Women & HIV

This is one in a series of four info sheets on the human rights of women living with or vulnerable to HIV in Canada.

1. Women in Prison, HIV and Hepatitis C
2. Women and the Criminalization of HIV Non-Disclosure
3. Women, Sex Work and HIV
4. Women and HIV Testing

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

Women in Prison, HIV and Hepatitis C

"I would say about 80 percent of the women in the prison were using drugs. 35 percent would have to do sexual favours for the drugs. And 25 to 50 percent of the women would be injecting drugs. To inject, we would use used needles from the nurse's office, which we stole. Anywhere from 10 to 15 people would share one needle over a month's time.... I also got a tattoo. I know the needle for my tattoo had been used a lot; I don't know where it came from or who had used it. Back then, we were not allowed bleach, so we never used it to clean our needles. We were aware of getting hepatitis C and HIV from sharing needles, but we didn't care. Being in there, we felt our lives sucked so it didn't matter anyway."

— Woman formerly incarcerated in the Prison for Women in Kingston, Ontario

Women in prison: a Canadian snapshot

Incarcerated women constitute a small minority of the prison population in Canada. Nevertheless, they are among the most marginalized people in Canadian society, not only because they lack power in the prison context, but also because of the economic, social and political realities of their lives. Women in prison, more often than men, suffer from chronic health conditions resulting from poverty, drug use, gender-based violence, adolescent pregnancy, malnutrition, poor access to preventive health care and for Aboriginal and Black women, the effects of colonization, slavery and racism.

Among federally incarcerated women, one third is Aboriginal, 80 percent are survivors of physical and sexual abuse (a percentage that rises to 90 percent for Aboriginal women), a significant number are struggling with substance use, one in five is struggling with mental health problems, and many are single mothers with primary childcare responsibilities. While more than 80 percent of women in Canada have completed education beyond the ninth grade, the figure for women in prison is closer to 50 percent. Drug use also tends to figure more prominently in the lives and criminal offences of incarcerated women, who often perpetrate income-generating crimes to support their drug use. In particular, a previous history of injection drug use is consistently found more frequently among female than male prisoners in Canada. Consequently, more than half of all charges which bring female accused in contact with police are non-violent, property and drug offences.

Historically, the welfare of women prisoners was secondary to that of the larger male population. While women's correctional needs are profoundly different from men's, the Canadian Human Rights Commission has noted that the criteria by which federal prisoners are classified are designed according to white, male, middle-class standards, resulting in skewed discriminatory assessments of federally sentenced women and too many women being deemed a high-security risk. This leads to numerous hardships for these women since maximum-security prisoners are isolated in segregated living units and, unlike their minimum- and medium-security counterparts, are not eligible to participate in work-release programs, community-release programs or other supportive programming designed to enhance prisoners' chances of reintegration. Moreover, because there are fewer women's institutions and some exist in isolated locations, women are less likely to have

access to community-based support, and are more likely to be located far from their families, communities and other support networks. Geographic dislocation has a particularly isolating impact on Aboriginal women, many of whom come from more remote communities.

Incarcerated women are further neglected with respect to service provision. Because there are relatively small numbers of them in a given institution, it becomes difficult for prison authorities to justify specific services for women. As a result, women in prison struggle to access HIV services that are equivalent to those available to women outside prison, or even to men inside prison. This is compounded by the troubling reality that, as a whole, women infected with HIV or hepatitis C virus (HCV) already do not receive diagnostic and treatment services as early as do men. The needs of women infected with HIV or HCV also differ from those of men, yet appropriate social and community support is less frequently available and less accessible. Thus, women are often less educated than men about HIV and HCV infection and do not have the necessary support structures. Moreover, disease manifestations attributable to HIV infection can be different in women, leading to under-recognition or delays in diagnosis, when disease may be further advanced.

The inadequacy of health services in prison was evident in a 2003 study of women in federal institutions, the most comprehensive study of the specific needs of federally incarcerated women regarding HIV/HCV prevention, care, treatment and support to date. The majority of women interviewed described an overall dissatisfaction with the quality and accessibility of prison medical services, and women living with HIV and/or HCV identified numerous barriers to accessing adequate medical services. These included difficulty in obtaining blood tests, accessing physicians or specialists, obtaining adequate pain management, and accessing medications to relieve the side-effects of HIV and HCV therapies. Women also felt that HIV prevention education programs did not meet their needs, and women living with HIV and/or HCV strongly identified a lack of support and counselling services specific to their needs. In a subsequent 2010 study of federally incarcerated women by the Correctional Service of Canada (CSC), a recurring theme among the women surveyed was their dissatisfaction with the adequacy and accessibility of physical and mental health facilities in prison, and specifically the need for testing for sexually transmitted infections.

Facts and figures: women and the HIV and HCV epidemics behind bars

- Conflict with the law and incarceration are often a result of offences arising from the criminalization of certain drugs, and related to supporting drug use, or to behaviours brought about by drug use. **In Canada's federal prisons, over 1 in 4 women have been incarcerated on drug-related charges**.
- With some exceptions, **HIV and HCV infection is generally more prevalent among women than men in prison, particularly among those who have a history of injection drug use**. In a study of provincial prisons in Quebec, the HIV and HCV rate among incarcerated women was, respectively, 8.8 and 29.2 percent, compared to 2.4 and 16.6 percent among male prisoners. In a 2007 nationwide survey by CSC, the HIV and HCV rate among federally incarcerated women was 5.5 and 30.3 percent, compared to 4.5 and 30.8 percent among federally incarcerated men. Aboriginal women reported the highest rates of HIV and HCV, at 11.7 and 49.1 percent, respectively. In a study of female prisoners in British Columbia (B.C.), self-reported rates of HIV and HCV were 8 percent and 52 percent, respectively.

> ***"Women in prison struggle to access HIV services that are equivalent to those available to women outside prison, or even to men inside prison."***

- While the majority of women in prison are voluntarily tested for both HIV and HCV, the provision of **pre- and post-test counselling has been reported to be poor, and in some cases, non-existent**. Women in prison are more likely than women in the general population to have faced violence and abuse; therefore, counselling accompanying HIV diagnosis is particularly important.
- Women in prison have **concerns about the privacy and confidentiality of their HIV status**. Women have reported being forced to draw unwanted attention

to themselves by accessing HIV medications, HIV and HCV testing services, therapies and diets (which may be dispensed at specific times in a public space) and by requesting safer sex materials and bleach from correctional staff. Violations of women's right to privacy and confidentiality have significant repercussions in prison, where rampant stigma and discrimination exists against people living with HIV.

> ***"Women in prison are more likely than women in the general population to have faced violence and abuse."***

- For many women, drug use in prison is a means of coping with trauma and alleviating pain and anxiety, including anxiety about losing custody of their children as a result of their criminal record. In a 2007 national survey, **1 in 4 women in federal prisons admitted using drugs** in the past six months in prison, and **15 percent of women admitted injecting drugs**. Of those women, **41 percent used someone else's used needle, and 29 percent shared a needle with someone who had HIV, HCV or an unknown infection status**. Similarly, in both a national study of federally incarcerated women and a provincial study of women in a B.C. prison, **1 in 5 women was engaging in injection drug use behind bars**.
- In a 2007 national study, **30 percent of federally incarcerated women reported oral, vaginal or anal sex**. In a 2003 study of women in federal prisons, **1 in 4 was having unprotected sex**.
- In a 2003 study of women in federal prisons, **1 in 4 women was tattooing**. In a 2003 study of provincial prisons in Quebec, 9 percent of women had engaged in tattooing or piercing in prison.
- **Women are more likely than men to take part in self-harming behaviour such as slashing and cutting** as a coping strategy frequently linked to experiences of sexual abuse in childhood. In a 2003 study of women in federal prisons, 9 percent of the women interviewed had engaged in slashing or cutting of their own skin or other forms of self-injury. In a subsequent 2010 study of women in federal prisons, 36 percent took part in some form of self-harming behaviour during incarceration.
- Chronic pain can be a symptom of both HIV and HCV infection, so access to effective pain management is a common health concern for people living with these diseases. However, women have reported barriers to pain management in prison. Women whose **pain management needs** are ignored by staff may resort to managing their pain by using illicit drugs via non-sterile injection equipment.

