pennsylvania, the state House of Representatives unanimously passed a bill in July that allows for

prosecution for exposure or attempt to expose law enforcement officers to communicable disease such as HIV or hepatitis B. The measure would make it illegal for anyone intentionally to cause or attempt to cause a member of the law enforcement community to come in contact with HIV or hepatitis B. The legislation creates two new offences: assault of law enforcement officer in the second degree, with a maximum penalty of 10 years in prison and a US$25,000 (CAN$24,000) fine; and assault of law enforcement officer in the third degree, with a maximum penalty of seven years in prison and a US$15,000 (CAN$14,400) fine.[11]

[1] National Alliance of State & Territorial AIDS Directors, "National HIV/AIDS Strategy Imperative: Fighting Stigma and Discrimination by Repealing HIV-specific Criminal Statutes," statement, February 2011.

[2] Ibid.

[3] Ibid.

[4] Global Network of People Living with HIV/AIDS, *2010 Global Criminalization Scan Report.* July 2010.

[5] Center for HIV Law & Policy, *Ending and Defending Against HIV Criminalization: State and Federal Laws and Prosecutions, Vol.1*. 2010. On-line: www.hivlawandpolicy.org/resources/view/564.

[6] Center for HIV Law & Policy, *HIV Criminalization Fact Sheet.* December 2010. On-line: http://hivlawandpolicy.org/resources/view/560.

[7] Center for HIV Law & Policy, *Prosecutions for HIV Exposure in the United States, 2008–2011*. August 2011. On-line: www.hivlawandpolicy.org/resources/view/456.

[8] J. Delmundo, "The National HIV/AIDS Strategy and Nebraska's 'Spitting Bill'," *The Body,* 8 July 2011.

[9] LB 226, Section 5 a). Text available at www.nebraskalegislature.gov.

[10] Ibid., Section 2.

[11] R. Lefever, "Proposed bill targets those who try to infect police", *York Daily Record,* 4 July 2011.

Global: health federation issues ethics guidelines on forced female sterilization

The International Federation of Gynaecology and Obstetrics (FIGO) recently released new ethics guidelines in response to the continuing forced sterilization of women, including those living with HIV, in parts of the developing world.[1]

The guidelines reaffirm the reproductive rights of women and call for informed decisions on sterilization to be made solely by women. FIGO says that such decisions must also be accompanied by counselling and be free from exploitation, harassment and any other external pressure, such as preventing access to medical treatment. The guidelines indicate that specific populations of women may be more vulnerable to coerced sterilization, including those who are HIV-positive, use drugs or have disabilities.[2]

Among its recommendations is that "[n]o woman may be sterilized without her own, previously-given informed consent, with no coercion, pressure of undue inducement by healthcare providers or institutions," and that consent to sterilization "must not be made a condition of receipt of any other medical care, such as HIV/AIDS treatment."[3]

Significantly, the FIGO guidelines assert that "[f]orced sterilization constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies."[4]

The guidelines come amid accounts of coerced sterilization in Africa and in Latin America. The United States-based organization Project Prevention has launched efforts in Kenya and South Africa to pay women living with HIV or those who use drugs to undergo sterilization or accept long-term birth control in the form of intra-uterine devices (IUDs). It claims that birth control and sterilization are the only ways to eradicate HIV and prevent future pregnancies that may result in the "suffering" of children.[5] Project Prevention's work in Kenya, for example, pays women living with HIV US$40 (CAN$39) to accept IUDs, while a doctor is paid US$7 per patient.[6]

Women living in poverty in sub-Saharan Africa are targeted, as they are more likely to participate in the program due to the financial incen-

tive. In addition, Project Prevention gives money not only to a woman who is sterilized or receives long-term contraception, but also directs funds into a pool of larger groups of women for income-generating activities.[7]

For its part, the ethics committee of the British Medical Association has publicly opposed the work of Project Prevention — which also operates in the United Kingdom — saying that any consultation on sterilization or long-term contraception "must be on the overall interests of the patient." It believes that doctors should inform patients "of the benefits of reversible contraception so that the patients have more reproductive choices in the future."[8]

— Eli Arkin

Eli Arkin (earkin@aidslaw.ca) is a research and program support officer at the Canadian HIV/AIDS Legal Network.

[1] International Federation of Gynaecology and Obstetrics, *Female Contraceptive Sterilization.* March 2011. On-line: www.figo.org/publications/miscellaneous_publications/ethical_guidelines/new_ethical_guidelines.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] A. Thom, "US project planning to sterilize HIV+ women in South Africa," *Health-e News Service*, 11 April 2011.

[6] Ibid.

[7] Ibid.

[8] C. Davies, "First £200 vasectomy 'bribe' paid to British drug addict," *The Guardian*, 18 October 2010.

Uganda's anti-homosexuality bill fails, for now

In May 2011, Parliament in Uganda adjourned without debating a bill that included the death penalty for some homosexual acts.

In 2009, member of Parliament David Bahati introduced a private member's bill that sought to introduce the death penalty for those found guilty of "aggravated homosexuality," the aggravating factors being either a participant who is a minor, HIV-positive, disabled or a "serial offender," and in cases involving rape.[1]

The bill also stipulated that anyone convicted of committing a homosexual act would face life imprisonment, while those who aided, abetted, counselled or procured another to commit a homosexual act — including landlords who rented rooms or homes to homosexuals — could face up to seven years' imprisonment.[2]

Despite rumours of an eleventh-hour vote in early May 2011, Uganda's Parliament adjourned without debating the controversial bill, news welcomed by international human rights activists. Avaaz, a group that began an Internet campaign against the bill and gathered almost 1.4 million signatures to oppose it, called Parliament's action "a victory for all Ugandans and people across the world who value human rights."[3]

As per Kakoba Onyango, a Ugandan Member of Parliament, the inaction was largely due to criticism from various national and international human rights groups, prompting President Yoweri Mueveni to resist supporting its passage.[4] Maria Burnett of Human Rights Watch commented that "the international pressure over the last year and a half has been very important to show that Uganda cannot act in isolation from the international community."[5]

The U.S. State Department called the bill "odious," stating that no amendments to the bill's wording could justify its enactment.[6] Despite this, Bahati said he would re-introduce the bill when the next session of Parliament convened, after elections in February 2012.[7] He claimed the revised bill would not contain the death penalty, although he had yet to release an amended version at the time of writing.

Homosexuality is illegal in Uganda and is largely unpopular within mainstream Ugandan culture, with politicians and Christian pas-

tors denouncing it vociferously.[8] Lesbian, gay, bisexual and transgender (LGBT) rights groups in Uganda claim that their community has been increasingly targeted since the introduction of the bill in 2009.[9]

In particular, a tabloid newspaper in 2010 published the names and photos of several LGBT persons with the caption "Hang Them." Shortly afterward, David Kato, a well-known gay rights activist whose picture had been published, was found bludgeoned to death in his home. Although the investigation has yet to be completed, authorities claim Kato's sexual orientation was irrelevant to his murder.[10]

— Shalini Thomas

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[1] "Uganda anti-gay bill 'shelved by parliament'," BBC News, 13 May 2011. "No vote: Future of Uganda's anti-gay bill in limbo," *San Francisco Chronicle*, 13 May 2011. See also "Bills in Uganda would infringe upon rights of homosexuals and people living with HIV/AIDS," *HIV/AIDS Policy & Law Review* 15(1), October 2010, pp.13–15. On-line: www.aidslaw.ca/review.

[2] "No vote: Future of Uganda's anti-gay bill in limbo," *supra*.

[3] Ibid; G. Olukya and J. Straziuso, "Uganda's anti-gay bill dropped from agenda after international outcry," *The Globe and Mail*, 11 May 2011.

[4] "No vote: Future of Uganda's anti-gay bill in limbo," *supra*.

[5] "Uganda anti-gay bill 'shelved by parliament'," *supra*.

[6] "Uganda's anti-gay bill dropped from agenda after international outcry," *supra*.

[7] "Uganda anti-gay bill 'shelved by parliament'," *supra*.

[8] "Uganda's anti-gay bill dropped from agenda after international outcry," *supra*.

[9] "No vote: Future of Uganda's anti-gay bill in limbo," *supra*.

[10] "Uganda's anti-gay bill dropped from agenda after international outcry," *supra*.

France: Recent immigration-related developments affecting persons suffering from serious illnesses

France enacted a new immigration law on 16 June 2011.[1] Among other things, the law changes the criteria for issuing residence permits on medical grounds. Foreigners with a medical condition who apply for a residence permit must now show that treatment and care are unavailable in their country of origin. It is no longer sufficient to show a lack of *effective* access to such treatment or care.

For the moment, people living with HIV/AIDS (PLHIV) are exempt from this provision.

Starting in 1998, foreigners with a medical condition could obtain a residence permit by showing they did not have effective access to the care and treatments necessary for their survival in their country of origin. Henceforth, they must prove that such care and treatments do not exist in their country of origin, a condition that is considerably harder to meet.

This new criterion will also apply to renewals of residence permits that were granted on medical grounds. The status of nearly 28 000 people, representing close to 1 percent of foreigners living in France, could be called into question.[2]

However, the new law provides that, even if appropriate treatments exist in the country of origin, a foreigner who is sick may be admitted to France if he or she shows that there are exceptional humanitarian circumstances in France or in the country of origin. This merely gives the government the option to admit the foreigner. The government is

under no obligation to do so and, as such, gives it considerable discretion.[3]

Thanks to the combined efforts of advocacy groups and certain political figures, foreigners living with HIV/AIDS benefit from an exception. Such foreigners from less-developed countries (LDCs) do not have to prove that treatment is unavailable in their country of origin. This will make it easier for them to obtain residence permits on medical grounds.

Commentary

The exception for PLHIV is not contained in the statute. It is in an administrative circular[4] issued under the statute. This circular is easy for the government to change. Therefore, it is possible that the French government will decide, someday soon, to treat HIV/AIDS like any other serious illness and demand proof that there is no care and treatment in the country of origin as a condition of issuing or renewing a residence permit on medical grounds.

While the exception secured for HIV/AIDS is a good thing, the law is a step backwards. The fact that medication and care exist in just about every country does not mean that the people of the country have access to them. In many LDCs, access to treatment remains theoretical for both economic and practical reasons.

It is particularly unfortunate that France's lawmakers chose to put in place this objective criterion of treatment unavailability in the country of origin. France's Constitutional Council, which was responsible for interpreting the provisions of the country's former immigration statute, had stated that a subjective approach should be used in relation to foreigners who have an illness.[5] The idea was to consider whether genuine access to treatment was available in a given country, not merely whether treatment existed there. Indeed, numerous LDCs have advanced medication and medical techniques; but, in practice, it is difficult for the vast majority of those countries' inhabitants to gain access to them.

France's specificity in this regard was interesting because it ran counter to the European Court of Human Rights (ECHR) case law in *N. v. United Kingdom*,[6] where the ECHR held that, even if effective access to treatments for the foreigner's condition (in this instance HIV) is not available, only exceptional humanitarian situations would justify barring the foreigner's removal to the foreigner's country of origin. Other European government bodies, such as the Swiss Federal Office for Migration, hid behind the ECHR's decision to deny entry to foreigners with a medical condition, and the French Constitutional Council's position on the matter represented progress in this regard. It is unfortunate that France is now treating foreigners with an illness more harshly.

— Rémi Weiss

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[1] *Loi nº 2011-672 du 16 juin 2011 relative à l'immigration, à l'intégration et à la nationalité.* [Law No. 2011-672 of 16 June 2011 on immigration, integration and nationality]

[2] CICI, *Rapport au Parlement : les orientations de la politique de l'immigration.* December 2009.

[3] Réseau des Associations Africaines et Caribéennes de lutte contre le sida en France, "Désobéir!" *Gingembre nº 10.* Summer 2011.

[4] *Circulaire DGS/MC1/RI2/2010/297 du 29 juillet 2010 relative aux procédures concernant les étrangers malades atteints de pathologies graves* [Circular DGS/MC1/RI2/2010/297 of 29 July 2010 on procedures concerning foreigners with serious medical conditions.] Schedule 4 reproduces an earlier administrative instrument, namely *Circulaire DGS/SD6A/2005/443 du 30 septembre 2005 relative aux avis médicaux concernant les étrangers atteints par le VIH* [Circular DGS/SD6A/2005/443 of 30 September 2005 on medical opinions concerning foreigners with HIV.]

[5] Conseil d'État, 7 April 2010, No. 301640 and No. 316625.

[6] *N. v. United Kingdom*, 27 May 2008, No. 26565/05.

In Brief

UN passes historic resolution to protect LGBT rights

A resolution aimed at protecting the rights of people on the basis of sexual orientation and gender identity was passed by the United Nations Human Rights Council (HRC) in June 2011.

Among other things, the resolution instructs the High Commissioner for Human Rights to commission a study that documents discriminatory laws and acts of violence around the world against people based on sexual orientation and gender identity. The HRC will also convene a panel to analyze the information obtained in the High Commissioner's study and discuss appropriate follow-up measures.[1]

The resolution is noteworthy, given that homosexuality is criminalized in 76 countries worldwide, 5 of which can impose the death penalty.[2] It explicitly calls for an end to violence and rights violations based on sexual orientation and gender identity, directly challenging these countries' laws.

The final vote on the resolution was 23 to 19, an indication that there is still significant opposition to recognizing the rights of lesbian, gay, bisexual and transgender (LGBT) people among members of the international community and specifically, among members of the HRC.

— Eli Arkin

United Kingdom: government compensates prisoners and former inmates for poor treatment

The Ministry of Justice and the National Health Service settled a lawsuit brought forth by 499 prisoners and ex-prisoners who claimed they did not receive acceptable standards of treatment for their drug addictions while in prison between 2004 and 2009.

Although the government did not accept liability, it agreed to pay compensation of over one million pounds (CAN$1.57 million). In addition, the government will pay £960,000 to the prisoners' lawyers.[3]

The plaintiffs decided to take legal action on the grounds that the prison service had been clinically negligent towards them. They argued that their rights had been breached under the *Human Rights Act* and under Article 3 of the *European Convention on Human Rights*, which prohibits inhumane or degrading treatment.[4]

A similar settlement was reached in 2006, when 200 prisoners and ex-prisoners sued the government for being subjected to a rapid detoxification regime while in prison. That judgment added to this latest decision brings to over £3.5 million (CAN$5.5 million) the total compensation paid out to prisoners by the U.K. government for failing to treat addiction in jail.[5]

— Eli Arkin

Cambodia: harsh new drug law threatens increased human rights violations

In July 2011, Cambodia's Prime Minister Hun Sen approved a controversial draft drug law that activists fear could entrench and worsen the country's already draconian approach to drug treatment.

While the latest text of the law was not available at time of writing, a draft version circulated in 2010 carried several troubling provisions, including the freedom for authorities to force a person into involuntary drug treatment for up to two years. Furthermore, the draft law contained an overly broad definition of a person who uses drugs as any person who "consumes drugs and is under the influence of drugs."[6]

Although United Nations agencies offered constructive input, the law's drafting process was described as "opaque"[7] and it remains unclear whether any of the recommendations were adopted.