While CSC and some provincial and territorial prison systems mandate the provision of condoms, dental dams, lubricant, bleach to sterilize injection equipment, and methadone treatment, their availability is inconsistent across the country. Where there is a policy in place directing the provision of a harm reduction measure, women have cited irregular distribution, insufficient quantities and a lack of confidentiality as an impediment to access. For example, women are required to request safer sex measures or bleach from either health care staff or correctional officers, forcing them to self-identify as sexually active or as an injection drug user, activities that are prohibited behind bars and for which women can be heavily punished, including through the imposition of longer sentences and solitary confinement.

No prison system in Canada permits harm reduction measures such as needle and syringe programs and safer tattooing options, despite significant evidence of high-risk behaviours related to these practices and women's desire to access such measures. The absence of sterile injection equipment is particularly problematic in light of the pervasiveness of injection drug use behind bars, the frequency of sharing used needles to inject drugs and the inadequacy of bleach to sterilize injection equipment. As the Canadian Human Rights Commission has noted, the impact of sharing injection equipment is greater on women than on men "because of the higher rate of drug use and HIV infection in this population," an impact that "may be particularly acute for federally sentenced Aboriginal women." The Commission further noted that denying prisoners harm reduction measures that are consistent with accepted community health standards exposes them to increased risk, and recommended that "the Correctional Service of Canada implement a pilot needle exchange program in three or more correctional facilities, at least one of which should be a women's facility."

Women, prison and law

Canadian and international law and policy requires that prisons be gender-sensitive, particularly with respect to women's health. In federal prisons, for example, the Correctional Service of Canada (CSC) mandates that "[t]he gender and cultural requirements of individuals and groups shall be respected and reflected in all activities aimed at addressing infectious diseases in the inmate population" (Commissioner's Directive 821, s. 10), while the *Corrections and Conditional Release Act* requires that CSC provide programs designed particularly to address the needs of women and Aboriginal people in prison (ss. 77 and 80).

Internationally, there is increasing recognition that the needs of women prisoners are not being met and that States must give recognition to incarcerated women's specific needs. For example, the 1993 *WHO Guidelines on HIV Infection and AIDS in Prisons* state that "special attention should be given to the needs of women prisoners," and specify that "staff should be trained to deal with the psychosocial and medical problems associated with medical infection in women" (Guideline 44). Correspondingly, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (United Nations Office on Drugs and Crime, 2006) calls for initiatives that "reflect the fact that in many countries women face increased vulnerability to HIV infection, have higher rates of HIV infection in prisons than men, engage in risk behaviours differently than male prisoners, and generally serve shorter sentences than men" (Action 56, p. 24).

As with all prisoners, women do not surrender their rights when they enter prison, and retain all human rights that are not necessarily removed as a consequence of their imprisonment.[1] This includes:

- the right to the "highest attainable standard of health;"[2]
- the right to life;[3]
- the right to liberty and security of the person;[4]
- the right to equality and non-discrimination, including with respect to health services;[5]
- the right not to be subjected to cruel and unusual treatment or punishment; and[6]
- access to a standard of health care that is equivalent to that available in the community.[7]

These provisions require, at minimum, that women in prison have access to health care at least to the standard available to women in the community. Given the considerably higher prevalence of HIV and HCV among incarcerated women, this means prisons must make a comprehensive range of harm reduction measures available, including prison-based needle and syringe programs.

Recommendations for policy and law reform

- **Develop alternatives to imprisonment**. Most women are in prison for non-violent offences and pose no risk to the public. Any comprehensive strategy in response to HIV in prison settings should seek to reduce overcrowding as it can create conditions which can lead to sudden outbreaks of violence, including sexual violence. Consideration should be given to the development and implementation of non-custodial strategies for women, particularly during pregnancy or when they have young children.
- **Provide equivalent health services to those available in the community**. All prisons should make condoms, dental dams, lubricant, bleach, opiate substitution therapy, adequate pain management medication, and information on safer slashing or cutting available and accessible. In particular, those provinces and territories that do not yet provide these harm reduction measures should develop policies to introduce them in all their prisons.
- Policies should be developed to **make sterile injection equipment and safer tattooing options available and genuinely accessible in prison**, as they are in the community, in accordance with accepted best practices governing such programs operating in the community.

- **Pre- and post-test counselling for HIV and HCV testing should be mandated and provided for all prisoners**. Women in prison should only be tested for HIV and HCV with their informed consent, and no one should be tested without receiving pre- and post-test counselling.
- **Prisoners' rights to confidentiality and privacy must be respected**. The security of women's personal information, such as medical records and health information, must always be respected. Furthermore, women's access to HIV- and HCV-related prevention education, therapies, diets, counselling and support, testing, and prevention and harm reduction measures should be promoted by ensuring the confidentiality of those who partake in such programs or measures.
- **Meaningfully involve prisoners living with or vulnerable to HIV/HCV in policy design**. Enabling those most directly affected to draw on their lived experiences will increase the effectiveness and appropriateness of policies and programmes to address HIV and HCV behind bars.

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[1] S. 4(e) of the *Corrections and Conditional Release Act* (CCRA) and *Basic Principles for the Treatment of Prisoners*, Principle 5.

[2] Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* and Article 12 of the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW). Section 86 of the CCRA also mandates CSC to provide every person in prison with "essential health care" that will contribute to his or her rehabilitation and reintegration into the community.

[3] Article 6 of the *International Covenant on Civil and Political Rights* (ICCPR) and s. 7 of the *Canadian Charter of Rights and Freedoms* (Charter).

[4] Article 9 of the ICCPR and s. 7 of the Charter.

[5] Article 26 of the ICCPR, CEDAW and s. 15 of the Charter.

[6] Article 7 of the ICCPR and s. 12 of the Charter.

[7] See, for example, UN *Basic Principles for the Treatment of Prisoners*, 1990, Principle 9; WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006; UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997), p. 3. Under Canadian law, s. 86(2) of the CCRA stipulates that medical care for prisoners "conform to professionally accepted standards," thereby implying a right to comparable health care as offered in the community at large.

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Women and the Criminalization of HIV Non-Disclosure

Women, HIV and the criminal law

In Canada, people living with HIV have a legal duty, under the criminal law, to disclose their HIV status to sexual partners before having sex that poses a "realistic possibility of transmission," as defined by the courts.[1] Regardless of whether HIV transmission occurs or not, people living with HIV can be charged with aggravated sexual assault, one of the most serious offenses in the *Criminal Code of Canada* even if they had no intent to cause any harm.

The legal obligation to disclose one's HIV status was established by the Supreme Court of Canada (SCC) in *R. v. Cuerrier* in 1998.[2] In 2012, the law became harsher after the SCC released its decisions in *R. v. Mabior* and *R. v. D.C.*[3] and established that people living with HIV were now at risk of prosecution *even if* they used condoms or had a low or undetectable viral load.

Criminalizing HIV non-disclosure has been widely criticized by the HIV community and women's rights advocates, legal experts, clinicians and nurses as the wrong approach for addressing HIV exposure. HIV criminalization undermines public health efforts to combat HIV and contributes to HIV-related stigma and discrimination. The current use of the criminal law in Canada ignores the complexity of disclosure as well as tremendous advances in HIV treatment and prevention, and often results in great injustice for those being prosecuted.

Arguments for criminalizing HIV non-disclosure often position the law as a tool to protect women from HIV infection and enhance women's dignity and autonomy with regard to sexual decision-making. In its 2012 decision, the SCC repeatedly asserted, without much explanation, that its approach was in line with the values of equality and sexual autonomy outlined in the *Canadian Charter of Rights and Freedoms*. This perception is reinforced by the fact that (a) most people charged to date are HIV-positive men who had sex with women and (b) sexual assault law is applied in cases of alleged non-disclosure — a body of law traditionally meant to protect women from gender-based violence.

As of this writing, at least 18 women in Canada have been charged in relation to HIV non-disclosure, but the impact on women goes much further. A gendered analysis of the current use of the criminal law with respect to HIV non-disclosure reveals that criminalization is a blunt, punitive and inflexible approach to HIV prevention that does little to protect women from HIV infection, violence, coercion or sexual objectification. The current use of the criminal law has serious adverse impacts on women living with HIV, especially those who live in poverty, face stigma and discrimination, have insecure immigration status, or are in abusive or dependant relationships.[4] Moreover, the use of sexual assault law in the context of HIV non-disclosure — where the sexual activity is consensual — is a poor fit and can ultimately have a detrimental impact on sexual assault law as a tool to advance gender equality and renounce gender-based violence.[5]

Facts and Figures

- People living with HIV can be prosecuted for not disclosing their HIV-positive status to a sexual partner before having sex that represents "**a realistic possibility of HIV transmission**."
- **The courts decide what "realistic possibility of transmission" means.** In *R. v. Mabior*, the SCC stated that "as a general matter, a realistic possibility of transmission of HIV is negated if: (i) the accused's viral load at the time of sexual relations was low and (ii) condom protection was used." The Crown must also prove that the complainant would not have consented to sex if they had known about their partner's HIV-positive status.

- Based on scientific evidence, the probability of HIV transmission during one act of penile-vaginal intercourse (without a condom or a low viral load) is about 0.08% or 8 in 10,000. Studies suggest that the **probability of HIV passing from a woman to a man** is about half that of it passing from a man to a woman (i.e. 0.04% or **4 in 10,000**).[6]

- Where a **condom** is used ***or*** where the HIV-positive individual is on **effective antiretroviral** therapy, vaginal or anal sex poses **negligible**[7] to no possibility of transmitting HIV.

- In 2016, the PARTNER study found **zero HIV transmissions after HIV sero-discordant couples had condomless sex** over 58,000 individual times.[8] The HIV-positive partner was on antiretroviral therapy and had a viral load below 200 copies/ml.

- When used correctly and no breakage occurs, **condoms are 100% effective** at stopping the transmission of HIV.[9]

- Oral sex performed by an HIV-positive individual on an HIV-negative individual poses no possibility of transmitting HIV. **Cunnilingus** performed on an HIV-positive woman has **never been definitely associated with transmission of HIV**.[10]

- **Being spat** on by an HIV-positive individual poses **no possibility** of transmitting HIV.[11]

- **Being bitten** by an HIV-positive individual poses a **negligible possibility** of transmitting HIV when the biting breaks the other person's skin and the HIV-positive individual's saliva contains blood. Otherwise, being bitten by an HIV-positive individual poses no possibility of transmitting HIV.[12]

- **More than 180 people have been charged for HIV non-disclosure before sex in Canada (i.e., from 1989 to December 2016) including 18 women living with HIV, 6 of whom are Indigenous**.[13] Indigenous women are over-represented among women charged for HIV non-disclosure.

- Women living with HIV have also been charged in relation to spitting and biting.

- With the exception of a handful of prosecutions related to other sexually transmitted infections (i.e., herpes, hepatitis B and hepatitis C), **prosecutions for non-disclosure have focused on HIV only**.

- Nearly all women charged for HIV non-disclosure in Canada have been charged with **aggravated sexual assault** which carries a **maximum penalty of life imprisonment and sexual offender registration**.

- Women living with HIV, including women who have been charged for non-disclosure, are at high risk of violence. In a recent study of women living with HIV in Canada, **80% of participants** reported having **experienced violence** in adulthood, **including 43%** who reported experiencing **sexual violence**.[14]

Protecting women?

Effective prevention requires full access to HIV testing, care, treatment and support. It involves encouraging testing and safer sex practices and making disclosure safe for people living with HIV. It includes empowering women to protect themselves and others by implementing programs that take into account the intersectionality of race, gender, experience of colonization, and other social determinants of health. It also requires addressing the pervasive violence against women that increases their risk to HIV and creates barriers to access to treatment, care and support and to HIV disclosure.

The criminalization of HIV non-disclosure does not respond to any of these objectives. While more research on the specific impact of the criminalization on women's access to care, treatment and support is needed, existing evidence suggests that the criminalization of HIV non-disclosure compromises access to HIV prevention and treatment by increasing HIV-related stigma, discouraging HIV testing for some individuals and spreading misinformation about HIV and its transmission. The current use of the criminal law also compromises engagement in care by reducing the willingness of people living with HIV to have open and candid discussions regarding HIV disclosure and their sexual lives due to a fear that discussions with clinical care providers, public health professionals or other support workers may be used as evidence against them in criminal proceedings.[15]

Moreover, the criminalization of HIV non-disclosure does nothing to advance sexual autonomy or protect women from gender-based violence. Many women are unable to make autonomous decisions about when to have sex, with whom, what type, and whether to use condoms. The reasons for this lack of autonomy are diverse and include being under the pressure of cultural norms, living in a situation of dependence or economic insecurity, lacking confidence and negotiation skills, as well as experiencing

violence and coercion. But the criminalization of HIV non-disclosure will not change any of these factors or make women any more autonomous. On the contrary, the threat of prosecution for alleged non-disclosure has been used as a tool of abuse by vindictive partners against women living with HIV. The threat of prosecution can also discourage some women living with HIV from leaving abusive relationships or reporting sexual assaults to the police for fear that their HIV status might be used against them,[16] thus pushing women further away from autonomy, justice, dignity and safety.

Women living with HIV: from "victims" to "sexual offenders"

Because most of the prosecutions for HIV non-disclosure have been against men who had sex with women, women are usually seen as "victims" in HIV non-disclosure cases. But once infected with HIV, women become vulnerable to prosecution, being cast as "sexual offenders" if they do not disclose their status (or cannot prove they disclosed).

Most of the women convicted of HIV non-disclosure occupy marginalized positions that may have contributed to putting them at risk for HIV infection. Moreover, their social position in society may have made disclosure of their HIV status particularly challenging. Some are survivors of violence including sexual violence, some are living in socioeconomic insecurity, some were struggling with mental health issues, some have insecure immigration status or are members of racial or ethnic minority communities who continue to suffer from the effect of colonization, slavery and racism. Some have acquired HIV through forced or coerced sex. As a result of HIV criminalization, they have become the new faces of sexual offenders.[17]

The fact that the law has not caught up with the science also increases the risks of prosecutions for women who are marginalized. Some women may not be in a position to impose condom use on their male sexual partner.[18] Others may not be able to achieve a low or undetectable viral load. Indeed, evidence suggests that women living with HIV in Canada experience specific barriers to treatment access and outcomes.[19] By suggesting that the law requires both a condom and a low or undetectable viral load to preclude a legal duty to disclose under the criminal law, the decision of the Supreme Court of Canada in *R. v. Mabior* is not only at odds with medical evidence regarding the risk of HIV transmission, but also very problematic from a gender perspective.[20]

A recent Canadian study conducted among sexually active men and women living with HIV who inject drugs confirmed these concerns. The study showed that nearly half (44%) of participants could face a legal obligation to disclose their HIV status because they either did not practice consistent condom use or did not have a low viral load. Notably, women were significantly more likely than men to face a legal duty to disclose based on a strict reading of the *R. v. Mabior* decision (55% of women v. 35% of men). However, and consistent with evidence showing a negligible risk of HIV transmission associated with condom use or a low viral load, if either of these HIV prevention strategies were considered sufficient to avoid criminal liability for non-disclosure, less than 2% of participants would face a legal obligation to disclose.[21]

HIV disclosure: a personal and complex undertaking

Disclosure of one's HIV-positive status is generally an intensely personal and complex undertaking.[22] Moreover, stigma and discrimination against people living with HIV remain very real in our society, making it difficult for people to reveal their status. Research on women and HIV highlights the difficulty that many women experience in disclosing to men, especially men on whom they are dependent.[23]