The abuse of people who use drugs in Cambodia's drug treatment centres is already well documented. The signing of the new law comes days after the UN Committee on the Rights of the Child expressed its deep concern about torture and ill-treatment experienced by children and teenagers in drug rehabilitation and youth centres.[8] In 2010, Human Rights Watch (HRW) released *Skin on the Cable*, a report documenting the shocking abuses of people who use drugs in Cambodia, including

beatings, rapes and forced donations of blood.

Commenting on the new law, Joe Amon, director of the health and human rights division at HRW, said that Cambodia can either "recognize that this is the wrong approach, or they can blindly continue pursuing policies that don't work and put them in violation of their human rights obligations."[9]

— *Vajdon Sohaili*

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[1] UN Human Rights Council, *Human rights, sexual orientation and gender identity,* 17th session, Agenda item 8, A/HRC/17/L.9/Rev. 1, 15 June 2011. On-line: www.un.org/Docs/journal/asp/ws.asp?m=A/HRC/17/L.9/Rev.1.

[2] Human Rights First, "Good Vibes from South Africa: Foreign Policy Breakthrough, Michelle Obama's Visit," 21 June 2011.

[3] C. Dyer, "Poor treatment of drug addicts in prison costs UK more than £3.5m in compensation and fees," British Medical Journal (13 July 2011): 343: d4438.

[4] Ibid.

[5] Ibid.

[6] "PM approves drug law," *Phnom Penh Post*, 11 July 2011.

[7] Ibid.

[8] UN Committee on the Rights of the Child, 57th Session (30 May – 17 June 2011), "Concluding Observations: Cambodia." On-line: http://www2.ohchr.org/english/bodies/crc/crcs57.htm.

[9] "Cambodia Prime Minister Signs Controversial Drug Control Law Likely to Lead to Abuse," Stop Torture in Health Care, 11 July 2011. On-line: www.stoptortureinhealthcare.org.

HIV/AIDS IN THE COURTS — CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Sandra Ka Hon Chu (schu@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Unless otherwise indicated, all articles in this section were written by Ms. Chu.

Federal Court rules that persons in Canada contrary to immigration laws have no right to health coverage

The Federal Court dismissed an appeal by a Grenadian national without legal status in Canada who had sought to receive health coverage under the *Canadian Charter of Rights and Freedoms* (*Charter*).[1]

Nell Toussaint entered Canada legally as a visitor in 1999, but overstayed her temporary resident visa. Because she did not have legal status in Canada, she was not entitled to coverage under provincial health insurance.

In September 2008, Toussaint applied to Citizenship and Immigration Canada (CIC) for per-

manent residence status. Several months later, she applied to CIC for a temporary residence permit so she could become eligible for provincial health coverage. In both applications, she requested a waiver of the fees, which was refused. Because the fees remained unpaid, the applications were never considered.

In May 2009, Toussaint applied to CIC for medical coverage under its Interim Federal Health Program (IFHP), which is administered by CIC as a measure to provide emergency and essential health-care coverage to eligible individuals who do not qualify for private or public provincial coverage and who demonstrate need. In particular, the IFHP sought to serve four groups of recipients: refugee claimants, resettled refugees, persons detained under the *Immigration and Refugee Protection Act* and victims of trafficking. Because she did not fall within any of those categories, a CIC director found Toussaint ineligible to receive medical coverage under the IFHP and rejected her application.

Toussaint argued that the conditions for IFHP eligibility, established by a federal Order in Council, violated her Section 7 rights to life and security of the person and her Section 15 right to equality under the *Charter*. Her case was unsuccessful before the Federal Court, which dismissed the application for judicial review.[2]

The Federal Court of Appeal agreed with the CIC director's interpretation of the Order in Council, which "could not have been intended to pay the medical expenses of those who arrive as visitors but remain illegally in Canada …. Coverage for those persons would be against the whole tenor of the Order in Council, the history of the Order in Council, and the Minister's stated rationale."[3]

With respect to the constitutional arguments, the Federal Court of Appeal found that Toussaint was exposed to a significant risk to her life and health, a risk significant enough to trigger a violation of her rights to life and security of the person. However, it held that Toussaint failed to show that the conditions for eligibility under the IFHP were the "operative cause" of any injury she had sustained to those rights.

The Court noted that the provision of public health-care coverage and the regulation of access to it are primarily a provincial responsibility. If there was an operative cause of injury to Toussaint's life and security of the person, it was because provincial law did not sufficiently provide the medical treatment she required. Toussaint had not, however, challenged the constitutionality of provincial laws limiting her access to health care.

As the Court held,

> Further, and more fundamentally, the appellant by her own conduct — not the federal government by its Order in Council — has endangered her life and health. The appellant entered Canada as a visitor. She remained in Canada for many years, illegally. Had she acted legally and obtained legal immigration status in Canada, she would have been entitled to coverage under the Ontario Health Insurance Plan.[4]

With respect to Toussaint's Section 15 argument, the Federal Court of Appeal held that there was no violation of her right to equality because "immigration status" did not qualify for protection under Section 15 of the *Charter*. In particular, the court held that "immigration status" was "not a '[characteristic] that we cannot change.' It is not 'immutable or changeable only at unacceptable cost to personal identity.'"[5] Even had Toussaint prevailed on this point, the court held that the Order in Council did not discriminate against her by perpetuating or promoting prejudice or stereotyping, nor was it the operative cause of the disadvantage Toussaint encountered.

Finally, the Court noted that

> [i]n any analysis of justification [of a *Charter* violation] in this case, the interests of the state in defending its immigration laws would deserve weight. If the appellant were to prevail in this case and receive medical coverage under the Order in Council without complying with Canada's immigration laws, others could be expected to come to Canada and do the same. Soon, as the Federal Court warned, Canada could become a health care safe haven, its immigration laws undermined …. In the end, the Order in Council — originally envisaged as a humanitarian program to assist a limited class of persons falling within its terms — might have to be scrapped.

Toussaint's appeal was accordingly dismissed.

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[1] *Toussaint v. Canada (Minister of Citizenship and Immigration)* 2011 FCA 213 (Federal Court of Appeal).

[2] *Toussaint v. Canada (Attorney General)*, 2010 FC 810 (main decision) and *Toussaint v. Canada (Attorney General)*, 2010 FC 926 (decision on motion for reconsideration).

[3] *Supra*, note 1 at para. 40.

[4] Ibid. at para. 72.

[5] Ibid. at para. 99.

No tort for invasion of privacy, holds Ontario court

On 23 March 2011, the Ontario Superior Court of Justice held that there is no tort for invasion of privacy in the common law.[1]

The plaintiff, Sandra Jones, and the defendant, Winnie Tsige, worked at different branches of the Bank of Montreal ("BMO"), where the plaintiff did all of her personal banking. Over the course of four years and on numerous occasions, Tsige accessed and reviewed Jones's private banking records on her computer screen at work. After BMO discovered Tsige doing this, Tsige acknowledged that she had no legitimate purpose in reviewing those records. As a result, Tsige was disciplined, apologized and agreed not to access Jones's banking records again.

Jones asserted that Tsige committed a tort for invasion of privacy and breached a fiduciary obligation to her. She relied on a series of Ontario trial decisions for the proposition that a free-standing tort of invasion of privacy existed in the province. Jones sought damages and a permanent injunction to restrain any similar further conduct by Tsige. Tsige argued that there was no tort for invasion of privacy, she owed no fiduciary obligation to Jones and that Jones had suffered no damages.

The court acknowledged that most provinces have statutes that govern and regulate privacy issues, some of these creating statutory torts that deal with the protection of privacy. In Ontario, where statutes exist to regulate very specific privacy concerns, the court held that "it cannot be said that there is a legal vacuum that permits wrongs to go unrighted — requiring judicial intervention."[2] Moreover, the court held that there was a specific statute in Ontario available to Jones to initiate a complaint, with eventual recourse to the Federal Court.

The court proceeded to adopt the reasoning of the Ontario Court of Appeal, which provided in *obiter* in a 2005 decision, that there was "no 'free standing' right to dignity or privacy under the Charter or at common law…"[3] The Court ultimately concluded that there was no tort for invasion of privacy in Ontario.

The court further held that the relationship between Jones and Tsige did not fall within any of the traditional relationships in which a fiduciary duty is owed. Moreover, there was no relationship between the parties, let alone a mutual understanding between them that Tsige had relinquished her own interests and agreed to act on behalf of Jones. The Court thus concluded that there was no fiduciary obligation owed by Tsige to Jones.

Commentary

This case has significant implications for people living with HIV (PLHIV), many of whom have their personal health information disclosed without their consent. An individual's HIV status is considered to be one of the most sensitive categories of information and deserving of special protection, in part because PLHIV often suffer discrimination (e.g., the loss of employment, housing, insurance and personal relationships with friends and family) as a result of the unauthorized disclosure of their HIV status.

Statutes in Ontario only cover privacy in very specific situations, and there is no free-standing tort for breach of privacy in existing privacy legislation. While this case involves private banking records, if (as the judge in *Jones v. Tsige* held) there is no common law tort for invasion of privacy, there would be no cause of action when one's HIV status is disclosed without one's consent.

The case is also inconsistent with a 2007 decision of the Ontario Superior Court of Justice involving the involuntary disclosure of a man's HIV status by his aunt to other family members.[4] There, the court recognized that one's HIV-positive health status was information that a reasonable person would consider private, held that there was an actionable breach of privacy available in the common law in Ontario and provided a framework for future breach of privacy cases.

Jones v. Tsige has been appealed. Given the importance of the right to privacy, a number of organizations will be seeking leave to intervene, including the HIV & AIDS Legal Clinic (Ontario) and the Canadian HIV/AIDS Legal Network.

[1] *Jones v. Tsige*, 2011 ONSC 1475 (Ontario Superior Court of Justice).

[2] Ibid., at para. 53.

[3] *Euteneier v. Lee*, (2005) 260 D.L.R. (4th) 145 (Ontario Court of Appeal).

[4] *Caltagirone v. Scozzari-Clouiter*, [2007] O.J. No. 2003 (QL). For a discussion of the case, see R. Lang, "Case of disclosure of HIV status helps to clarify privacy law in Ontario," *HIV/AIDS Policy & Law Review* 13(1), July 2008, p. 48.

Ontario courts reaffirm right to marijuana for therapeutic purposes

In a judgment dated 11 April 2011,[1] the Ontario Superior Court declared that the *Medical Marijuana Access Regulations* (MMAR), and Sections 4 and 7 of the *Controlled Drugs and Substances Act* (CDSA), that prohibit the possession and production of cannabis, are unconstitutional because, in practice, they prevent effective access to marijuana for therapeutic purposes, and therefore violate Section 7 of the *Canadian Charter of Rights and Freedoms* (*Charter*).

This is the third case involving Canada's medical marijuana access system to be brought before the province's courts since 2000. The first two were *Parker*[2] and *Hitzig*.[3]

Matthew Mernagh, who suffers from the constant pain of debilitating fibromyalgia, epileptic seizures, severe scoliosis and depression, was charged with the offence of producing marijuana, contrary to Section 7(2)(*b*) of the CDSA.

Now 37, Mernagh began using marijuana in his second year of university, relying on the services of a compassion centre in Toronto.

The MMAR authorizes access to medical marijuana for patients suffering from certain conditions, such as cancer and AIDS, which cause considerable suffering. However, such access is made conditional on a case-by-case basis on the approval of one or two physicians. Patients who obtain these approvals can get a licence to possess or perhaps even produce marijuana based on their medical needs, without fearing prosecution in the criminal courts.

Despite several searches, Mernagh was unable to find a physician who would agree to sign the papers necessary for him to obtain marijuana lawfully. He therefore had no choice but to produce his own marijuana illegally.

Mernagh is not an isolated case. The court considered the affidavit and *viva voce* evidence of 21 Canadians, representing each of Canada's provinces, who suffer daily. Their testimony confirmed the positive impact of marijuana on the lives of the sick by reducing their suffering and enabling them to function on a daily basis much as they did prior to their illnesses. It also confirmed the great difficulty or near impossibility of finding a physician prepared to sign the form that would allow them to obtain marijuana legally.

The court found one statistic particularly striking: in Canada, less than one percent of medical marijuana access applications submitted by applicants who fulfil all the statutory requirements are authorized by a physician.

Canadian physicians have frequently expressed concern about being the gatekeepers in this system. Marijuana is not an approved or tested drug, and many doctors feel they face an ethical dilemma when asked to prescribe a substance labelled as a narcotic, when they can prescribe tested and approved medications instead — albeit ones that do not provide the same benefits as marijuana.

Mernagh argued that the system put in place by the MMAR was ineffective because it prevented him from getting effective access to medical marijuana. He argued that this violated his right to liberty and security of the person, guaranteed by Section 7 of the *Charter*. He noted that, in

Parker and *Hitzig*, the Ontario Court of Appeal had established that, even though physicians were given a fundamental role in the medical marijuana access scheme, access to marijuana by individuals suffering from an illness was a constitutional right under Section 7 of the *Charter*. The Court of Appeal had also held that using the criminal law to prevent suffering individuals from accessing drugs to treat their conditions was antithetical to notions of justice.

The prosecution argued that the MMAR and CDSA were constitutionally valid. It said that the fact that people entitled to access to drugs for therapeutic purposes are deprived of such access results solely from the attitudes of physicians, not from any flaw in the legislation. It also noted the compelling public health and anti-trafficking objectives pursued by the impugned legislation.

In its decision, the Ontario Superior Court began with a reminder that, as the Supreme Court of Canada held in *Morgentaler*,[4] the rights guaranteed by Section 7 of the *Charter* include the right to medical treatment for a condition representing a danger to life and health, without fear of criminal sanction. In the Ontario Superior Court's opinion, the defence in the MMAR for individuals charged with possession or production of marijuana is therefore illusory and contrary to Canadian principles of fundamental justice, because, in reality, the MMAR is inaccessible to the overwhelming majority of those who need it.

The Court undertook a classic analysis of the purpose and effects of the law. It concluded that the purpose of the legislative scheme was valid, and that it was necessary to protect public health and to control drugs by making access to marijuana conditional on compliance with strict rules. However, the effects of the legislative scheme were found invalid, because the end result in practice is to prevent sick people from getting access to marijuana for therapeutic purposes. This is an unjustified violation of Section 7 of the *Charter*, notably because there is no rational connection with the legislative purpose and because the impairment of the right is not minimal.

In response to the prosecution, which attributed the system's failure to physicians, the court emphasized that, if physicians are placed at the heart of a legislative scheme, it is up to Parliament to ensure physician cooperation and education. Thus, the deficiency of the legislative scheme in question is not the physicians' doing; rather, it results from the fact that Parliament has done nothing to ensure their cooperation and their effective participation in the program.

For these reasons, the Ontario Superior Court held that the MMAR, and Sections 4 and 8 of the CDSA, which prohibit the possession and production of marijuana, were constitutionally invalid because they violate the protections afforded by Section7 of the *Charter*. Consequently, Mernagh was acquitted of the criminal charges brought against him.

The prosecution has appealed from the Superior Court's decision. The declaration of invalidity has therefore been stayed until the Ontario Court of Appeal issues its decision.

— Rémi Weiss

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[1] *R v. Mernagh*, [2011] O.J. No. 1669, 2011 ONSC 2121.

[2] *R v. Parker* (2000), 49 OR (3d) 481, 188 DLR (4th) 385 (Court of .Appeal).