Studies have suggested that the desire to be morally responsible towards their sexual partners and to protect their partners' health often motivates women living with HIV to disclose their status. But fear that a partner may share the information with others and concerns around preserving the confidentiality of their HIV status prevent some women from disclosing.[24] These concerns around confidentiality are particularly real in tight-knit communities in which many immigrant women live in Canada and where the experience or fear of gossip is particularly prominent.[25] They are also particularly real for mothers who may be concerned about the repercussions of disclosure on their children. Mothers living with HIV already face increased surveillance by health and social service providers, friends, family and their community, which, in turn, may result in a need to isolate themselves to protect their privacy and reduce HIV-related stigma and discrimination.[26]

HIV disclosure is not always a simple, one-step process; in fact, the decision to disclose and the timing for disclosure may differ depending on the context and the nature of the sexual relationship. Moreover many women in longer-term heterosexual relationships may face gender-specific

HIV Criminalization: Listening to women's stories

In 2005, D.C. was charged in Quebec for not disclosing her status to her ex-partner before the first time they had sex. The couple had a relationship for four years after she disclosed her status to him. The end of the relationship was marked by violence, and she turned to the police for protection. At this point, he complained to the police that she had not disclosed her HIV-positive status before their first sexual encounter.[27] He said that this first instance of sex had been unprotected, whereas she said they had used a condom. At trial, she was convicted of aggravated assault and sexual assault and sentenced to twelve months' house arrest. In contrast, for his assaults, her ex-partner received an absolute discharge. HIV was never transmitted. In 2010, D.C. was acquitted by the Court of Appeal on grounds that her viral load was undetectable at the time of the relevant sexual encounter. As a result, although the trial judge had found that no condom was used, sex did not represent a significant risk of HIV transmission triggering the duty to disclose. In 2012, the SCC upheld D.C.'s acquittal but solely on technical legal grounds regarding how the trial judge dealt with the evidence on condom use in the case. If it weren't for this technicality, she would have been convicted based on a strict application of the Mabior decision.[28]

In 2009, a woman pleaded guilty to aggravated sexual assault after a single sexual encounter. She had asked for a condom to be used and then disclosed her HIV status when the condom broke. Despite the fact that she had practised safer sex, disclosed when the condom broke and that her partner was not infected with HIV, she was still sentenced to two years' house arrest, three years' probation and registered as a sex offender. She was described by the sentencing judge as "a lonely woman who feared rejection" because of her HIV status.[29] That may explain, at least in part, why she chose not to disclose her HIV-positive status. As a result of the prosecution, her picture and story were published in the media.

In 2011, a 17-year-old girl, living on the streets was charged for not disclosing her HIV status before having sex with two teenage boys. The community centre where she found shelter contacted the police.[30] Her name, picture and HIV-positive status were published and distributed by the media prior to a publication ban being issued.[31]

In 2013, a 50-year-old woman was sentenced to 10 months in jail for spitting on police officers. She had called police because a man who was drunk had refused to leave her apartment.[32]

In 2013, a woman living with HIV was convicted to 39 months in jail in Ontario for not disclosing her status before one instance of casual sex without a condom.[33] Her viral load at the time was undetectable and the risk of transmission was therefore close to zero, if not zero. The woman was also charged for receiving oral sex while her viral load was undetectable. The Crown prosecutors refused to drop charges although their expert testified that "you have a better chance of having a piano fall on your head than you do contracting HIV through oral sex." [34] She was eventually acquitted on the oral sex charge.

In March 2016, a 29-year-old Indigenous woman was sentenced to two years in jail for the crime of aggravated sexual assault. More than four years ago, she had sex without a condom with a friend on three occasions. She did not disclose the fact that she was HIV positive. The woman, a survivor of sexual violence in both her family and her relationships with partners, is now registered as a sex offender.[35] At the time of this writing, she is appealing her conviction.

challenges related to HIV disclosure; e.g., a partner's expectations that safer sex practices will cease once a relationship becomes "serious," expectations related to childbearing, or assumptions about women's sexuality that may vary from one community to another.

Given the gendered power relations in many relationships, the prevalence of violence against women in our society, and ongoing HIV-related stigma, many women worry about the reaction of their partners if they reveal that they are living with HIV. Fear of violence, abandonment or rejection can lead some women to conceal their status or delay disclosure.[36] A study conducted among African and Caribbean communities in Toronto reported that some women living with HIV encounter problems with male partners after an HIV diagnosis: women "described verbal, psychological or physical abuse, which either followed or was aggravated by disclosure of their HIV status to their partners."[37] Recent evidence from British Columbia shows that women whose status has been disclosed without their consent are five times more likely to experience HIV-related violence.[38]

By its nature, the criminal law is unable to respond to the challenges and complexities of HIV disclosure for women. Instead, it increases the vulnerability of women living with HIV to abuses by exposing them to the possibility of false allegations, investigations and even criminal trials. Service providers have reported that some HIV-positive clients in serodiscordant relationships (where one partner is HIV positive and the other is HIV negative) have been blackmailed and harassed by vindictive partners.[39] Studies also have reported high rates of sexual abstinence among women living with HIV, associated with HIV-related stigma.[40] Emerging evidence demonstrates that intentional sexual abstinence is partly driven by concerns about HIV criminalization and fear of HIV disclosure.[41] By creating anxiety and fear and by reinforcing vulnerabilities, criminalization has an impact on women's well-being that goes far beyond actual prosecution.

The misuse of the law of sexual assault

The specific use of the law of aggravated sexual assault in cases of HIV non-disclosure is particularly problematic. The offence of aggravated sexual assault is usually reserved for the most violent rape that "wounds, maims, disfigures or endangers the life of the complainant," [42] but people living with HIV have been convicted of aggravated sexual assault even when transmission did not occur.[43] Most importantly, HIV non-disclosure cases are very different from sexual assaults. In these cases, both partners consented to the sexual activity. (If they do not, then HIV non-disclosure is not the crux of the issue.)

Violence against women generally — and sexual assault in particular — remains a persistent and deplorable reality in Canada. Equating HIV non-disclosure with a violent crime like sexual assault trivializes the offence of sexual assault and diverts the law of sexual assault and associated resources from its original purposes. HIV non-disclosure may result from a lack of power as opposed to an exercise of power or objectification of the complainant, making the aggravated sexual assault charge and sexual offender label even more disproportionate and unjust. Equating HIV non-disclosure with assault also reinforces stigma associated with HIV and results in disproportionate penal consequences for HIV-positive women charged for HIV non-disclosure.

The way forward

Because of the numerous human rights and public health concerns associated with HIV-related prosecutions, the Joint United Nations Programme on HIV/ AIDS (UNAIDS) and the United Nations Development Programme (UNDP),[44] the UN Special Rapporteur on the right to health,[45] and the Global Commission on HIV and the Law,[46] among others, have **all urged governments to limit the use of the criminal law only to cases of *intentional transmission of HIV*** (i.e., the HIV-positive person knows their status, acts with the intention to transmit HIV, and does in fact transmit it). Moreover, UNAIDS recommends that no prosecutions should take place when people have used a condom or had a low viral load or practiced oral sex.[47]

In November 2016, the UN Committee on the Elimination of Discrimination against Women denounced Canada's "concerning application of harsh criminal sanctions (aggravated sexual assault) to women for non-disclosing their HIV status to sexual partners, even when the transmission is not intentional, when there is no transmission or when the risk of transmission is minimal" and advised Canada to "limit the application of criminal law provisions to cases of intentional transmission of HIV/AIDS, as recommended by international public health standards." [48]

In Canada, women's rights advocates and researchers also are increasingly expressing concerns about the current use of the criminal law against people living with HIV.[49] In spring 2014, the Canadian HIV/AIDS Legal Network convened leading feminist scholars, frontline workers, activists and legal experts for a ground-breaking dialogue on the (mis)use of sexual assault laws in cases of HIV non-disclosure. The conclusions of the dialogue demonstrated this approach both over-extends the criminal law against people living with HIV and threatens to damage hard-won legal definitions of consent aimed at protecting women's equality and sexual autonomy. Multiple research projects looking at the impact of HIV criminalization and increased surveillance of women living with HIV are also underway.[50]

These efforts led to a historical recognition in December 2016 by the federal government of the problematic overly broad use of the criminal law against people living with HIV in Canada.[51] Measures now need to be taken at both provincial and federal levels to put an end to unjust prosecutions.

Recommendations for policy and law reforms

The following recommendations are in line with best practice, and international, evidence-based recommendations:

- The use of the criminal law should be limited to extremely rare cases of **intentional transmission of HIV**.
- In **no circumstances** should the criminal law be used against people living with HIV who use a condom or have condomless sex with a low or undetectable viral load or who practice oral sex for not disclosing their status to sexual partner(s).
- The offence of **sexual assault should not apply** to HIV non-disclosure as it constitutes a stigmatizing misuse of this offence.

In consultation with the community, federal and provincial governments must take action to limit HIV criminalization and bring the law in line with international recommendations, science and human rights by

- exploring possible options for **legislative reform**
- developing sound **prosecutorial guidelines** at a provincial level
- exploring **alternatives** to criminal charges and prosecutions
- providing **support to potential complainants** in cases of HIV non-disclosure
- developing **training and resources** for police, Crown prosecutors and prison staff around HIV
- taking measures to combat **violence, harassment, stigma, discrimination and intimate partner violence** against women, including women living with HIV

For more information

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HIV Disclosure to Sexual Partners: Questions and answers for newcomers, Canadian HIV/AIDS Legal Network, 2015. Available at www.aidslaw.ca/site/hiv-disclosure-to-sexual-partners-qa-for-newcomers.

Women living with HIV and intimate partner violence: Questions and Answers, Canadian HIV/AIDS Legal Network, 2016. Available at www.aidslaw.ca/site/women-living-with-hiv-and-intimate-partner-violence-questions-and-answers.

For more information on HIV non-disclosure and the law of sexual assault, see the resources and publications listed at www.consentfilm.org/resources-and-publications.

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Women & HIV

This is one in a series of four info sheets on the human rights of women living with or vulnerable to HIV in Canada.

1. Women in Prison, HIV and Hepatitis C
2. Women and the Criminalization of HIV Non-Disclosure
3. **Women, Sex Work and HIV**
4. Women and HIV Testing

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Women, Sex Work and HIV

"Where are our rights, our human rights? You're allowed to talk. Even if the person is doing prostitution. I think it's their own rights. It's not anyone else's business."

— Canadian woman in sex work

Women and sex work: a Canadian snapshot[1]

In Canada, the exchange of sexual services for money or other valuables is legal. However, it is virtually impossible for those working in the sex industry to engage in it without running afoul of the criminal law, because prostitution-related provisions in the *Criminal Code* render activities related to sex work illegal in all but the narrowest circumstances.[2] This endangers the health and safety of sex workers because most measures that could be taken to increase their personal security are against the law. Sex workers may be forced to make decisions that render them unsafe in order to comply with the law or to reduce their risk of arrest, as well as that of their clients and managers. It also compromises the ability of sex workers to report violence against them.

Section 210

Under Section 210 of the *Criminal Code*, it is illegal to "keep," be found in, or knowingly be an owner, landlord, lessor, tenant, occupier, agent or otherwise have charge or control of a brothel or "common bawdy-house," which is defined in Section 197 as "a place that is (a) kept or occupied, or (b) resorted to by one or more persons for the purpose of prostitution or the practice of acts of indecency." This includes any defined space, public or private, enclosed or uncovered, used permanently or temporarily, which a person charged need not have exclusive right to use, and in which sexual intercourse need not necessarily occur.[3] Section 211 of the *Criminal Code* further outlaws knowingly transporting or directing a person to a common bawdy-house.

These provisions mean a sex worker who is working from her own home can be convicted of being "found in" a common bawdy-house, and where there are two or more sex workers working together under one roof, the sex worker with her name on the lease will likely be charged with "keeping" a common bawdy-house. These provisions have also been used to arrest owners, managers and support staff of brothels. In effect, Section 210 precludes the establishment of facilities where sex workers can bring their clients, including indoor venues where street-based sex workers can provide services in a clean and supportive space with effective security measures in place. A person found guilty of keeping a common bawdy-house can be imprisoned for up to two years. A person found guilty of being found in, or transporting or directing a person to, a bawdy-house can be sentenced to a maximum fine of $2000, six months' imprisonment, or both.

If a person is convicted of keeping a common bawdy-house and she does not own the premises, notice may be served on the owner, landlord or lessor of the

premises, who must take reasonable steps to terminate the person's tenancy or right of occupation or face a charge of keeping a common-bawdy house if the person re-offends.

Section 212

Section 212 of the *Criminal Code* prohibits a person from "procuring" a person to engage in prostitution. It also prohibits a person from "living on the avails" (i.e., the earnings) of a sex worker. Specifically, Section 212 makes it illegal to:

- induce a person to enter into, or engage in, sex work, whether through enticement or exploitation (economic or otherwise);
- conceal a person in a common bawdy-house or direct, take or induce a person to frequent a common bawdy-house; and
- live wholly or in part on the avails of prostitution.

Courts have interpreted the offence of living on the avails as only criminalizing "parasitic" relationships — that is, relationships between sex workers and people they are not legally or morally obliged to support. Individuals may be prosecuted for this offence even in the absence of evidence of coercion or control over a sex worker. For example, escort agency owners have been convicted of this offence even where the court has recognized a supportive relationship between the owner and sex workers. Evidence that a person lives with or is habitually in the company of a sex worker, or lives in a bawdy-house, is also considered proof that the person is living on the avails of prostitution, unless there is evidence to the contrary.

Offences related to procuring and living on the avails of prostitution each carry a maximum penalty of 10 years in prison. Section 212 also includes separate subsections stipulating lengthier minimum and maximum sentences for offences related to prostitution involving a person under the age of 18.[4]

Section 213

Section 213 of the *Criminal Code* outlaws sex workers and clients from communicating in a public place for the purpose of prostitution, including by stopping, attempting to stop or impeding traffic. "Public place" is defined broadly to include any place to which the public has a right of access or that is open to public view. This provision places a great deal of power in the hands of police to arrest sex workers and their clients, or threaten them with arrest. A person found guilty under this section may be fined up to $2000, imprisoned for six months, or both. For sex workers and clients living in poverty, a fine may be tantamount to a jail sentence if they can be imprisoned for non-payment.

The vast majority of *Criminal Code* charges for prostitution-related offences are laid against street-based workers and their clients. Street-based sex workers, who work on the street for a range of reasons (including in some cases limited options arising from factors such as poverty, drug dependency, homelessness or inadequate housing, and mental and physical illness), are disproportionately criminalized as a result. Police repression of street-based sex workers and their clients also displaces them to isolated areas and cuts sex workers off from health and harm reduction services. As the section below describes, such criminalization is also linked to significantly elevated rates of violence against street-based sex workers.

> ***The* Criminal Code *forces street-based sex workers to work in greater isolation, rendering them more vulnerable to violence.***

Violence against sex workers

To avoid arrest, sex workers often work in situations that limit the control they exercise over their working conditions, increasing the health and safety risks. For example, evidence shows the communicating provision in the *Criminal Code* forces street-based sex workers to work in greater isolation. This includes moving out of commercial areas (where there are businesses open late at night) into industrial areas, and by working alone in order to avoid attracting police attention, rendering them more vulnerable to violence. After the communicating provision was passed in 1985, sex workers from across the country reported being forced to adopt riskier operating styles and feeling less safe than prior to the

law's passage. In particular, there was a large increase in British Columbia of violence against and murders of sex workers and in Montréal, sex workers reported working in more remote areas with a diminished number of customers, accompanied by an increase in violence.[5]

Criminalization also institutionalizes an adversarial relationship between sex workers and police and impedes sex workers' ability to report violence directed against them. This creates a climate of impunity which fosters and fuels further violence. Statistics Canada has reported high levels of violence experienced by women working in street-based prostitution, yet resolution rates of violence towards sex workers are incredibly low.[6] For a sex worker, reporting a violent experience may mean not only incriminating herself, but her employer, colleagues and clients, leading to a loss of work and income. Reporting a violent incident may also mean police subsequently harass and target her and the men with whom she is in personal relationships for arrest, because they assume that those men are her clients.