[3] *Hitzig v. Canada* (2003), 231 DLR (4th) 104 (Court of Appeal).

[4] *R v. Morgentaler,* [1988] 1 S.C.R. 30.

Ontario court affirms negotiated settlement in class action suit over use of non-sterile equipment at tattoo parlour

In early 2011, the Ontario Superior Court affirmed a negotiated settlement between Peel Region and Peel Public Health and a class of individuals who were exposed to blood-borne infection as a result of the use of non-sterile equipment at Moonshin Tattoo parlour.

The former were alleged to have failed in their common law and statutory duty of care towards the individuals, because they did not conduct yearly inspections of the Moonshin Tattoo parlour between March 2005 and February 2009, thereby exposing those individuals to the risk of contracting hepatitis B and C and HIV.[1]

Peel Public Health is a department of the Regional Municipality of Peel and was responsible for regulating and investigating the activities of the Moonshin Tattoo parlour, pursuant to the *Health Protection and Promotion Act*. In March 2009, Peel Region and Peel Public Health issued a public warning stating that approximately 3000 individuals who received tattoos or piercings at Moonshin Tattoo between March 2005 and February 2009 may have been exposed to blood-borne infection, including hepatitis B and C and HIV, due to the use of non-sterile instruments or equipment.

Ruben Travassos obtained a tattoo at Moonshin Tattoo in March 2007. He commenced a class action on behalf of all persons who received tattoos during the issued warning period and either contracted hepatitis B or C or HIV ("infected persons"), or were exposed to the risk of hepatitis B or C or HIV infection ("uninfected persons"), or were the living family members of infected persons or uninfected persons.

The plaintiffs and Peel Region and Peel Public Health entered into negotiations and successfully reached a settlement. The defendants agreed to establish a fund of $900,000 for uninfected persons, with each individual receiving an equal amount of no more than $225 each, and a fund of $200,000 for infected persons. The parties agreed that living family members of infected or uninfected persons would receive no separate compensation.

The Court confirmed that the application satisfied all the requirements for certification as a class action pursuant to the *Class Proceedings Act, 1992* and also approved the settlement, finding it to be fair, reasonable and in the best interests of the members of the class.

— Shalini Thomas

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[1] *Travassos v. Moonshin Tattoo*, [2011] O.J. No. 1693 (Ontario Superior Court of Justice).

Costs of compassion club marijuana to be covered

In 2010, the Appeals Tribunal of the Workplace Safety and Insurance Board (WSIB) of Ontario held that Gary Simpson's cannabis costs should be reimbursed.[1] Simpson sustained an acute back injury in 2000 while working as a heavy equipment mechanic. In 2003, Health Canada approved his application for medical marijuana.

While marijuana helped reduce Simpson's need for pain medication, the WSIB did not recognize it as medicine, including when Simpson obtained marijuana from the Toronto Compassion Centre. This decision was overturned by the Appeals Tribunal, which ruled that the WSIB should cover the cost of marijuana Simpson obtained from the compassion club.

[1] "Cannabis Costs Reimbursed by Law," *The Compassionate Voice: Newsletter of the BCCS*, April/May/June 2011, p. 3.

Criminal law and HIV non-disclosure

Ontario: dangerous offender status for man convicted of first-degree murder for HIV transmission

On 2 August 2011, the Ontario Superior Court of Justice granted a request by Crown prosecutors to designate Johnson Aziga a dangerous offender because he was considered a high risk to re-offend.[1] As a dangerous offender, Aziga will face an indefinite prison term until he is eligible for a parole review in seven years. He will also be subject to a life-long supervision order if he is ever released.

In 2009, Aziga was convicted by a jury of two counts of first-degree murder, 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault in relation to unprotected sex he had with 11 women without telling them he was HIV-positive. He was the first person in Canada to be charged and convicted of first-degree murder after two of the seven women who subsequently tested positive for HIV died of AIDS-related cancers.

According to Ontario Superior Court Justice Lofchik, without dangerous offender status, Aziga would "represent a gamble on the safety of the women in this community" upon his release.[2] Justice Lofchik further ruled that Aziga demonstrated little remorse for the complainants and their families.

Aziga was also ordered to register with the national sex crimes database, submit to a DNA test, have his laptop removed and be barred from communicating with any of the complainants without their consent.[3] In custody since 2003, Aziga is expected to appeal his murder convictions, for which he already faces an automatic life sentence of 25 years.

Charges of attempted murder dismissed against man accused of HIV non-disclosure

On 13 July 2011, Ontario Court Justice David Wake dismissed four

charges of attempted murder against Steven Paul Boone.[4] In his decision, Justice Wake was reported to say that HIV is no longer an "automatic death sentence" and that dying from HIV is no longer an "inevitable or even a probable consequence" of contracting the virus.[5] Moreover, the judge found that there was insufficient evidence for a reasonable jury, properly instructed, to conclude that Boone had intended to kill the complainants.[6]

The ruling, which followed a preliminary hearing, removes the four most serious charges against Boone, who still faces 21 charges against him, including aggravated sexual assault, attempted aggravated sexual assault, sexual assault, administering a noxious substance and attempting to administer a noxious substance. An aggravated sexual assault charge against one of the complainants was discharged at the request of the Crown.

Boone was first charged in May 2011 when a man contracted HIV after the two had unprotected sex; more men subsequently came forward alleging sexual contact with Boone. He has remained in custody since his arrest. A trial on the outstanding charges has yet to be scheduled.

B.C. Court of Appeal dismisses Mzite's appeal

On 10 June 2011, the British Columbia Court of Appeal dismissed Charles Mzite's appeal of his convictions on four counts of aggravated sexual assault.[7] The B.C. Supreme Court had convicted Mzite in March 2009 after it found he had unprotected sex with four complainants without disclosing his HIV-positive status to them.[8]

Mzite advanced two grounds of appeal. First, he argued that the trial judge erred by admitting as evidence his statements to the police while in custody, thus breaching his Section 10(b) right pursuant to the *Canadian Charter of Rights and Freedoms* (*Charter*) to consult counsel of his choice.[9] Second, Mzite contended that the convictions were unreasonable and unsupported by the evidence, the central factual issue being whether he knew he was HIV-positive at the time he had unprotected sex with the complainants.

In September 2007, Mzite was arrested and detained in Vancouver, at which time he requested to speak with a particular lawyer whose name and contact information he could not recall. Mzite eventually spoke to a legal aid lawyer. When he was transferred to Victoria, he spoke to another legal aid lawyer.

The trial judge found that Mzite was not denied a reasonable opportunity to retain and instruct counsel of his choice, and the advice he received from the legal aid lawyers was consistent with Section 10(b) of the *Charter* and what he needed to know during the subsequent police interrogation. The trial judge consequently held that Mzite had failed to establish on a balance of probabilities a breach of his *Charter* rights and admitted the evidence.

Mzite argued that he had the right to consult with counsel of his choice, that he made clear to the police his wish to do so and that the police failed in their duty to implement or facilitate that right. Therefore, his statements to the police should have been excluded. The Court of Appeal found the trial judge's conclusions were well-founded and entitled to deference. Moreover, the Court found that, by speaking to two different legal aid lawyers and by failing to complain on either occasion about advice received, Mzite's *Charter* right to counsel was met. That ground of appeal was thus dismissed.

With respect to the second ground of appeal, the critical issue was whether Mzite knew he was HIV-positive at the time he had sex with the complainants, in the face of conflicting evidence.

In 2001, Mzite tested positive for HIV at a clinic in Victoria, but the clinic had no record that he ever attended to be informed of the results of that test. Mzite submitted that he did not know that he was HIV-positive until November 2004 when one of the complainants told him that she had tested positive for the virus, after which Mzite went for a further test, which was also positive.

In July 2006, the same complainant testified that she had a conversation with Mzite in which he told her that he had known of his HIV-positive status since 1995, and apologized for lying to her and for infecting her. While Mzite did not dispute this admission, he testified that he had lied to the complainant about when he first learned of his HIV status because he thought that this admission would end the discussion and she threatened to go to the police otherwise.

Among the other evidence the trial judge considered was the expert opinion evidence concerning the likely duration of Mzite's HIV-positive status. According to one doctor, based on blood test results in February 2005, Mzite had been HIV-positive

for between five to seven years and could have been HIV-positive as far back as 1995. After a review of all the evidence, the trial judge found that the Crown had proven beyond a reasonable doubt that Mzite knew he was HIV- positive at the time he had unprotected sex with each of the four complainants.

The Court of Appeal found that the evidence amply supported the trial judge's finding that Mzite knew he was HIV-positive at the time he had sex with the complainants. Although there was conflicting evidence, there was a substantial body of evidence that supported the trial judge's finding. Therefore, the Court of Appeal dismissed Mzite's appeal.

Court of Québec sentences HIV-positive man to prison

On 17 March 2011, the Court of Quebec convicted Michel Lavoie of one count of aggravated sexual assault for exposing his spouse to HIV and transmitting the virus to her.[10] In addition, the judge found that the elements of two other charges brought against Lavoie — namely, aggravated assault and criminal negligence causing bodily harm — had been proven. However, to avoid multiple convictions based on the same facts, the judge ordered a conditional stay of proceedings on those charges.

Lavoie found out that he was HIV-positive in 1997 after a test. In April 2003, he started dating the complainant and engaging in sexual relations with her. By May, the complainant was experiencing various health problems and wound up in hospital, where she tested positive for HIV.

Lavoie testified that he disclosed his HIV-positive status to the complainant prior to their first sexual encounter, and that condoms were used. However, the complainant testified that he had hid his status from her, and that they had unprotected sex several times. She said she only learned Lavoie was HIV-positive when she received her own diagnosis and her physician asked Lavoie to undergo a test that proved positive. The complainant and Lavoie remained together until October 2005, when she left him after suffering several instances of marital violence.

The judge found that Lavoie's testimony did not cast doubt on the complainant's testimony, and he sentenced Lavoie to imprisonment for a term of six years and seven months.[11]

Commentary

Several important factors were not addressed in this decision that raise various concerns. Firstly, the transmission of HIV from Lavoie to the complainant was accepted as a given by all parties, even though no evidence to that effect was submitted. While it is plausible that the complainant contracted HIV from Lavoie, it is troubling that this element was taken for granted in a criminal prosecution, especially since transmission was considered an aggravating factor in the sentencing.[12]

Secondly, Lavoie was convicted for sexual contact that took place after the complainant became HIV-positive and knew of Lavoie's status — a point that was not raised by the defence or by the judge. Indeed, the complainant learned of her own HIV-positive status in May 2003 and learned of Lavoie's status in June of that year; however, the majority of the charges pertained to sexual relations between June 2003 and the end of the couple's relationship. Yet, the law is clear: there can only be conviction where an accused has failed to disclose his status to his partner.

This decision also raises concerns about the limited knowledge of HIV and surrounding issues on the part of individuals who decide the fates of people charged. The judge in this case stated several times that Lavoie denied his illness, refused to get treatment and thought he could emerge from his illness on his own. He condemned Lavoie's inability to come to terms with his disease, even suggesting that Lavoie had an obligation to get treatment: "By continuously denying his illness — that is, HIV — and by dealing with himself and with others as though he did not have the illness, he lied to everyone, including himself, hence his gross negligence as far as obtaining the ongoing medical supervision he was recommended, and such treatments as were needed."[13]

Lastly, in passing sentence, the judge again referred to Lavoie's denial of his illness, holding that it was an aggravating factor.

— Stéphanie Claivaz-Loranger

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Federal Court upholds removal order of woman convicted of HIV non-disclosure

Suwalee Iamkhong, a landed immigrant from Thailand, had been convicted in 2007 of aggravated assault and criminal negligence causing bodily harm for knowingly infecting her husband of HIV through unprotected sex.[14] She was sentenced to three years' imprisonment, which subjected her to potential removal from Canada for "serious criminality."

As a result of Iamkhong's conviction, an inadmissibility report was issued against her, rendering Iamkhong liable for removal from Canada. This was subsequently confirmed by the Immigration Appeal Division (IAD) of the Immigration and Refugee Board. In its view, while Iamkhong was not a "hardened criminal," her convictions satisfied the test for removal under the *Immigration and Refugee Protection Act*, and the seriousness of her criminal actions was such "as to establish an extremely high bar to her remaining in Canada."[15] The IAD consequently made a removal order against her.

Iamkhong appealed her criminal conviction and sentence, and in June 2009 the Ontario Court of Appeal confirmed the conviction but reversed the sentenced to two years less one day. The reduction in her sentence enabled Iamkhong to seek judicial review of the IAD's decision, for which leave was granted in December 2010.

In March 2011, the Federal Court issued its judgment.[16] In reviewing the IAD's decision, the court found that its reasons were "detailed and provide for a reasonable assessment of the evidence that was before the IAD."[17] It held that it was not open for the court to re-weigh the evidence or otherwise substitute itself for the decision-maker, but to determine whether the IAD's decision was reasonable, which it found it was. Therefore, it dismissed Iamkhong's application.

HIV-positive Ontario woman sentenced to prison for aggravated assault

The Ontario Court of Justice sentenced June Tippeneskum to three-and-a-half years' imprisonment for aggravated assault pleading guilty for failing to disclose her HIV-positive status to her former partner, who contracted the virus as a result.[18]

Tippeneskum, a 23-year-old Aboriginal woman, was aware of her HIV-positive status when she was in a domestic sexual relationship with the complainant, Bruce Koostachin, for several years. During this time, she did not disclose her medical condition to him, and the complainant only became aware that he had contracted HIV from her after their relationship had ended.

Tippeneskum, a member of the Attawapiskat First Nation, had been exposed to violence, abuse and neglect since the age of five, when she first became involved with child protection services. By the time she was 13, she was using drugs and alcohol, had been expelled from school, and had her first encounter with the criminal justice system. Since then, her criminal record included crimes of violence, property offences and offences against the administration of justice. Tippeneskum had two young children who were in the care of her extended family.

In determining the appropriate sentence, the court turned to Section 718 of the *Criminal Code*, which sets out the purposes and principles of sentencing.[19] These include deterrence, rehabilitation and the provision of reparation for harm done to victims. Section 718.1 also requires sentences to be proportionate to the gravity of the offence and to the degree of responsibility of the offender. In *R v. Gladue*,[20] the Supreme Court of Canada stated that section 718.2 reaffirmed that, in cases dealing with Aboriginal offenders, courts must consider any aggravating and mitigating circumstances, including systemic and background factors that may have played a part in bringing the individual before the court, prior to sentencing.

Tippeneskum entered guilty pleas for the following charges: aggravated assault, breach of probation, theft of property and failure to attend court. She also expressed remorse for her conduct.

As per Justice Cory in *R v. Cuerrier,* deterrence and denunciation are the primary sentencing objectives to be achieved in cases of aggravated assault of this nature.[21] The Ontario court considered the evidence and took into account Tippeneskum's relative youth, the systemic factors that contributed to her crime and the sentencing objective of rehabilitation. It also recognized that the complainant's life had been "irrevocably altered" and the need for a sentence that would deter Tippeneskum and others from similar conduct.