Correspondingly, there are reports of police abuse of sex workers, particularly street-based, Aboriginal and transgender sex workers, in the form of harassment, verbal abuse, physical assaults, excessive force, arbitrary detention, sexual misconduct, sexual assault and the confiscation and destruction of property, including harm reduction and safer sex materials such as condoms. Where there is a pattern of negative encounters with the police, sex workers are highly unlikely to turn to them for help. These disincentives to reporting mean sex workers often have little recourse for violence, including in contexts outside of work (e.g., domestic violence).

On the whole, the criminalization of activities related to prostitution, abuses committed by police against sex workers, stigma against sex workers, and the accompanying perception that sex workers are not credible witnesses have meant sex workers have not had equal access to justice in the form of police protection or the prosecution of crimes committed against them. This effect is especially acute for racialized and Aboriginal sex workers, whose access to justice is already compromised due to systemic racism in the judiciary. In particular, the legacy of colonization and dispossession of many Aboriginal people in Canada has resulted in conditions that lead to over-policing and incarceration of, as well as a documented pattern of police non-responsiveness to, Aboriginal sex workers.

Facts and figures: HIV risks faced by sex workers

- **There is no epidemiological evidence in Canada to show that transmission of HIV from sex workers to their clients regularly takes place**. In fact, there is research to suggest that sex workers tend to be better informed than the general population about modes of HIV transmission and ways to prevent the transmission of HIV and other sexually transmitted infections (STIs).
- Despite research indicating that many sex workers take precautions to reduce their risk of contracting STIs, **stigma, discrimination and the criminalization of sex work hinder sex workers' access to essential health services and create barriers to HIV testing, sexual health education and HIV-related treatment, care and support**. Sex workers may fear that disclosing their occupation to health and social service workers could trigger a report to the police or to child protection authorities. These barriers have a particularly serious effect on sex workers who struggle with intersecting forms of disadvantage, are likely to have the greatest need for services, and already face barriers to accessing them.
- Court- or police-imposed "red zone" orders either on arrest or as a condition of sex workers' probation prohibit them from certain neighbourhoods, particularly urban areas where sex workers may live and work and many crucial health and social services exist (e.g., food banks, emergency shelters, drop-ins, methadone clinics, health clinics and needle and syringe programs). Because contravening a red zone order means its recipient risks re-arrest, **sex workers may be forced to choose between relinquishing their housing and access to health and social services or risking incarceration for breaching the conditions of the red zone order, both of which have negative repercussions for sex workers' health and their vulnerability to HIV**.
- **When criminalization leads to the incarceration of sex workers living with HIV, it often involves a disruption of their HIV treatment**. Sex workers are also put at risk of contracting HIV due to elevated rates of HIV in prisons, and inadequate access to harm reduction materials such as condoms and sterile injection equipment behind bars.[7]

Sex work and the law

Sex workers are entitled to human rights under the *Canadian Charter of Rights and Freedoms* (Charter) and international human rights law. Recognition of such rights by policy- and decision-makers is essential to realizing the human dignity of sex workers.

In Canada, four rights guaranteed in the Charter are especially relevant when considering the effect of the prostitution-related offences in the *Criminal Code* on the rights of sex workers:

- Section 2(b) guarantees everyone freedom of expression, which the prohibition on communicating for the purpose of prostitution (Section 213) violates;
- Section 2(d) guarantees everyone freedom of association, but sex workers who "associate" with clients in public or who choose to work with others for economic or safety reasons are prohibited from doing so by prohibitions on bawdy-houses (section 210), procuring and living on the avails of prostitution (section 212) and communicating (section 213);
- Section 7 protects everyone from violations of "life, liberty and security of the person," which encompasses one's physical and psychological integrity. In light of evidence linking the criminal law to the violence perpetrated on many sex workers, sex workers' section 7 rights are violated by the prostitution-related offences in the *Criminal Code*; and
- Section 15 guarantees everyone equality before and under the law, and equal protection and benefit of the law, yet the criminal law singles out sex workers for adverse treatment that exacerbates and perpetuates the disadvantages they otherwise face and its impact is disproportionately felt by women and others who fall into the categories of disadvantage represented by the enumerated or analogous grounds under Section 15.

Female sex workers are vulnerable to the discrimination and social and economic marginalization that all women face, and face further marginalization that comes from their status as sex workers.

Three current and former sex workers in Ontario recently sought an order to strike down the *Criminal Code* provisions dealing with common bawdy-houses, living on the avails of prostitution and communicating for the purpose of prostitution. They claimed that those provisions were unconstitutional because they infringed upon their constitutional rights to free expression and to life, liberty and security of the person. In 2010, an Ontario trial court agreed, and found that the provisions had the effect of forcing sex workers to choose between their constitutional rights to liberty (by virtue of the threat of incarceration upon conviction) and personal security. The Court also found the communicating provision had the effect of increasing the risk of violence faced by sex workers. Therefore, the provisions were ordered to be struck down (*Bedford v. Canada*, 2010 ONSC 4264).

In 2012, Ontario's appellate court unanimously recognized that those three provisions of the *Criminal Code* have serious and negative impacts on the security and liberty rights of sex workers by reducing their ability to take steps to conduct their work more safely and make more informed decisions to protect themselves from harm (*Canada (Attorney General) v. Bedford*, 2012 ONCA 186). It struck down the restriction on common bawdy-houses and revised the prohibition against living on the avails of prostitution by limiting criminalization to situations where there are demonstrated "circumstances of exploitation." However, three of five justices upheld the prohibition on communicating, concluding that it legitimately works to reduce nuisance and harm to communities. By upholding this prohibition, the law effectively keeps it illegal to engage in outdoor sex work. While the decision is only applicable in Ontario, the case has been appealed to Canada's Supreme Court.

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Under international law, governments must not violate people's human rights, and governments must also protect against human rights violations by other people. Like the Charter, international human rights law protects sex workers' freedom of expression, freedom of association, rights to life, liberty and security of the person and right to equality. But international law goes further. As a party to the *International Covenant on Civil and Political Rights*, the *International Covenant on Economic, Social and Cultural Rights* and the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), Canada has an obligation to take steps to ensure sex workers enjoy the rights to:

- work, including the right to freely choose a job, and to enjoy just, favourable, healthy and safe conditions of work;
- social security, including social insurance;
- special protection for mothers during a reasonable period before and after childbirth, including paid leave or leave with adequate social security;
- an adequate standard of living for themselves and their families; and
- the highest attainable standard of physical and mental health.

Specific to women in sex work, Canada is legally obliged to take the following measures:

- refrain from any act or practice of discrimination against women and ensure that public authorities and institutions act in conformity with this obligation;
- modify or abolish laws, regulations, customs and practices which discriminate against women; and
- modify social and cultural patterns of conduct of men and women, with a view to eliminating prejudices and practices that are based on the idea of the inferiority or the superiority of either sex, or on stereotyped roles for men and women.

In particular, Article 6 of CEDAW requires States to "take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women." In clarifying this provision, the CEDAW Committee has stated that sex workers "are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence" (General Recommendation 19, 1992).

In other words, female sex workers are vulnerable to the discrimination and social and economic marginalization that all women face, and face further marginalization that comes from their status as sex workers. CEDAW is not based on the premise that prostitution should be eradicated, but on protecting all women, including sex workers (who face greater prejudice and abuse when they turn to police and the courts for redress), from discrimination, including violence.

International guidelines about HIV/AIDS and human rights recommend that criminal laws that increase the health and safety risks (including the risk of HIV infection) of sex workers should be repealed. The UN's *International Guidelines on HIV/AIDS and Human Rights* recommend that for "adult sex work that involves no victimization," criminal law should be reviewed with the aim of decriminalizing sex work (Guideline 4 (para. 29c)). Correspondingly, in their *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, UNAIDS and the Inter-Parliamentary Union, which represents legislators from all over the world, recognize that criminal regulation of prostitution impedes the provision of HIV prevention and care by driving sex workers underground and calls for the review of those laws with a view towards decriminalization (pp. 56–59).

(*Facts and figures, cont.*)

- A prohibition against bawdy-houses (Section 210) penalizes sex workers who work from their own home and precludes the establishment of secure facilities where sex workers can bring their clients. **Eviction, or the constant threat of it, leads to sex workers' precarious and unstable housing, which renders them more vulnerable to abuse, violence and HIV treatment disruptions. The threat of prosecution also deters those working in bawdy-houses from making large quantities of condoms, other safer sex materials or violence prevention resources available**, for fear of tipping off police about what they do.
- The prohibition on living on the avails of prostitution (Section 212) criminalizes sex workers who work together, people sex workers may hire, and in some cases, sex workers' voluntary personal or professional relationships. This provision **forces sex workers to work in isolation, alienates them from their networks of support, and prevents them from taking measures to ensure their safety (which, in turn, facilitates the practice of safer sex), such as hiring bodyguards or drivers**.
- Penalizing communication in public for the purpose of prostitution (Section 213) forces sex workers to hastily conclude a transaction for fear of police intervention and leaves them with **inadequate time to screen a potential client and negotiate the terms of a transaction, including condom use**. This provision has also been shown to **displace sex workers to more secluded areas to avoid police detection, which further renders sex workers more vulnerable to violence and diminishes their ability to practise safer sex**. Because they are more visible, street-based sex workers are also more likely than their indoor counterparts to have their **condoms confiscated by police**, who may use those condoms as evidence of criminal activity.

It is important to recognize that HIV transmission is related to unprotected sex, not the exchange of sex for money. By unfairly characterizing sex workers as vectors of disease, they have become scapegoats in the HIV epidemic. Increasingly, however, evidence shows that it is the criminalization of sex work, and the accompanying lack of respect for sex workers' human rights, that forces sex workers to work in circumstances that diminish their control over their working conditions. This leaves them vulnerable to abuse by aggressors as well as to other risks to their health and safety, and without the protective benefit of labour or health standards. Reforming prostitution laws in a way that respects, protects and fulfills sex workers' human rights is a necessary prerequisite for improving prevailing conditions so that sex workers can work free from violence and other health and safety risks, including HIV infection.

> ***"It is important to recognize that HIV transmission is related to unprotected sex, not the exchange of sex for money."***

Recommendations for policy and law reform

- Research shows that police, prosecutors and judges are often unwilling to take seriously the complaints of sex workers who seek help and do not see them as credible witnesses. A sex worker's complaint can also result in her or her managers' being criminalized instead of focusing on the aggression. This leads to a climate of impunity that renders sex workers vulnerable to violence, robbery and other abuse. **Sex workers must have equal access to police protection and the justice system**.
- **Repeal the following offences in the *Criminal Code***: Section 213 that makes it an offence to communicate in a public place for the purpose of prostitution; Sections 210 and 211 concerning common bawdy-houses; Sections 212(1)(b), (c), (e) and (f) or the procuring sections that relate to bawdy-houses; Section 212(1)(j) prohibiting living on the avails of adult prostitution; and Section 212(3), the reverse-onus subsection as it applies to living on the avails of adult prostitution. **Parliament should consult sex workers, and organizations whose staff, directors or membership are made up of sex workers or former sex workers**, concerning reform of the subsections of the *Criminal Code* that deal with procuring and exploitation (subsections 212(1)(a), (d), (g), (h) and (i).

- Reform in other areas of law and policy should conform to internationally recognized best practices. **Sex workers' rights should be protected under employment standards and occupational health and safety legislation**; sex workers should be given the option of being classified as employees rather than independent contractors so they can contribute to, and obtain, **state social welfare and industrial benefits; HIV testing and medical certificates should not be mandatory for sex workers or clients**; and controls on organized prostitution should be analogous to other legal business enterprises in terms of zoning, licence conditions and fees, and health requirements.
- **Involve sex workers in law reform**, in order to take account of their views about how to minimize the potential for harm. Federal, provincial/territorial and municipal governments must commit to the meaningful participation of sex workers in future decision-making about law and policy, including by making funding available to support such participation. In particular, sex workers must have a say in determining what laws and policies should apply to prostitution and sex workers.

A note on terminology

In this info sheet, we use the terms "sex work" and "sex worker" to focus attention on the fact that sex work is work, and out of respect for the dignity of people involved in sex work. However, we sometimes also use the term "prostitution" to refer to the in-person exchange of sexual services by one person for payment by another, as this is the legal term used in the provisions of the Canadian *Criminal Code* that are referenced here.

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[1] This info sheet focuses on adult women, including transgender women, in sex work, because it is one in a series of four info sheets examining the relationship between women and HIV in various contexts. However, male sex workers are also criminalized by prostitution-related offences and subject to stigma and many of the same abuses female sex workers experience, with negative repercussions for their sexual health. Note that this info sheet also does not discuss child prostitution or sex trafficking, for which there are a wide range of resources.

[2] At the time of writing, Ontario's Court of Appeal had struck down the restriction on common bawdy-houses and revised the prohibition against living on the avails of prostitution in *Canada (Attorney General) v. Bedford*, 2012 ONCA 186. While this decision only applies in Ontario, the case is expected to be appealed to the Supreme Court of Canada, which has the authority to change the laws concerning prostitution for the entire country.

[3] See s. 197(1) of the *Criminal Code* and, for example, in *Marceau v. R.*, 2010 QCCA 1155 (Quebec Court of Appeal), where a majority of the Court held that women who performed private nude dances in a bar, which involved customers touching or caressing their breasts and buttocks, constituted "prostitution" for the purposes of the bawdy-house provision and convicted those dancers, as well as a doorman and a customer, of being found in a common bawdy-house.

[4] Although sex workers' organizations in Canada support decriminalization of the laws surrounding prostitution, they are not contesting the validity of these subsections.

[5] E. N. Larsen, "The Limits of the Law: A Critical Examination of Prostitution Control in Three Canadian Cities," *Hybrid: Journal of Law and Social Change* 3(1) (1996): 19–42; Federal/Provincial Territorial Working Group on Prostitution, *Report and Recommendations in respect of Legislation, Policy and Practices Concerning Prostitution Related Activities*, 1998; J. Lowman, "Violence and the Outlaw Status of (Street) Prostitution in Canada," *Violence Against Women* 6(9) (2000): 987–1011at 1003; and *Étude sur les violences envers les prostituées à Montréal*, Rapport de recherche soumis au ministère fédéral de la justice, Juin 1994.

[6] D. Duchesne, "Street prostitution in Canada," *Juristat Service Bulletin* 17(2) (1997), Canadian Centre for Justice Statistics.

[7] See "Women in Prison, HIV and Hepatitis C," part of this series of four info sheets on the human rights of women living with or vulnerable to HIV in Canada.

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Women & HIV

This is one in a series of four info sheets on the human rights of women living with or vulnerable to HIV in Canada.

1. Women in Prison, HIV and Hepatitis C
2. Women and the Criminalization of HIV Non-Disclosure
3. Women, Sex Work and HIV
4. **Women and HIV Testing**

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

Women and HIV Testing

"I was given a requisition form with all manner of other tests on it. I recognized my test for thyroid, and I think maybe one or two other tests on it. And I did notice written in 'HIV,' which I didn't question or ask why because I was just assuming it was mandatory at that point."

— Testing experience of a pregnant woman in Canada[1]

HIV testing for women in Canada

Since it was first realized that HIV could be transmitted from a mother to her child during pregnancy, labour and delivery, or through breastfeeding, women have been a central focus of HIV testing. If a woman is not pregnant or of childbearing age, however, she might not seek, or be offered, an HIV test. For many people, the perception remains that HIV predominantly affects men who have sex with men, people who use drugs, and newcomers from Africa and the Caribbean; therefore, other women may not be seen as at risk.