Tippeneskum was therefore sentenced to prison for the charge

of aggravated assault. The court credited her five months of pre-sentence custody. Tippeneskum was also ordered to provide a DNA sample, as aggravated assault is a primary designated offence. Pursuant to the *DNA Identification Act*, courts have the authority to order samples from offenders of primary and secondary designated offences, which would then be stored in a national databank for use in investigating unsolved crimes.[22]

— Shalini Thomas

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Ontario Court sentences man to prison for failing to disclose HIV-positive status to two complainants

In July 2010, Lester Felix was convicted of five counts of aggravated sexual assault and one count of sexual assault for failing to disclose his HIV-positive status to complainants N.S. and M.F. before having sex with them.[23] On 1 December 2010, the Ontario Court of Justice sentenced him to five years' imprisonment for those convictions.[24]

Felix had been in custody since his arrest in August 2009, and counsel for both the Crown and defence agreed that he should be given the benefit of his pre-trial custody on a two-for-one basis. As a result, Felix was given 30 months of pre-trial custody credit.

The Crown argued that Felix should be incarcerated for a further four years, which would be the equivalent of a six-and-a-half year global sentence. Defence counsel for Felix submitted that he should be incarcerated for a further two years less one day, giving him a global sentence of four-and-a-half years.

According to Justice Wright, "where an offender knowing he is HIV-positive fails to disclose this fact to his sexual partners, denunciation and deterrence must be the primary objectives for the sentencing judge."[25] The judge also considered the fact that both complainants had to endure the humiliation of testifying in a public courtroom about events that had a devastating effect on their lives.

In making her decision, Justice Wright considered the range of sentences from one to 11 years in cases involving HIV non-disclosure. Among the aggravating circumstances were the facts that Felix had a criminal record, was conscious of the probable consequences of his actions and was fully aware of his obligation to disclose his HIV-positive status to all sexual partners, as well as the impact his failure to disclose had on the complainants, who were "uniquely vulnerable" women.[26] Among the mitigating circumstances were the facts that neither complainant had contracted HIV; Felix was relatively young with future plans and a supportive and loving family with whom he had remained close, which increased his chances of rehabilitation; and with respect to one complainant, there was only one incident of sexual activity.

Taking all this into consideration, Justice Wright sentenced Felix to a global sentence of five years. His pre-trial credit of two-and-a-half years meant he had a further two-and-a-half years left to serve. In addition, Felix was ordered to provide a sample of his DNA and was prohibited from having possession of any firearms, weapons or ammunition.

HIV-positive man pleads guilty to sexual assault for unprotected sex without disclosure

In May 2011, Varney Kawah pleaded guilty to sexual assault for having unprotected sex with a woman without disclosing his HIV-positive status to her.[27]

Kawah, who came to Canada from the United States of America in June 2009, had sex with the woman approximately 40 to 50 times for a period of over one year, and did not always use a condom. He did not disclose his HIV-positive status to her at any time.

According to the prosecutor, the woman learned of Kawah's HIV status in January 2011 after opening a letter addressed to him from the University of Ottawa Medical Associates requesting money for counselling people living with HIV. The woman has since been tested for HIV and has not contracted the virus.

Kawah, who was charged with aggravated sexual assault, pleaded guilty to the lesser charge of sexual assault. Originally from Liberia, Kawah had made an unsuccessful refugee claim in Canada in 2009. Kawah's guilty plea was stayed and he was deported to Liberia in June 2011.[28]

Calgary man pleads guilty to sexual assault for HIV non-disclosure

In a Red Deer, Alberta court, Paul Thomson pleaded guilty to sexual assault in June 2011 for failing to disclose his HIV-positive status to his partner, a 25-year-old woman.[29] Thomson originally faced 11 counts of sexual assault against the complainant, who did not contract the virus.[30]

In custody since July 2009, Thomson was sentenced to 46 months' imprisonment, which he had already served because he was given two-for-one credit for the time already spent incarcerated. However, Thomson was ordered to attend a psychiatric hospital in Ponoka, Alberta, under a public health order. Thomson was also ordered to provide a DNA sample as part of his plea and to register with the national sex offender registry.

Ontario man given probation for failing to disclose HIV-positive status before unprotected sex

In May 2011, Colin Ubdegrove pleaded guilty to assault for having unprotected sex with a woman without disclosing his HIV-positive status to her.[31] The complainant did not contract the virus. On a joint recommendation from Crown and defence counsel, Ubdegrove was placed on probation for 26 months. As a condition of his probation, Justice Belch ordered that Ubdegrove disclose his HIV status to all of his sexual partners.

While Ubdegrove contended that he did disclose his HIV status to the complainant, his counsel told the judge that Ubdegrove was "willing to concede that [the complainant] believes otherwise and considers her consent vitiated."[32]

According to Crown counsel, Ubdegrove had sex with the complainant approximately 15 times, and on three of those occasions a condom was not worn. The complainant allegedly told police that the relationship ended after she discovered Ubdegrove's HIV medication in a cupboard.

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[1] "HIV killer ruled dangerous offender," CBC News, 2 August 2011.

[2] L. Nguyen, "HIV-killer declared a dangerous offender," Postmedia News, 2 August 2011.

[3] Ibid.

[4] A. Humphreys, "HIV infection not a death sentence: judge; Dismisses charges; Man accused of knowingly spreading disease," *The National Post*, 15 July 2011, p. A5.

[5] Ibid. At the time of writing, the decision had yet to be reported.

[6] A. Seymour, "Judge in attempted murder case finds HIV no longer automatic death sentence, *Ottawa Citizen*, 13 July 2011.

[7] *R. v. Mzite*, 2011 BCCA 267 (British Columbia Court of Appeal).

[8] *R. v. Mzite*, Victoria Docket No. 140259-2, 2 March 2009 (Supreme Court of British Columbia).

[9] *Canadian Charter of Rights and Freedoms*, 1982, R.S.C. 1985, App. II, No. 44, Schedule B, Section 10(b): "Everyone has the right on arrest or detention to retain and instruct counsel without delay and to be informed of that right."

[10] *R c. Lavoie,* 400-01-051831-089, unreported, 17 March 2011, Justice Poudrier (Court of Quebec).

[11] Sentencing judgment of Justice Poudrier, 7 April 2011, audio CD (unpublished).

[12] Ibid.

[13] *R. c. Lavoie, supra*. Legal Network translation.

[14] For a discussion of the case, see S. Chu, "Two years imprisonment for woman who 'ought to have known' that she was HIV-positive," *HIV/AIDS Policy & Law Review* 12(2/3), December 2007, p. 45.

[15] *Suwalee Iamkhong v. the Minister of Public Safety and Emergency Preparedness* (31 May 2010), IAD File No. TA9-13213 (Immigration and Refugee Board) at paras. 14 and 20.

[16] *Suwalee Iamkhong v. the Minister of Citizenship and Immigration and the Minister of Public Safety and Emergency Preparedness*, 2011 FCC 355 (Federal Court).

[17] Ibid. at para. 72.

[18] *R. v. Tippeneskum*, [2011] O.J. No. 1925.

[19] R.S.C. 1985, c. C-46, s. 718.

[20] [1999] 1 S.C.R. 688.

[21] [1998] 2 S.C.R. 371 at para 142.

[22] S.C. 1998, c.37.

[23] *R. v. Felix*, 2010 ONCJ 322 (Ontario Court of Justice). For a discussion of the case, see S. Chu, "Ontario Court convicts man of aggravated sexual assault and sexual assault based on his unreliable evidence," *HIV/AIDS Policy & Law Review* 15(1), October 2010, pp. 24–25.

[24] *R. v. Felix*, 2010 ONCJ 654 (Ontario Court of Justice).

[25] Ibid., at para. 13.

[26] Ibid., at para. 24.

[27] A. Seymour, "HIV-positive man admits to sex assault; Failed refugee claimant lied to partner," *Ottawa Citizen*, 18 May 2011, p. C1.

[28] M. Pearson, "Man deported after pleading guilty to sex assault; Refugee claimant failed to reveal HIV status to partner," *Ottawa Citizen*, 17 June 2011.

[29] St. Massinon, "HIV-positive Calgary man sent to hospital under isolation order; Pleads guilty to sexual assault for not telling partner his status," *Calgary Herald*, 22 June 2011.

[30] J. Wilson, "Rare public health act isolation order for HIV-positive man," *Red Deer Advocate*, 21 June 2011.

[31] S. Yanagisawa, "Man pleads guilty; COURT: HIV patient had unprotected sex with woman," *Kingston Whig-Standard*, 21 May 2011, p. 2.

[32] Ibid.

HIV/AIDS IN THE COURTS — INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the *Review*. Coverage of U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Mikhail Golichenko (mgolichenko@aidslaw.ca), senior policy analyst at the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, the articles in this section were written by Mr. Golichenko.

Russia: European Court of Human Rights rules HIV-positive foreign national suffered discrimination

On 10 March 2011, the European Court of Human Rights (ECHR) held that refusing a residence permit to a foreign national solely on the basis of his HIV-positive status amounted to unlawful discrimination.[1] This case is a significant boost to the rights of persons living with HIV/AIDS (PLHIV) in Europe and beyond.

Viktor Kiyutin, a national of Uzbekistan, had married a Russian national with whom he had a child in 2004. In 2002 and 2003, his own mother and brother emigrated from Uzbekistan to Russia. In 2003, Kiuytin applied for a Russian residence permit, which was subsequently refused due to the fact that he had tested positive following a mandatory HIV test. A Russian district court upheld this decision; however,

Kiyutin remained in Russia with his wife and child.

In 2009, Kiyutin filed a new application, which the Russian Federal Migration Service (FMS) rejected because, pursuant to the *Foreign Nationals Act*, an alien unable to demonstrate an HIV-negative status cannot be granted a Russian residence permit. The FMS also determined that Kiyutin was in Russia illegally and fined him. Russian district and appeal courts continued to uphold the FMS decision. His health having deteriorated, Kiyutin petitioned the ECHR.

The court examined the case from the standpoint of both Article 8 (right to privacy) and Article 14 (right to equal protection of the law) of the *European Convention on Human Rights*, which prohibits discrimination based on several characteristics, such as religion or gender. Article 14 also prohibits discrimination based on any "other status," and the ECHR adopted the view that these words covered health-related impairments such as an individual's HIV-positive status.

The court also noted that PLHIV are a vulnerable group that has been heavily discriminated against and stigmatized since the onset of the epidemic. Therefore, it ruled that a state has only a narrow margin of movement when enacting measures that single out this group. The ECHR went on to say that there is no consensus among Members States of the Council of Europe regarding the exclusion of HIV-positive immigrants, and that restriction to immigration for HIV-positive individuals based on their health status was now limited.[2]

In 2006, the Russian Constitutional Court issued a decision that found the *Foreign Nationals Act* constitutional, as it pursued a valid state interest: the protection of public health. Nevertheless, the ECHR found that the means employed by Russia in pursuing that interest were clearly disproportionate and, in relying on the existing consensus among experts, clearly stated that "[t]he mere presence of an HIV-positive individual in a country is not in itself a threat to public health."[3]

Russia currently has laws that make it a criminal offence to transmit HIV. Yet, the court wondered, if Russia were really concerned about fighting the spread of HIV at its borders, why were nationals not required to test for HIV when they come back to Russia and why were short-term visitors not required to test for HIV when applying for a visa? It therefore found the Russian law clearly discriminatory toward HIV-positive aliens seeking to settle down permanently in the country and that such legislation was grossly disproportionate.

Commentary

It is interesting to note that the ECHR found that legislation excluding HIV-positive immigrants, such as the one in Russia, was ineffective and might be counter-productive in the fight against the spread of the disease. For one, such laws might encourage foreign nationals to remain illegally in a country without undergoing an HIV test. As a result, their health status would remain unknown to authorities and, worse, prevent them from adopting safe preventative behaviour. Second, this kind of legislation might create a false sense of security for the general public and propagate stereotypes, such as migrants being vectors of diseases. The public might then believe that excluding HIV-positive individuals is enough to fight the epidemic.

The ECHR ruling in *Kiyutin v. Russia* is tempered by two points that the court made. Firstly, the court stressed that international law does not grant an individual a right to enter or settle in a foreign country, and that travel restrictions might be legitimate if applied in a neutral fashion, even towards HIV-positive individuals. Secondly, the Court considered that differential treatment of HIV-positive individuals might be objectively justified by the risk that a long-term settler could become a public burden and place an excessive demand on a publicly funded health-care system. (This is not the case in Russia, where foreign nationals are not entitled to free medical assistance, except for emergency treatment.)

Be that as it may, the ECHR is the first regional court to decide a case regarding immigration law and policies forbidding entry in a country for HIV-positive individuals. The precedent it sets is therefore likely to have a broad reach and not only have an impact on States that are not members of the Council of Europe, but also in areas other than immigration such as employment or access to health care.

— Rémi Weiss

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[1] *Kiyutin v. Russia,* 10 March 2011, Application no. 2700/10. On-line: http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=882651&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649.

[2] Out of the 47 Member States, and at the time of the decision, only 6 required an individual applying for a residence permit to submit negative HIV test results, one State required a declaration to that effect and only three States had provisions for the deportations of foreign nationals found to be HIV-positive.

[3] *Kiyutin v. Russia, supra,* at nº 68.

U.S. government's "anti-prostitution" pledge deemed unconstitutional

In July 2011, the United States Court of Appeals for the Second Circuit upheld a lower court decision stating that a provision in the *United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Leadership Act) was unconstitutional.

The provision, known as the "anti-prostitution" pledge, prevented funding from going to organizations that did not explicitly oppose prostitution or sex trafficking in a statement or as organizational policy. It also prohibited funding to organizations that advocated for the decriminalization of sex work. It further required organizations to maintain the pledge even when working with privately donated funds, including from governments and organizations other than the United States Agency for International Development (USAID).[1]

The non-governmental organizations (NGOs) Alliance for Open Society International, Pathfinder International, Global Health Council, and InterAction launched the case against USAID, the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention. The plaintiffs work in developing countries to improve global health, including efforts to halt the spread of HIV.

The NGOs contended that the anti-prostitution pledge violated the First Amendment of the U.S. Constitution — which enshrines the right to free speech — by forcing organizations to adopt the government stance regarding sex work in order to obtain funding.[2] They argued that their programs would suffer "imminent harm as a result of the policy requirement."[3]

A key component of the NGOs' work is to support public outreach to sex workers to provide education, care, treatment and access to services to those who are vulnerable to HIV. The NGOs argued that the pledge further stigmatized sex workers.

A majority decision agreed with the plaintiffs that, not only did the anti-prostitution pledge require organizations to refrain from certain conduct, it also required them to espouse the government's viewpoint.[4] Justice Straub, in dissent, stated that the policy requirement is constitutional because the Leadership Act gives the government the right to subsidize and advance the message of its preferred methods to combat HIV and is therefore not necessarily open for public debate.[5] Justice Straub also called on the Supreme Court to take up the case because he felt that the majority had further complicated matters instead of clarifying them.[6]

"The U.S. government's 'anti-prostitution' pledge undermines its global efforts against HIV/AIDS," said Rebecca Schleifer of Human Rights Watch following the ruling. "It also violates freedom of speech for anti-AIDS groups and undermines the fundamental right of sex workers to get lifesaving information about HIV/AIDS."[7]

Although U.S.-based organizations are now no longer bound by the anti-prostitution pledge, organizations based outside the country are not protected under the First Amendment and therefore must continue to comply with the policy in order to receive funding.

The pledge originally applied to organizations based outside the U.S.; however, a directive by USAID in 2005 made it applicable to U.S.-based organizations as well.[8] The policy falls under the auspices of the President's Emergency Plan for AIDS Relief (PEPFAR), which provides funding to worldwide organizations and governments fighting HIV.

— Eli Arkin

Eli Arkin (earkin@aidslaw.ca) is a research and program support officer at the Canadian HIV/AIDS Legal Network.

[1] Pathfinder International, "Victory for Free Speech and Public Health," news release, Washington, DC, July 6, 2011.

[2] Pathfinder International, *The Anti-Prostitution Loyalty Oath: Undermining HIV and AIDS Prevention and US Foreign Policy*, March 2006.

[3] *Alliance for Open Society International v. U.S. Agency for International Development*, United States Court of Appeals, 2nd Circuit, No. 08-4917-cv, 6 July 2011.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] "Court Over-rules Anti-Prostitution Gag Rule for US Groups," AlertNet, 8 July 2011.

[8] International Women's Health Coalition, "The New Litmus Test: Limiting free speech, compromising sound practices." On-line: www.iwhc.org/index.php?option=com_content&task=view&id=319&Itemid=800.

Russia: district court upholds legal ban on opioid substitution treatment

On 27 May 2011, the Leninsky district court of Kaliningrad Region upheld the refusal of the Ministry of Health of Kaliningrad Region to ensure access to opioid substitution therapy (OST) as an effective treatment for opioid dependence and an effective intervention for HIV prevention among people who inject drugs.

The complaint had been filed on 27 April by Irina Teplinskaya. As a result of unsafe injecting drug use, she contracted HIV and hepatitis C. Teplinksaya was imprisoned on five separate occasions for drug-related offences and, in total, has spent 16 years in Russian prisons. While serving her last sentence, from 2005 to 2009, Teplinskaya acquired tuberculosis and her HIV condition degraded to AIDS.

For three decades, Teplinskaya has been unable to cope without illicit opioids. She stated that the psychological consequence of withdrawal from them was a constant fear and that, if OST with the use of methadone or buprenorphine were available and accessible, she could cease her use of illicit opioids and lead a stable life.

Her complaint, prepared with the assistance of the Canadian HIV/AIDS Legal Network, argued that, by refusing access to effective treatment of drug dependence, the Russian ministry of health violates her right to health, to freedom from inhuman and degrading treatment, to private life and to freedom from discrimination. These rights are protected by the Constitution of the Russian Federation. Significantly, Article 15(4) says that "[u]niversally-recognized principles and norms of international law and international treaties of the Russian Federation are components of its legal system. If an international treaty … establishes rules other than domestic laws, the rules of the international treaty prevail."[1]

Russia has ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention for the Protection of Human Rights and Fundamental Freedoms.

The complaint was based on the constitutional rule of supremacy of international treaties of the Russian Federation over its domestic laws, specifically, Articles 14 and 31(6) of the federal *Law on Narcotics and Psychotropic Substances, 1998*, which explicitly prohibits the use of methadone and buprenorphine for drug dependence treatment.

Teplinskaya noted that the Council of the Federation — the upper chamber of the Russian federal parliament — determined that "if a court or other state authority refuses to apply a provision of an international treaty as a rule for direct implementation, this authority shall first provide an appropriate proof for such a point."[2] The argument further said that the Supreme Court of the Russian Federation clearly directed the lower courts not to apply domestic laws if an international treaty provided for rules different to them. In such cases, the international treaty prevails.[3] Teplinskaya also indicated that the Supreme Court had previously informed the lower courts that "the meaning of international laws can be revealed in particular with help of the documents of the United Nations and its specialized agencies."[4]

A week before the trial, the Committee on Economic, Social and Cultural Rights recommended in its Concluding Observations to the Russian Federation that it "provide clear legal grounds and other support for the internationally-recognized measures for HIV prevention among injecting drug users, in particular the opioid substitution therapy (OST) with use of methadone and buprenorphine."[5] The district court was informed about this conclusion during the hearing; however, justice Chesnokova ignored this and the complainant's arguments. In her brief ruling, the judge rejected Teplinskaya's claim for access to OST based simply on the *Law on Narcotics and Psychotropic Substances*.

The fact that the International Narcotics Control Board recognizes that OST does not constitute a breach of any treaty provisions, whatever substance may be used for such treatment,[6] did not factor into the judgment, nor was consideration given to the fact that ensuring availability

of narcotic drugs and psychotropic substances for medical purposes is the basic requirement of the UN drug conventions.

The effectiveness of current drug treatment in the Russian Federation is very low.[7] According to Russian specialists, only 8.6 percent of Russian people who use drugs remain drug-free within a year from entering a treatment program. On average a drug-dependent person is hospitalized about five times a year.[8]

Teplinskaya promptly filed an appeal of the Leninsky district court judgment. On 3 August, the court of appeal upheld the district court ruling. On 25 August, Teplinskaya filed a complaint to the European Court of Human Rights.

[1] Translation by the author.

[2] Resolution of 8 February 2006 No 36-SF.

[3] Resolution of the Supreme Court Plenary No 8 of 31 October 1995.

[4] Resolution of the Supreme Court Plenary No 5of 10 October 2003. The complaint pointed to many documents of UN bodies and specialized agencies, such as the General Assembly, the Commission on Narcotic Drugs, the World Health Organization, the UN Office on Drugs and Crime (UNODC) and the Joint UN Programme on HIV/AIDS (UNAIDS), where OST is recognized as an effective method of drug dependence treatment, HIV prevention and treatment, as well as an effective intervention for crime reduction.

[5] Committee on Economic, Social and Cultural Rights: Concluding Observations on 5th Periodic Report of the Russian Federation. Geneva, 20 May 2011. Para. 29.

[6] Report of INCB for 2003, para 222.

[7] Human Rights Watch, *Rehabilitation Required. Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment.* 2007.

[8] From the commentary of Dr. Tatyana Klemenko of the Serbsky Psychiatric Centre, Moscow, on the state anti-narcotic strategy. http://stratgap.ru/includes/periodics/comments/2009/1124/3841/detail.shtml.

India: High Court rules mandatory death penalty for drug crimes unconstitutional

On 16 June 2011, the Bombay High Court issued a judgment that overturned the law providing for a mandatory death penalty for certain drug crimes, becoming the first court in the world to do so.[1]

A petition had been filed by the Indian Harm Reduction Network (IHRN), which considered the capital punishment provision under Section 31-A of the *Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPSA)* arbitrary, excessive and disproportionate to the crime of dealing in drugs.[2]

IHRN challenged the law as violations of two Articles of the Constitution of India: Article 14, which says that "the State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India"; and Article 21, which stipulates that "[n]o person shall be deprived of his life or personal liberty except according to procedure established by law."

The court, however, did not strike down Section 31-A, preferring to read it down instead.[3] It did not agree with the argument of the petitioner that the death penalty, *per se*, constituted cruel, inhumane and degrading punishment. It stated that this argument "is no more *res integra,* as the Apex Court [Supreme Court of India] has, time and again, negatived that argument."[4]

The argument by the petitioner that the death penalty for drug offences is disproportionate was rejected with reference to the "repeated observations of the Supreme Court that offence relating to narcotic drug or psychotropic substance is even more heinous than culpable homicide, because the latter affects only an individual, while the former affects and leaves its deleterious effect on

the society, besides crippling the economy of the nation as well."[5]

In its ruling, the court stated:

> We have rejected the challenge to Section 31-A of the NDPS Act, being violative of Article 14 of the Constitution. However, as we find merits in the challenge to the said provision, being violative of Article 21 of the Constitution, as it provides for mandatory death penalty, the appropriate relief would be to declare Section 31-A as unconstitutional.[6]

The court went on to say

> that the said provision [Section 31-A] be construed as directory by reading down the expression '*shall* be punishable with death' as '*may* be punishable with death' in relation to the offences covered under Section 31-A of the Act. Thus, the Court will have discretion to impose punishment specified in Section 31 of the Act for offences covered by Section 31-A of the Act. But, in appropriate cases, the Court can award death penalty for the offences covered by Section 31-A, upon recording reasons therefor.[7]

IHRN President Luke Samson said that the decision was "a positive development, which signals that Courts have also started to recognize principles of harm reduction and human rights in relation to drugs."[8]

Rick Lines, the Executive Director of Harm Reduction International, noted that "[t]he Court has upheld at the domestic level what has been emphasized for years by international human rights bodies — capital drug laws that take away judicial discretion are a violation of the rule of law. India's justice system has affirmed that it is entirely unacceptable for such a penalty to be mandatory."[9]

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[1] International Drug Policy Consortium, "Indian court overturns mandatory death penalty for drug offences – first in the world to do so!" 16 June 2011, on-line: www.idpc.net/alerts/india-death-penalty.

[2] Ibid.

[3] Ibid.

[4] *Indian Harm Reduction Network v. The Union of India.* High Court of Bombay. 16 June 2011, at para. 65.

[5] Ibid, at para. 75.

[6] Ibid. at para. 81.

[7] Ibid, at para. 89.

[8] International Drug Policy Consortium, *supra.*

[9] Ibid.

Ireland: Press Ombudsman censures newspaper for spreading hatred of people who use drugs

In June 2011, the Press Ombudsman of Ireland ruled in favour of a coalition of three organizations that had lodged a complaint against the *Irish Independent* for a February 2011 column that strongly disparaged people who use drugs.

In the column, titled "Sterilising junkies may seem harsh, but it does make sense," Ian O'Doherty described people who use drugs as "vermin," "feral worthless scumbags getting up to mischief all the time," and said that "if every junkie in this country were to die tomorrow I would cheer."[1]

The Irish Needle Exchange Forum, CityWide Drugs Crisis Campaign and Harm Reduction International, supported by about thirty drug-use service providers and professionals, filed a complaint with the Press Ombudsman, who subsequently found that the column by O'Doherty "was likely to cause grave offence to or stir up hatred against individuals or groups addicted to drugs on the basis of their illness."[2]

The *Irish Independent* was found to be in breach of the *Code of Practice* for newspapers and magazines, specifically Principle 8 on Prejudice. It states that "[n]ewspapers and magazines shall not publish material intended or likely to cause grave offence or stir up hatred against an individual or group on the basis of their race, religion, nationality, colour, ethnic origin, membership of the travelling community, gender, sexual orientation, marital status, disability, illness or age."[3]

According to the Ombudsman, "Neither the justification advanced in the article for the comments complained about…nor the subsequent publication by the newspaper of letters from other complainants, or the publication of a feature reacting to the article, can obviate the need to make it clear that this article represents a breach of Principle 8 of the Code."[4]

"We believe this to be the first time that drug users have been identified by a media watchdog as an identifiable group, entitled to protections against hate-type speech in the press," said Rick Lines, Executive Director of Harm Reduction International. "In this sense, we think the decision of the Press Ombudsman has international significance."[5]

According to Tim Bingham of the Irish Needle Exchange Forum, "Drug use is ultimately a health issue and needs to be addressed as such…. We hope that the decision of the Ombudsman will play a role in reorienting the media discourse away from prejudice and stigma, and therefore promote a discussion based on evidence of effectiveness and on public health."[6]

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[1] Harm Reduction International, CityWide and Irish Needle Exchange Forum "*Irish Independent* censured for 'offensive' column likely to stir hatred against drug users," news release, London, 13 June 2011.

[2] Ibid.

[3] Press Council of Ireland, *Code of Practice*, on-line: www.pressombudsman.ie/code-of-practice.150.html.

[4] "The International Harm Reduction Association and others and the *Irish Independent*," *Irish Independent*, 27 June 2011, on-line: www.independent.ie/national-news/the-international-harm-reduction-association-and-others-and-the-irish-independent-2806529.html.

[5] "*Irish Independent* censured for 'offensive' column likely to stir hatred against drug users," *supra*.

[6] Ibid.

South Africa: ANC Youth League President issues apology following conviction for hate speech

In June 2011, fifteen months after he had been found guilty of hate speech and discrimination, African National Congress (ANC) Youth President Julius issued a formal apology and agreed to pay a R50,000 (CAN$7,120) fine that was part of the conviction.[1]

In March 2010, the Equality Court found Malema guilty of hate speech and discrimination and ordered him to issue a public apology and pay a fine of R50,000 within one month of the verdict.[2]

The ruling came about as a result of action taken by the Sonke Gender Justice Network in March 2009. While speaking in front of a group of Cape Peninsula University students about the woman accusing then-ANC President (and current South African President) Jacob Zuma of rape, Malema stated that "those who had a nice time will wait until the sun comes out, request breakfast and ask for taxi money. In the morning,

that lady requested breakfast and taxi money."[3]

Sonke sought an apology from Malema on behalf of the woman accusing Zuma of rape and on behalf of all rape survivors in general. It argued that Malema's sexist statements amounted to hate speech, perpetuated rape myths and sexual violence. Such beliefs undermined the work conducted by Sonke, which works with boys and men to prevent domestic and sexual violence, promote gender equality and reduce the spread and impact of HIV/AIDS.

In his apology, Malema explained that he did not consider himself to be an expert on rape victims or the conduct of women after sex. Rather, he stated his comment was an explanation for why Zuma was still an ANC candidate.[4]

While Sonke welcomed Malema's late apology, it noted his refusal to abide with the precise terms of the court order, which created the impression that he believed himself to be above the law. It also expressed concern over the fact that the ANC refused to discipline Malema for his statements or require his prompt compliance with the court order. Sonke Deputy Director Desmnd Lesejane urged Malema to "show a consistent respect for the country's constitution and the rights embedded within it."[5]

— Shalini Thomas

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[1] Sonke Gender Justice Network, "Sonke welcomes Julius Malema's apology, but…," news release, June 2011, on-line: www.genderjustice.org.za/issue-9-july-2011/sonke-welcomes-julius-malema-s-apology-but-notes-with-concern-that-it-has-taken-15-months-for-him-to-comply-with-the-equality-court-ruling.

[2] See K. Sinclair, "South Africa: ANC Youth League President found guilty of hate speech," *HIV/AIDS Policy & Law Review* 14(3), pp. 45–46.

[3] "Malema explains himself," News 24, 21 September 2009, online: www.news24.com.

[4] *Ibid.*

[5] "Sonke welcomes Julius Malema's apology, but…," *supra.*

Criminal law and HIV non-disclosure

Belgium: first successful prosecution in HIV transmission case

On 9 June 2011, a Belgian tribunal convicted an individual for transmitting HIV to his wife, sentencing him to three years' imprisonment. This marks the first successful conviction for HIV transmission in Belgium.[1]

Baky J. was diagnosed HIV-positive in 1994 and never disclosed his status to his partner, whom he met in 2004. She became his wife and, in 2005, during the course of her pregnancy, tested positive following a pre-natal HIV test. She filed a formal criminal and civil complaint in May 2006, given that her husband was the only one who could have infected her. The couple's child was born HIV-negative, but the mother has seen her health deteriorate since then.

The legal basis for the prosecution of HIV transmission in Belgium is Article 421 of the *Criminal Code*, which allows for the conviction of "anyone who involuntarily causes a person to contract an illness or work disability by administering substances to that person that are fatal or seriously harmful to health."[2]

Baky J., a deeply religious man who resorted to prayers instead of medication, explained that he believed himself to be cured of HIV because he never transmitted the virus to his previous wife and their two children. He claimed that his illness was something deeply personal and also not very important, which is why he never disclosed it to his wife. He also tried to dismiss the prosecution, contending there was no scientific certainty that he was responsible for transmitting HIV to his wife.

The Belgian Crown attorney argued that the accused posed a grave threat to women and the community, and asked the Court to sentence him to a five-year term, the maximum sentence provided by the law. The *Tribunal correctionnel* of Huy convicted Baky J. and sentenced him to

three years' imprisonment, with two years suspended. The court noted the lack of remorse shown by the accused and his disrespect for the life of his sexual partners, whom he consciously exposed to HIV.

Additionally, the complainant was awarded a conditional damage award totalling 2,500 Euros (CAN$3,400).

Baky J. plans to appeal the sentence.

— Rémi Weiss

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UK: Zimbabwean national imprisoned for HIV transmission

On 25 July 2011, the Wolverhampton Crown Court sentenced Nkosinati Mabanda to four years in prison for HIV transmission. He had pleaded guilty to recklessly exposing one of his partners to HIV. Mabanda was also handed an anti-social behaviour order that prohibits him from engaging in sexual activity with any person without first disclosing his HIV status to that person.[3]

Mabanda, who is originally from Zimbabwe, could also face a deportation procedure following his release.

The accused admitted to having unprotected sex with nine different partners while fully aware of his HIV-positive status. One of those women said she had learned of Mabanda's status after finding a text message on his mobile phone. When she later tested positive for the virus in April 2009, he was immediately reported to police.

Superintendent Jan Thomas-West of the West Midlands Police said, "This has been a complex and lengthy investigation throughout which we have been required to employ the services of many experts to establish that Mabanda did in fact infect his partner with HIV. The particularly disturbing element of this case is Mabanda's blasé attitude towards his victim and his various other partners."[4]

For her part, the victim said, "[Mabanda] should have been given life because that's the sentence he has given to me. He's just scum … I'm on medication now for the rest of my life."[5]

France: man sentenced to prison for transmitting HIV to former partner

In March 2011, a man was found guilty of knowingly passing on the HIV virus to his then-partner in 1999. A court in Strasbourg sentenced Emmanuel Baudard to five years in prison, two of which are suspended.[6]

During the trial, the victim indicated that she had a single, unprotected sexual encounter with Baudard in October 1999 and fell ill two months later. However, it was only in 2006 when she learned that Baudard had already known of his HIV-positive status at the time. Their relationship ended in 2003.

He admitted having known his HIV status at the time of the unprotected encounter but said he believed that the victim was also HIV-positive because both were injection drug users and because she agreed to unprotected sex.[7]

Baudard said that he was infected during his military service in 1988–1989, but only began antiretroviral therapy in 2008.

— David Cozac

David Cozac (dcozac@aidslaw.ca) is the managing editor of the *HIV/AIDS Policy & Law Review*.

[1] E.J. Bernard, "First criminal conviction under poisoning law, advocates caught unawares," Criminal HIV Transmission (blog), 13 June 2011. On-line: criminalhivtransmission.blogspot.com. See also, J-L, Tasiaux, "HIV volontairement transmis à sa femme : un an de prison," L'avenir.net, 10 June 2011.

[2] Original French-language version: « *celui qui aura involontairement causé à autrui une maladie ou une incapacité de travail personnel, en lui administrant des substances qui sont de nature à donner la mort ou à altérer gravement la santé* ».

[3] "Man jailed for recklessly infecting Darlaston woman with HIV," Walsall Local Policing Unit, 25 July 2011.

[4] Ibid.

[5] "Victim brands HIV lover 'scum'," *Express & Star*, 26 July 2011.

[6] "Prison ferme pour avoir sciemment transmis le sida," *Le Figaro*, 26 March 2011.

[7] E.J. Bernard, "Man sentenced to five years for alleged transmission during one-off unprotected sex encounter in 1999," Criminal HIV Transmission (blog), 29 March 2011. On-line: criminalhivtransmission.blogspot.com.

LITIGATING FOR CHANGE:

PROCEEDINGS FROM THE 3RD SYMPOSIUM ON HIV, LAW AND HUMAN RIGHTS

Introduction

From 9–10 June 2011, the 3rd Symposium on HIV, Law and Human Rights took place in Toronto, drawing over 150 participants from across Canada. The event built on the success of the two previous Symposia and brought together policy-makers, legal professionals, health researchers, students, activists, community organizations and people living with HIV or from communities particularly affected by HIV.

The attendees gathered in downtown Toronto to explore two related themes:

- how the use of the courts has influenced, and is currently influencing, HIV-related law and policy in Canada; and
- how communities can engage with or organize around litigation as a strategy for advancing the human rights of people living with or vulnerable to HIV.

Two days of skills-building workshops and panel discussions provided delegates with the opportunity to learn about HIV-related legal and human rights issues, attain skills to advance human rights in the response to HIV, and develop new partnerships and alliances.

On 9 June, a series of workshops took place on the following subjects: the protection and privacy of health information in the age of electronic communications and social media; coverage of HIV in the mainstream

media; and how social media can advance the rights of people affected by HIV. A parallel gathering of representatives from Canadian AIDS-service organizations continued discussions held at the previous year's Symposium about the formation of a national advocacy coalition that would collaborate on initiatives to address local and regional HIV-related policy issues as they emerge. The objective was to generate a more unified national response to HIV-related policy concerns, share information on best practices and support members' struggles in the current political climate that is increasingly hostile to harm reduction initiatives and human rights/evidence-based policy responses.

A reception took place on the evening of 9 June that included presentation of the annual Awards for Action on HIV and Human Rights, administered jointly by the Canadian HIV/AIDS Legal Network and Human Rights. The Canadian recipient was the Prisoners' HIV/AIDS Support Action Network (PASAN), while the international award honoured the Caribbean Vulnerable Communities and its late co-founder, Dr. Robert Carr.

The night concluded with a keynote address by Alan N. Young, Associate Professor at Osgoode Hall Law School in Toronto and counsel in *Bedford v. Canada (Attorney General)*, a constitutional challenge to Canada's prostitution laws that harm sex workers.

In the morning of 10 June, two panels were held on strategic litigation. One was from the perspective of lawyers involved in HIV-related cases and the other brought together a group of community activists to offer their insight. In the afternoon, a "World Café" was held, in which Symposium attendees gathered in groups to engage in an interactive discussion on strategic litigation in the context of HIV. Discussant for this was Doug Elliott, a partner in Roy Elliott O'Connor LLP, who reflected on litigating HIV and human rights in Canada.

Panel — Lawyers' perspectives on strategic litigation

This article contains summaries of the four presentations made during this panel. David Eby provides a framework for questions every organization should consider before deciding to proceed with litigation. Derek Olson discusses the criminal law of aggravated sexual assault as related to the strategic litigation in *R v. Mabior*. Jonathan Shime stresses the need for players in the legal sector to educate themselves better on the science surrounding HIV. Finally, Elin Sigurdson outlines the legal arguments advanced in *SWUAV*, British Columbia's parallel litigation to Ontario's *Bedford* case, challenging the constitutional validity of provisions of the *Criminal Code* that endanger the lives of sex workers.

Questions to consider for strategic litigation

David Eby, President of the Board, Canadian HIV/AIDS Legal Network, and Executive Director of the British Columbia Civil Liberties Association (BCCLA)

Before pursuing "impact litigation" or "strategic litigation," organizations should address the following questions and reach out to lawyers at organizations such as the Canadian HIV/AIDS Legal Network or the BCCLA to ensure that they have considered all the relevant issues:

- **What is the issue?** It should be something that affects a wide constituency of individuals that your organization seeks to help.
- **Is your organization committed to litigation?** Do you have the resources to fund litigation? Have you tried all other means

to address the issues? (A court will ask if you have issued formal applications, written letters or otherwise advocated the issue.)

- **Do you have a client?** Do you need an individual client? If so, then do you have someone who is stable but also impecunious (which will help reduce the costs awarded at the end of litigation)? Can your organization achieve standing to act as the client or as an intervener? (Interveners are able to raise larger umbrella issues.)
- **Do you want to go through the court system or be heard by a human rights tribunal (or another type of tribunal)?** Different venues have distinct advantages and disadvantages. It is important to canvass your options prior to deciding which venue would best advance your organization's larger goals.
- **What is your strategy?** Does "impact litigation" or "strategic litigation" fit into the larger goals of your organization's campaigns?
- **What is your campaign timeline?** You should be aware that litigation is a lengthy process.
- **What happens if you lose?** A loss in court can make the public think that you do not have a proper "rights entitlement" and impact your constituents. Are you able to pursue advocacy that would push a judicial interpretation a certain way? Judges will often split a decision both ways. In that event, are you prepared for just a partial victory? Is it better for the law to be uncertain rather than have it firmly established that you lost in court?

Insite as strategic litigation

Insite is a supervised drug injection facility that the City of Vancouver established in order to deal with the health crisis presented by people who inject drugs. The program also offers a detox facility, Onsite, as well as housing and welfare support, among other services. Insite was able to operate due to a special temporary exemption from prosecution for people who use drugs and for staff for activities that were otherwise contrary to the *Controlled Drugs and Substances Act* (CDSA).

The *Insite*[1] case is an example of strategic litigation. The PHS Community Services Society challenged the power of the federal government to allow or deny people with addictions access to Insite's facilities, based on Section 7 of the *Canadian Charter of Rights and Freedoms,* which guarantees the rights to life, liberty and security of the person. The rights to life and personal security of individuals who face addictions are at peril, as they face the threat of an overdose or serious health consequences, such as contracting HIV or hepatitis C by using unclean needles. The liberty rights of such individuals are also infringed upon due to the threat of arrest and imprisonment for being in possession of drugs or facilitating drug use.

These violations of Section 7 rights cannot be justified because they are not in accordance with the principles of fundamental justice. The court needs to recognize that this case is about the rights of people living with addictions and, as such, is a health and disability concern. A law should not make someone's activity illegal if they are not voluntarily engaging in it.

Those in the throes of an addiction do not make a conscious choice to use drugs; rather, they are compelled to use drugs lest they become physically ill. Such individuals should have access to facilities that allow for a safer venue for treatment, and the right to life and health should trump the power of the federal government to regulate these facilities.

Furthermore, the current laws are overly broad in achieving the goals of the CDSA. Health-care workers in the facility potentially expose themselves to criminal prosecution under Section 5(1) of the CDSA, which defines "trafficking" to include facilitating criminal activity, such as being in possession of needles or drugs.

Mabior and the criminal law of aggravated sexual assault

Derek Olson, Partner, Hill Sokalsi Walsh Trippier LLP, Winnipeg

Learning the science behind HIV/AIDS and the social issues surrounding disclosure of HIV status clarifies that an individual, who has an undetectable viral load or used a condom, should not be convicted of sexual assault for not disclosing his/her HIV status. This knowledge has proven invaluable in strategic litigation.

A case in point is *R. v. Mabior*.[2] Upon learning in 2004 that he was HIV-positive, Clato Mabior was counselled by public health nurses to disclose his HIV status to his sexual partners, and always to use condoms. Shortly thereafter, he began antiretroviral treatment (ART) and soon had an undetected viral load. Mabior had

sex with six young women between 2004 and 2006, who said they would not have had sex with him if he had disclosed his status.

Mabior was convicted in a Manitoba trial court of six counts on aggravated sexual assault for non-disclosure of his HIV status among other charges, and sentenced to 14 years of incarceration. In reaching this finding, the court applied the test from the 1998 Supreme Court of Canada (SCC) decision in *R. v. Cuerrier*.[3] In this ruling, the SCC answered the specific legal question of whether failing to disclose an HIV-positive status to a sexual partner may amount to fraud, which would vitiate the partner's consent, thereby rendering the intercourse a sexual assault. The SCC held that the Crown must meet two elements to establish fraud: there must be a dishonest representation, for which deliberate deceit or non-disclosure respecting HIV status meets the criteria; and the dishonesty must result in some deprivation to the complainant.

In *Cuerrier*, Justice Cory stated that, to amount to "deprivation," there must be actual harm or a significant risk of harm, but cannot be a "trivial harm" or a risk of harm that will satisfy the requirement of sexual assault cases where the activity would have been consensual if the consent had not been obtained by fraud. The examples of a minor scratch or catching a cold would not be sufficient to establish deprivation. Rather, the Crown must establish a dishonest act, either falsehoods or the failure to disclose one's HIV-positive status, which has the effect of exposing the person consenting to a significant risk of serious bodily harm. The risk of contracting HIV as a result of engaging in unprotected intercourse would meet the test.

Thus, Justice Cory was saying that the failure to disclose one's HIV status itself is not sufficient to sustain a conviction of sexual assault. Instead, there must be an additional component causing significant risk of serious bodily harm. The Court went on to say that the facts of each case would help determine if the test had been met. In an obiter comment, Justice Cory stated that disclosure may not be required in the event of protected intercourse, an opinion repeated in the concurring decisions of two other SCC judges.

> A law should not make someone's activity illegal if they are not voluntarily engaging in it.

Cuerrier was decided before ART was readily available to reduce the risk of HIV transmission. Today, more than ten years after *Cuerrier*, the science has significantly advanced, with new advances in treatment. An individual who uses ART or a condom will have a very low (even negligible or non-existent) transmission rate of HIV. That is to say, being HIV-positive is no longer a death sentence.

Despite the evidence presented by both the Crown and defence's expert witness, the trial judge stated that virtually any risk of transmission, however minimal, was sufficient to establish a significant risk of harm of bodily harm. The judge further stated that only when a condom was used *and* the individual had a low viral load could conviction be avoided. This ruling contradicted the test in *Cuerrier* and, if upheld, would have significantly widened the scope of criminalization.

On appeal, a main focus was to educate the Court of Appeal on the scientific evidence before them so that they could understand transmission rates, and to highlight the difference between a moral obligation to disclose one's HIV status versus using one of the most serious offences of the *Criminal Code* to regulate complex sexual behaviour.

The Manitoba Court of Appeal agreed the trial judge erred by incorrectly applying the "significant risk" test, and overturned the decision. In doing so, it stated that the *Cuerrier* test required the presence of a "significant risk," which must be more than an ordinary risk and recognized that the use of a condom *or* an undetectable viral load can reduce the risk below the threshold of "significant risk." The appeal court also said that the legal test must evolve in order to be consistent with the current science and to account appropriately for the development of HIV treatment. The *Mabior* case is now headed to the Supreme Court of Canada.

Education as a key to litigating for change

Jonathan Shime, Partner, Cooper & Sandler LLP, Toronto

The HIV/AIDS community has lived with widespread fear over what is or is not allowed in their private, sexual

lives due to the inconsistent application of the "significant risk" test from *Cuerrier*. Courts are only now realizing that the test must turn on scientific evidence, and the science is not readily understood by police officers, counsel for the Crown or defence, or judges. Every person in the criminal justice system is woefully under educated on the basic concepts surrounding HIV and the risk of transmission, and yet people do not have five to ten years for judges to become educated, while the police are "knocking on their doors."

People in the criminal justice system are under-educated on the basic concepts surrounding HIV and the risk of transmission.

Thus, a key aspect of litigating for change is the need for more education. Although defence lawyers usually take a defensive stance in the courtroom, the first task of a defence lawyer in cases related to non-disclosure of HIV status is to educate himself/herself on the basics of the disease, through consulting scientific literature and medical experts. Furthermore, defence lawyers should call on medical experts who can explain the science and the risk of transmission in a language that is accessible and understandable by the courts, such that innocent people do not get convicted.

The *Mabior* and *Bedford*[4] cases are clear examples of lawyers, with very little previous knowledge on the issues affecting their clients, taking the onus to educate themselves and the judges. In *Bedford,* by amassing evidence from various domestic, national and international sources, Alan Young was able to show the court that other countries were approaching the risks associated with sex work more effectively than Canada. As a result, Justice Himel ruled that the laws propagated by the government, and the way they are enforced, put sex workers at a level of risk that otherwise could be avoided. In other words, through education, the court was able to come to the right determination and recognize that the government was making the lives of sex workers more dangerous.

SWUAV and strategic litigation

Elin Sigurdson, Janes Freedman
Kyle Law Corporation, Vancouver

A Parliamentary subcommittee was created by the federal government to review the problematic aspects of the laws on sex work. At the same time, the Pivot Legal Society was looking for ways to assist sex workers in Vancouver's Downtown Eastside. These women were mainly involved in survival or subsistence sex work, and thus in extreme poverty, and facing dangerous circumstances as a result of the criminal laws that affected them. Several sex workers informed Pivot of their frustration at not being included in the federal government's review of the laws that affected them so severely. These women did not feel comfortable with the available methods for offering information, as they wanted to guarantee their anonymity and privacy while still speaking to Parliament directly.

Pivot thus took the opportunity to gather 98 affidavits from sex workers, detailing their opinions on the laws and how they must change. A large evidentiary package, complete with legal arguments, was then submitted to the subcommittee. After reviewing all the evidence and acknowledging that the laws needed reform, the subcommittee stated the matter required further study before any changes could be made. This was a huge disappointment. As a result, the women who had approached Pivot joined together to create their own organization: SWUAV (Downtown Eastside Sex Workers United Against Violence).

Distinctions between *SWUAV* and *Bedford*

SWUAV was joined by another plaintiff, Sheryl Kiselbach, a former sex worker for 30 years and current advocate for sex workers. Together, they have sued the federal government on the basis that several of the criminal law provisions that affect them, including the three provisions under review in *Bedford*, are constitutionally harmful. The plaintiffs in *Downtown Eastside Sex Workers United against Violence (SWUAV) and Kiselbach v. Canada*[5] are also challenging other procuring provisions of the *Criminal Code*, which affect the safety of survival sex workers by inhibiting them from working together to refer safe clients and spot one another.

As in *Bedford,* the laws are being challenged for violating Sections 2(b)

and 7 of the *Charter*. However, the *SWUAV* plaintiffs proceed further in stating the laws infringe on their freedom of association and are discriminatory (infringing the right to equality), by placing an unconstitutional burden of harm on some of the most vulnerable members of society, who are then denied access to legal protection and legal rights.

Even if a favourable result is achieved, litigation may not solve all the problems an organization is combating.

The Attorney General of Canada brought an application to strike down the case on the basis that neither of the plaintiffs has standing, as Kiselbach is a former sex worker and SWUAV is an organization, and thus neither are currently affected by the laws. It is difficult for current sex workers to come forward and publicly out themselves, as it could lead to dangerous repercussions from the public or the police, and could result in their losing access to social services, housing or their children.

Unfortunately, the trial judge agreed with the Attorney General, stating that there were other ways for the litigation to proceed, such as having a current sex worker charged and arrested. On appeal, the Court of Appeal found that both plaintiffs had public interest standing, as there was no other way for the litigation to proceed and, despite not being currently affected by the laws, they had sufficient interest in the issues. The Attorney General has appealed this decision and the question of "standing" will soon be heard by the Supreme Court of Canada.

Anticipating perils

SWUAV is a concrete example of how strategic litigation can hit roadblocks that draw out the length of time and resources spent on litigation. *SWUAV* was filed in 2008 and has since been caught in "standing" arguments. The actual legal arguments have yet to be heard by the courts. Furthermore, along with being time-consuming, litigation can end in disappointment; and, even if a favourable result is achieved, it may not solve all the problems an organization is combating.

On a positive note, the issue of "standing" has taken off as a public interest matter. Organizations working on similar issues, or with similarly affected populations, have embraced the notion of developing the doctrine of "standing" to advance the idea of access to justice. It can allow for similarly marginalized populations to enter the courtrooms and articulate the errors in how their country has framed the laws that profoundly affect them.

Litigation can also be a real media and public communications opportunity. Although seemingly "radical," in that litigation attempts to tear down some of the fabric of the laws the country has woven, it can also be a "de-radicalizing" method for organizations to pursue, which allows them to work from the inside. Advocacy and communications groups can seek to frame their work in a way that resonates with how the public reacts to the issues. This approach would be the most effective method to combat the stereotypes and stigma associated with HIV/AIDS and sex work, as the legal arena is not an effective method to educate the public.

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[1] *PHS Community Services Society v. Canada (A.G.)*, 2010 BCCA 15.

[2] *R. v. Mabior, (C.L.),* 2010 MBCA 93.

[3] *Cuerrier*, [1998] 2 S.C.R. 371.

[4] *Bedford v. Canada (A.G.),* 2010 ONSC 4264.

[5] *Downtown Eastside Sex Workers United Against Violence (SWUAV) and Kiselbach v. Canada (A.G.)*, 2010 BCCA 439.

Panel — Community activists' perspectives on strategic litigation

This article contains summaries of the five presentations made during this panel. Émilie Laliberté provides an overview of the activities of Stella, which fights for sex workers' rights in the Montréal region. Louis Letellier de St-Just speaks of the work of CACTUS Montréal and the question of public health policy in Quebec as it relates to drugs. Nikki Thomas outlines the dangers that sex workers face on a daily basis due to obstacles in the *Criminal Code*. Ann Livingston of the Vancouver Area Network of Drug Users and Glyn Thomson of the Positive Living Society of British Columbia each speak of the accomplishments of their respective organizations.

The rights of sex workers in Montréal

Émilie Laliberté, Executive Director, Stella, l'amie de Maimie, Montréal

Stella, l'amie de Maimie is a Montréal-based, non-profit organization founded in 1995 by and for sex workers. Its principal objective is to educate sex workers so that they can work in the safest possible environment. It does this through, for example, freely distributing condoms (5000 in 2010), preparing a list of aggressive clients (there were 67 recorded incidents in 2010, with the majority of those assailants the subject of a formal complaint) and offering legal advice or providing support and guidance (which can include helping men and women to enter or leave the sex trade).

Stella has a partnership with Médecins du Monde, whose nurses visit strip clubs, escort agencies and the streets in order to vaccinate against hepatitis A and B, and to educate sex workers. The goal is always to ensure sex workers' safety and to try to reduce the dangers and difficulties associated with prostitution. Stella estimates that, each year, between 5000 and 7000 sex workers in Montréal directly benefit from their activities.

Public education is an important component of Stella's work. This involves raising the awareness of doctors, students and legal professionals,[1] as well as police officers. These activities have allowed Stella to establish contacts, particularly with three police officers who receive complaints from sex workers without arresting them, regardless of whether or not there is a warrant out for them.

Using the court to ensure the rights of sex workers

Information is not the only aspect of Stella's work. The organization also turns to the law in order to ensure respect for the rights of sex workers.

Certain sex workers in Quebec were troubled by the *Bedford v. Canada*[2] decision of the Ontario Superior Court in 2010. Some sex workers will continue to ply their trade on the street whether or not prostitution is decriminalized. Therefore, it is necessary to reach consensus among members of Stella and to listen to and understand the needs expressed by them. On 28 September 2010, the organization did a media blitz to educate the public on the issue of prostitution and decriminalization.

Stella did not have the time to get intervener status in *Bedford v. Canada* before the Ontario Court of Appeal since the organization was unable to agree to a common position among its membership. Instead, Stella created a "reflection committee" ("*comité de réflexion*") on the issue of decriminalization that reviewed the interveners' affidavits in the appeal, and which is entrusted with meeting with potential lawyers to represent the organization in view of a possible intervention before the Supreme Court of Canada.

In 2002 in Montréal, Stella was present at a very strict application of municipal regulations that resulted in the widespread distribution of fines to not only many sex workers but also to so-called "squeegee" kids and vagrants. Stella fought against the fines and achieved partial success — subjecting them all to a challenge resulted in the judge voiding the fines — but avoided the legal issues for fear of setting a precedent. Conscious of the partial failure, the authorities subsequently continued

their harassment, no longer basing it on municipal regulations but on Section 213 of the *Criminal Code*, which prohibits solicitation for prostitution.

Individuals arrested under Section 213 are found in a specific, "quadrilateral" predicament. For example, for one or two years now, a sex worker is no longer authorized to operate within any given urban perimeter, be it one or two neighbourhoods (the size of Hocheloga–Maisonneuve) or even the entirety of the Island of Montréal. This prevents them not only from working but also from living their day-to-day lives, given that sex workers generally live in the neighbourhoods where they offer their services. The problem is that sex workers, in order to go on with their lives, must break the conditions that the law imposes on them; and the more they do this, the more they are repressed by the judicial system through heavy sentences.

Another important issue that mobilized Stella occurred in 2003, in which a sex worker sought compensation from the Directorate of Compensation for Victims of Criminal Acts after being stabbed 20 times. Her claim was refused due to the fact that her activities as a sex worker placed her in a dangerous situation. After fighting for two years, the original decision was annulled in favour of a ruling favourable to compensation for sex workers who have been victims of criminal behaviour during their work.

Despite these successes, awareness-raising among politicians is a daunting task, and it is up to sex workers to work with different members of civil society in the construction of a legal framework concerning prostitution.

Establishing harm reduction services in Quebec

Louis Letellier St-Just, President of the Board, CACTUS Montréal

CACTUS Montréal is a community-based organization that came into being in 1989. It set up one of the first needle exchange programs in North America. A small, multidisciplinary group created this organization with the primary objective of engaging in harm reduction, all during a time when no one was talking about it.

> CACTUS Montréal was involved in harm reduction during a time when no one was talking about it.

The arrival of HIV on the public scene caused the language and practices of public health to evolve, and it obliged everyone to "reinvent" public health. Today, CACTUS is a formal organization that employs 65 people and offers a variety of around-the-clock services. The main program is the "fixed site" where syringes are distributed to people who use drugs and to those who are seeking treatment. There are also reinsertion programs, like "PLAISIIRS," which aims to integrate users with weak amounts of drugs. This initiative collaborates with the Old Montréal Workers' Association. People who use drugs in the "PLAISIIRS" program take part in clean-up work in Old Montréal, thus giving them an opportunity to "reclaim their dignity."

Every year, CACTUS distributes 350 000 clean syringes and offers information, support and counselling. They also direct efforts toward awareness-raising and education, in particular, permitting those seeking assistance to be referred to other public or community groups that offer complementary services.

Community support is essential for CACTUS in order to be able to carry out its work. At the time of its founding, the public regarded its activities with suspicion. This is still sometimes the case; however, the public mindset has changed for the better. Since 2005, CACTUS has had a "good neighbour" committee that responds to any questions or problems from the community. This committee is comprised mainly of CACTUS employees, business owners and residents, and seeks to find solutions to any issues that emerge.

In 2002, when Insite opened its doors in Vancouver, CACTUS welcomed the move. However, the organization took its time before determining if the client needs in Quebec called for the creation of one or several supervised injection sites in the province. In 2009, CACTUS decided, following a provincial commission on vagrancy, to support the establishment of supervised injection sites. So, in November 2010, CACTUS announced its intention to open such a facility in Quebec in June 2011.

After Insite and the Vancouver Area Network of Drug Users decided to take legal action, the ministers of health from all provinces stepped

back in order to await the decision from the Supreme Court of Canada (SCC). In the meantime, the Canadian HIV/AIDS Legal Network approached CACTUS, along with Harm Reduction International, to become part of an international coalition. These three organizations were later granted intervener status in the Insite case before the SCC.

In 2009, the National Institute of Public Health of Quebec submitted to the provincial minister of health a detailed advisory on the suitability of supervised injection sites. The document addressed the social, historical, ethical, legal and epidemiological issues surrounding them. While the minister received the submission, he remained very circumspect and feared the political fallout. For this reason, he is waiting for the SCC ruling on Insite.

In the National Public Health Plan for Quebec, there are dispositions for possible measures to take in the context of harm reduction. In 2008, during the International AIDS Conference in Mexico City, the then-minister of health for Quebec had indicated the possibility of implementing supervised injection sites as part of the public health plan.

The Vancouver Area Network of Drug Users

Ann Livingston, Volunteer and Co-founder, Vancouver Area Network of Drug Users

The Vancouver Area Network of Drug Users (VANDU) was incorporated as a non-profit organization in 1998. Since the beginning, it has put its members at the forefront of the organization, as the idea was to create a user-run group. Its board of directors is a democratic assembly that allows people who use drugs not only to participate but also to develop "citizenship skills" that allow them to work in other organizations.

People who use drugs are often denied standing to sue in court when their rights are breached.

Other sub-groups of VANDU include the B.C./Yukon Association of Drug War Survivors and the Western Aboriginal Harm Reduction Society, which might be the world's only Aboriginal group of people who use drugs. Because the membership of VANDU consists of 40 percent of people who identify as Aboriginal, it was regarded as highly important for them to have a voice.

VANDU and its subgroups have a provincial scope for a specific reason: people who use drugs usually have limited access to resources, so this way they can form small chapters under the supervision of the main provincial group.

Over the years, VANDU has changed from being an organization seeking decriminalization of drug use to one that considers drug use as a health-care issue. People who use drugs have a right to inject them in their bodies and be intoxicated; they also want to be safe while doing so, to feel that they are not second-class citizens and to have enforceable legal rights. The problem is that people who use drugs, like all marginalized populations, are often denied standing to sue in court when their rights are breached. It is ironic that these vulnerable citizens have a hard time making their voices heard before courts of justice, given that the *Canadian Charter of Rights and Freedoms* was drafted to protect people like them.

The first time VANDU went to court to intervene in a case was in regard to the prohibition set out by a city zoning by-law that prevented the establishment of a drop-in centre providing healthcare to people who use drugs. It was called the Health Contact Centre. A concerned citizens committee supported the by-law and tried to prevent people who use drugs from accessing the facility. After five years of tension, VANDU filed an action before the Human Rights Tribunal of B.C. and later had to appeal the decision.

In Abbotsford, a zoning by-law makes any harm reduction service, including needle exchange programs, illegal. VANDU is looking for the right opportunity to challenge this municipal regulation.

Having legal counsel provides assurance to people who use drugs. Indeed, one of the benefits of legal proceedings is that, through the drafting of a factum, one has the opportunity to depict the lived realities facing people who use drugs. Judges and the media can then receive an accurate idea of what the real situation is like.

Generally speaking, an important question put forward during the Insite

case is that we must ask ourselves why, as a society, we choose to deny people who use drugs access to health care, when we provide it for people who put their health at risk in other ways, such as smokers, people who over-consume alcohol or people who over eat.

Prostitution and the *Criminal Code*: the story of a sex worker

Nikki Thomas, Executive Director, Sex Professionals of Canada

Formerly known as the Coalition for the Rights of Prostitutes, which was very active in the mid-1980s at the time of the Fraser report on prostitution, Sex Professionals of Canada (SPOC) promotes the rights of sex workers across the country and stands for the decriminalization of all forms of sex work in Canada. In 1990, SPOC intervened before the Supreme Court of Canada,[3] outlining the provisions in Canadian law that make it difficult or dangerous for men and women to work as prostitutes.

For instance, Section 210 of the *Criminal Code* allows a sex worker to work in a hotel room or even, technically speaking, on the streets. However, it is not nearly as safe as working in her own home. That way, she can control her environment and know who is there and who is not. Some sex workers have walked into hotel suites only to be assaulted by friends of the clients who were hiding in other rooms of the suite.

Despite the fact that a conservative government is currently in power federally and might seek to enact legislation that will prohibit prostitution in Canada, particularly if *Bedford* loses on appeal, the risk in the *Bedford* case is worth taking. The current laws that concern sex work are bad laws, for they unnecessarily endanger sex workers. They need to be removed first and foremost. The absence of a good law is no excuse to keep bad laws on the book.

There is a need to fight stereotypes when it comes to sex work. Sex workers are a heterogeneous social group, with street workers comprising only a fraction of all prostitutes. Although statistics depict sex work as a highly dangerous activity, the problem is that those statistics are almost exclusively based on police reports. Such a method will put an emphasis on certain incidents experienced by sex workers since the police will usually get called only when things get out of control.

The absence of a good law is no excuse to keep bad laws on the book.

It is also important to note that sex workers are not vectors of disease and are generally far more educated about sex and sexually-transmitted infections (STIs) than the general public. Therefore, the idea of mandatory testing for sex workers is ridiculous. In fact, jurisdictions that have implemented mandatory STI testing for sex workers experience no substantial decrease in STI transmission. Sometimes quite the opposite, as clients think mandatory testing ensures sex workers are "clean" and so are less likely to engage in safe sex practices.

Positive Living B.C. and the criminalization of HIV transmission

Glyn Townson, Chair, Positive Living Society of British Columbia[4]

With just over 5000 members, Positive Living Society of British Columbia is western Canada's largest AIDS-service organization (ASO). Its members have a strong interest in the issue of criminalization of HIV transmission, with the organization having intervened before the Supreme Court of Canada (SCC) in *R. v. Cuerrier*.[5]

One of the worst side effects of charges for HIV transmission is being outed in the media. Outlets usually release the identity and pictures of prosecuted individuals. Indeed, when such cases are publicized, and sometimes sensationalized, the stigma and fear associated with HIV once again come to the fore and HIV-positive individuals often end up being tried in the court of public opinion instead of being duly tried in a court of justice. This only serves to violate privacy rights and make things worse for those who are most vulnerable to HIV.

Police in British Columbia and the Royal Canadian Mounted Police seem to be reluctant to discuss issues related to HIV. Despite numerous community input meetings, the Vancouver police were never able

to provide an explanation as to why they disclose the accused's private data. It would seem that they believe that they have not done anything wrong. Positive Living filed a complaint with the provincial Privacy Commissioner addressing these issues, but it has been halted because individuals who had suffered privacy breaches were unwilling to consent to supporting the complaint.

For the benefit of every sex worker and every person living with HIV, strict guidelines must be established. People need to know when they might be charged or not and people need to be reassured that their identity, picture and serostatus will be protected against undue disclosure. Positive Living took a look at the extensive guidelines for the prosecution of HIV transmission in the United Kingdom and noted that, before those guidelines had been put in place, the country saw 400 cases a year. Now it is down to a handful.

Litigation is, of course, not inexpensive. Any ASO or other organization must carefully pick its battles and the court cases in which it will seek to intervene. Consequently, Positive Living's board recently decided that the organization would seek intervener status before the SCC in the *Mabior*[6] case. Further down the road, another upcoming legal battle will likely involve the issue of euthanasia and the right to die. Issues like euthanasia or HIV transmission poke at parts of our society with which we are not comfortable dealing; however, dialogue is the only way to solve them.

[1] In 2010, Stella carried out educational training to judges from the municipal court in the province of Quebec.

[2] *Bedford v. Canada (A.G.),* 2010 ONSC 4264.

[3] Reference re ss. 193 and 195.1(1)(c) of the *Criminal Code* (Man.), [1990] 1 S.C.R. 1123.

[4] Formerly the British Columbia Persons with AIDS Society.

[5] *R. v. Cuerrier,* [1998] 2 S.C.R. 371 (Supreme Court of Canada).

[6] *R.v. Mabior,* [2010] 2010 MBCA 93 (Manitoba Court of Appeal).

Workshop — E-Leaks: The privacy of health information in the age of electronic information

This workshop examined some of the new challenges to health-related privacy emerging as a result of the proliferation of electronic communications and data storage, including through social media, electronic health records and ready access to personal information on the internet. The right to privacy is a human right. As such, protecting privacy and enforcing the duty of confidentiality regarding health information are fundamental to treating people with autonomy, dignity and respect. For people living with HIV, unauthorized disclosure of their status can lead to discrimination and breaches of other human rights. While this is not new, in this information age a new breed of privacy violation is emerging and our legal protections are not necessarily keeping pace.

Micheal Vonn, policy director at the British Columbia Civil Liberties Association (BCCLA)

There is a difference between an electronic medical record (EMR) — information that is simply held in a computer in the office of a patient's medical practitioner — and an electronic health record (EHR), which is

the pan-Canadian model of e-health. This latter record is part of a longitudinal database that is not merely electronic. The privacy issue with EHRs is that they are centralized, resulting in the question: centralized by whom and who has control of it?

The answer is the government. The care and custody of these documents flows from health-care providers into the longitudinal database — that is to say, the linkages of the computer. It is a physical repository in the care of the government, which determines who will have access to it — not the doctor, who has the ethical and legal obligation to safeguard it and only distribute it without expressed consent within the circle of care. In the world of e-health, if someone has access to that person's records, the patient cannot control whether or not they access it. That decision is made by someone else.

For its part, the Canadian Medical Association (CMA) has become a champion of e-health. In a stark admission in its 2011 privacy policy guidelines, the CMA tells doctors that they have an obligation to inform their patients that, when information flows from EMRs to EHRs, the physician has no ability to ensure the confidentiality of the information.

In British Columbia, the province has gone from having some of the best e-health legislation to some of the worst, leading the BCCLA to fight for a disclosure directive. This is what it allows: even though a patient has no ability to stop the flow of information into the repository, he or she can still put a directive on it by way of a special PIN that means that the person not related to the patient will only get a blank screen. In other words, the health data will be locked down without that PIN. This method is not air-tight, but it is better than nothing. Nevertheless, it is problematic, for the government will not tell anyone that there is such a measure. What results is a de facto honour system: one does not look up records one is not supposed to look up.

In B.C., there are five planned health information repositories. A separate disclosure directive is needed for each of them, and each takes two to four months to enact, requiring a lot of paperwork simply to maintain a reasonable level of medical confidentiality.

The pervasiveness of social media can compromise a person's health privacy rights.

However, there are two associated developments that will greatly risk privacy rights. The first is a governmental workaround to this planned system in the form of Bill 11 of 2010. This legislation would allow the B.C. minister of health to commandeer any personal health information in that system and send it anywhere he chooses. It is unbelievably broad and done for an undefined "administrative purpose." Because the government makes privacy legislation, whenever it chooses it can provide the exemption for itself to allow it to do what it was planning to do in the first place: to give itself an "out."

Another recent announcement, to the shock of privacy advocates, is that the government is considering a smart card, which would be a combination driver's licence and medical services plan card. It would be chipped and unencrypted. No one knows what access to databases it would give.

The BCCLA has been promoting the so-called "push model" for e-health. The government "pull model" allows it to pull a patient's information from anywhere and put it in a giant "honey pot" it claims is secure, and distribute it wherever it is good to distribute to. Instead, what is required is an electronic highway where responsible health-care providers, in conjunction with patients, push the information where it needs to go and never anywhere it does not need to go.

Renée Lang, staff lawyer at HALCO, the HIV & AIDS Legal Clinic (Ontario)

The pervasiveness of social media can compromise a person's health privacy rights. An example is the HALCO case involving a client who was the target of a blog from a former friend. While the client's name was not on it, it was clear that is was about him. Because the blog was defamatory, HALCO sent a letter, which the individuals subsequently scanned and placed on the blog. As a result, anyone who looked at the blog would know that the client had HIV or could at least figure that out. In addition, his contact information was posted. Eventually, everything came down off of the site.

This illustrates that, even if someone does not put one's own sensitive health information up on-line, some-

one else might do so. There is not much that lawyers can do about it. Major Internet players like Google and Facebook will not respond. To be sure, one can sue either entity; and, once they are informed of such privacy violations or defamation, they have a duty to remove it in a reasonable time. However, that is the theory; the reality is usually another story.

If the person who violates someone's privacy rights does not have money, then there is no point in suing. There is also no protective legislation in place. The federal privacy legislation applies only to commercial activities; the Ontario privacy legislation applies to health information, but only to health information custodians. In the case of the HALCO client (cited above), he had to wait it out, with the help of lawyer letters. (The blog was up for about a year.)

Another example comes from Facebook. A client was suing someone for breach of privacy because the latter had revealed his HIV status. The person being sued responded to the legal action by creating a Facebook account in the client's real name with an actual photo (taken freely from the Internet). He began to "friend" the client's family, who did not know that he was HIV-positive. He had him join many HIV and gay groups via his profile. He also created fake posts in the client's name. To its credit, Facebook will respond to this behaviour and take corrective action. However, no legislation in Canada exists to protect Canadians from this.

What is to be done? There is the option to sue Facebook or Google. In the Ontario case *Jones v. Tsige*,[1] a Superior Court judge decided that there was no cause of action for breach of privacy. One cannot go to a judge and say, "I want him to pay me because he breached my privacy." HALCO is working to correct that, yet it remains difficult to prove that a client suffered actual harm from the breach. For example, how does one separate out the mental distress that might be caused by other things in a client's life?

In four provinces — British Columbia, Newfoundland, Saskatchewan and Manitoba — legislation exists in which a person can sue someone for breach of privacy and not have to prove damages. HALCO is pushing for Ontario to do the same. However, even if a person does win, damages will be very low: perhaps $5000 on average.

Recognition should exist of the right to privacy, not simply a right to sue for it. It is hoped that someone from a court or legislature will come out in explicit support of this right. In *Jones*, the judge basically said, "You do not have a right to this." Having a minimum damage level would very beneficial, too.

Maude Perras, Montréal-based litigation lawyer

The line between private and public life in the age of electronic information is often blurred, and it can impact on the right to one's image and privacy in social and traditional media. The definition of "private life" is now more fluid. The social media are transforming perceptions of what space is private and what space is public. As a result, traditional media are getting access to "public" information that would normally be considered private. This transformation can have major repercussions on "public interest" court cases where a person's HIV status is at issue.

In Quebec, the law is strong on protecting privacy rights. The provincial Supreme Court ruled that one has an almost absolute right to one's image and to control it. A person's image cannot be used without their consent unless the use is in the public interest. However, the weakness is in the determination of what constitutes the "public interest." It can encompass an issue or person of public importance or an issue of public security.

The definition of "private life" is now more fluid with the rise of social media.

Social media are not considered private life. In terms of images published in the social media, an image used on the Internet with the subject's consent has come into the public domain. A recent case-law example from Quebec highlights this point. A transsexual well-known in Quebec-based social networks had her image used without her consent. As a result, she took legal action, saying that her right to privacy had been violated. The image was used on a blog, and it was modified. The judge ruled that, at the moment that the image was used on several social media platforms, it fell into the public domain. It did not matter who took

and used that image for whatever ends (in the public domain).

Another example comes from Québec City. This case, currently before the courts, concerns an HIV-positive gay man accused of having unprotected sex without having divulged his status. He had been on a gay meet-up site where he advertized himself as a bare-backer. Many of those who had unprotected sex with him took action against him. As part of their investigation, the police created a false profile on the site in order to look at that of the accused, to see if he indeed offered unprotected sex without revealing his HIV status. They were also able to enquire of other users if they had had unprotected sex with the man. (It is a very public site.) In the end, 15 individuals took legal action against the accused. Thus, just by creating an account, police were able to get this information quickly — quicker than other traditional investigative means.

When information is placed on social sites like Twitter and Facebook, it no longer remains a part of private life. Most people are not aware of this. Moreover, that information can be used by police, the media and one's employer, creating further concerns for the integrity and privacy of one's personal data, health-related or otherwise.

Does an individual have a right of action against the media in such instances? According to the Supreme Court of Canada,[2] the right to a fair trial does not trump freedom of expression. The accused must prove that the media's dissemination of the information will cause him or her harm.

[1] *Jones v. Tsige*, 2011 ONSC 1475.

[2] *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835.

Workshop — HIV and the Media

Two separate workshops brought together panellists with experience in mainstream print and broadcast media, as well as in social media. Symposium participants were able to enrich their understanding of the role of the media — and the realities that they face — in covering issues related to HIV/AIDS.

The first session included six print, broadcast and on-line journalists, representing such media outlets as the Canadian Broadcasting Corporation, *The Toronto Star* and Global News. The panellists noted that coverage of HIV has changed and evolved over the years, and speculated on what factors would continue to attract media attention and garner broad public support.

Some of the key insights gleaned related to the need to overcome media fatigue with HIV — especially as the science is not evolving as quickly as it once did — and for advocates to find creative ways to present the ongoing challenges of their work. It was thought that a degree of complacency among media outlets with respect to HIV has become the norm, and that the social and public policy issues around HIV are currently the most compelling avenues for coverage. It was widely agreed that HIV is no longer making the front page as it once did; however, the journalists felt that organizations might pay closer attention to the news cycle and cultivate stronger relationships with sympathetic journalists. They expressed some frustration that

there was often not the high level of dialogue that should be happening around HIV. Overall, it was felt that preparation and proactive relations with media would ultimately result in better and more informed coverage.

In the second workshop, five experts in social media from such organizations as UNICEF Canada and the AIDS Committee of Toronto discussed the role that social media play in their work, particularly as an important tool for outreach in today's increasingly connected world. The panellists stressed that social media platforms are being used and accessed by people of all ages and that open dialogue on a range of topics — including HIV and human rights — is constantly evolving via these channels. In particular, the panellists noted that organizations around the world are now developing social marketing strategies to generate interest in their cause or product, and informing themselves about on-line social behaviour. Overall demand for information is increasing exponentially and the use of social media has become even more appealing as a result.

One important question among many tackled by the panel was how an organization can maintain credibility in the world of social media. The panellists responded that organizations should be accurate in their output, consistent in their use of social media, as well as patient with constantly evolving applications. The conclusion was that social media platforms are relevant, necessary and here to stay. The panellists challenged organizations to use these fora to expand and nuance their advocacy around important issues such as the intersection of HIV and human rights.