Yet many women are vulnerable to HIV infection and need access to high quality HIV testing and counselling that responds to their needs. HIV testing can and should be expanded, while promoting and protecting human rights in all aspects of the HIV testing process.

Early in the epidemic, it was recognized that HIV testing should be conducted in ways that took into account the widespread stigma and discrimination against people affected by HIV. Moreover, respecting and protecting people's rights would be central to successfully implementing HIV testing programs.

A broad consensus therefore emerged that people should only be tested with their informed, voluntary and specific consent; counselling should be provided both before and after testing; and HIV testing should occur only when confidentiality can be guaranteed. Policies in Canadian jurisdictions generally reflected this consensus which came to be called "the three Cs" of HIV testing — consent, counselling and confidentiality.[2]

Recently, in Canada and internationally, there has been some movement away from the "three Cs" consensus.[3] Calls for "routine testing" (i.e., including HIV testing in standard medical assessment without requiring specific consent) and "opt-out testing" (i.e., testing by default unless a person specifically refuses) have made reference to the need to "scale up" testing in order to get more people to know their HIV-positive status and onto treatment (because HIV treatment both improves the health of people living with HIV and prevents new infections by reducing HIV risks of transmission). Calls for "routine testing" and "opt-out" testing also highlight the high resource-commitment required in order to provide pre- and post-test counselling to everyone who is tested, and that treating an HIV test differently from other tests may add to HIV-related stigma and hence deter people from being tested.[4]

However, models that respect the "three Cs" may still be more effective in the long-run response to HIV in Canada, and legal and ethical requirements favour ensuring informed consent, appropriate counselling and confidentiality. An effective HIV response requires more than just increasing the numbers of people who are tested. Moreover, HIV disproportionately affects marginalized people who face multiple barriers to accessing health services. A shift towards more coercive measures will not improve HIV testing among these communities and could hinder efforts to curb the spread of HIV by contributing to fear and stigma.

For women, this shift away from the "three Cs" can pose particular difficulties. Many women do not feel that they really can decline an HIV test when recommended by their health care provider, even if they would prefer to access a different type of testing (e.g., anonymous) or defer testing until they feel more ready to deal with the results and manage personal risks. The unequal power relationships between women and their doctors, as well as the desire to do what is best for their child (in the pregnancy context), limit many women's ability to decline the test. Moreover, many women need time to consider it before consenting to an HIV test, which may not be possible in the short time allotted for a medical appointment. And if counselling in the pregnancy context focuses on the health of the child, not the woman's own needs and risks, women may not be prepared for possible negative consequences of testing. As noted in one report, people "may agree to be tested because they are used to agreeing to health professionals' requests, think that they will receive improved care, do not think they can decline, or have a diffuse sense that refusing would have adverse consequences."[5]

While some research indicates that a proportion of women find HIV testing more accessible if it is routinized, similar to Pap tests,[6] it is important to recognize that many women continue to face considerable barriers to testing, including many Aboriginal women, youth, women living in rural communities, women in prison, women from countries where HIV is endemic, and women in abusive or dependant relationships. HIV testing occurs in a social context marked by unequal gender and power relations and high levels of stigma. The public health objective of increasing testing cannot override the need to reduce women's risks and vulnerabilities to HIV-related abuses.

A supportive and enabling environment is needed in order for many women to be able to make free and informed decisions about HIV testing. Negative consequences of HIV testing and fears of disclosure are more frequently documented for women and approaches to testing should prioritize addressing these gendered factors.[7] If people are tested without being prepared, they may suffer negative outcomes (e.g., adverse psychological outcomes, inability to protect themselves from abuse if others discover their status), or lose confidence in the health care system, thus undermining their access to HIV prevention, treatment and care. Moreover, many women are tested for HIV during pregnancy, a time when they may require extra support. The significance of an HIV test is greater than the medical information that it provides. It can have a powerful impact on a person's life and test results have meanings that are tied to relationships, faithfulness, trust, and specific roles such as mothering.[8]

"The public health objective of increasing testing cannot override the need to reduce women's risks and vulnerabilities to HIV-related abuses."

Stigma and fear remain important impediments to seeking HIV testing for some women. Aboriginal women and women from countries where HIV is endemic may be particularly concerned about HIV testing because of racism, insecure immigration status, fear of the reactions of members of their families or communities, unfamiliarity with the Canadian medical system, language barriers, fear that they will lose custody of or access to their children, distrust of government institutions, lack of information about HIV, and the inability to take time off from work and family responsibilities to attend to their own health needs. For some women facing these various challenges, alternative modes of HIV testing, such as anonymous or rapid testing, may be preferable.[9]

The "three Cs" of HIV testing: grounded in human rights principles

- HIV testing should only occur with specific **informed consent** voluntarily given. This requirement derives from the *right to security of the person*[i] — that is, to be able to control what happens to one's body — as well as from the *right to information*,[ii] which is an integral part of the right to health.
- **Pre- and post-test counselling** of good quality gives effect to the *right to information* and is essential for both promoting the mental health of persons getting tested and protecting public health more broadly by helping to prevent onward transmission of HIV. Good-quality counselling is of particular importance for people who may not otherwise be able to get appropriate information on HIV.
- **Confidentiality** of results of medical tests, and of the fact of even seeking or having a test, derives from the *right to privacy*[iii] and is a central element of ethical medical practice.

[i] *International Covenant on Civil and Political Rights*, 9999 U.N.T.S. 171, Article 9 [ICCPR]; *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, at s. 7.

[ii] ICCPR, Article 19.

[iii] ICCPR, Article 17; *Canadian Charter of Rights and Freedoms*, ss. 7 and 8.

HIV test results can also have important legal implications that may be of particular concern for women in dependant or abusive relationships or for those lacking confidence in governmental institutions. Positive HIV test results are reported to public health authorities. In most jurisdictions, public health laws give public health officials the power to inform the sexual and drug use partners of a person who has tested positive for HIV (known as "partner notification" or "contact tracing"). Certain coercive interventions may be implemented if deemed necessary to protect public health. People living with HIV can also be criminally prosecuted in Canada for not disclosing their HIV-positive status to sexual partners. Such serious consequences require women to be fully informed of the medical *and* legal implications of HIV testing.

Facts and figures:

- According to the most recent data available from the Public Health Agency of Canada, **11 403 women and 224 female children (less than 15 years of age) have tested positive for HIV in Canada.**[10] Women represent an increasing proportion of the positive HIV tests performed in Canada, accounting for 26.2 percent in 2008.[11]
- It is estimated that **26 percent of Canadians living with HIV are unaware of their infection** because they have not been tested.[12]
- There are **three different methods of HIV testing** available in Canada: *nominal testing*, where the person's name is associated with the test result and reported to public health authorities; *non-nominal testing*, where a unique code, rather than the person's name is attached to the sample, which the health care provider who orders the test can use to match the result to the patient; and *anonymous testing*, where the test results are recorded and reported without revealing the name of the person who was tested. Non-nominal and anonymous testing, however, are not universally available.
- Standard HIV testing involves sending a blood sample to a laboratory for it to be tested for HIV antibodies. Results are available one to two weeks later. **A rapid HIV test can be done on a drop of blood from a finger prick. The testing is done at the testing site and the result is available in five to ten minutes**. If a rapid test returns a positive result, a second confirmatory test must be done to ensure accuracy of the results.
- HIV tests detect HIV antibodies, not the virus, in the blood. It takes time for a person's body to produce antibodies to HIV, therefore there is **a "window period" of up to three months between the point at which a person is infected and the point at which the test will show an infection**. During the "window

period," a person can test negative for HIV antibodies even though he or she is infected.

- All foreign nationals applying for permanent residence in Canada, and certain applicants for temporary residence, are required to undergo **an immigration medical examination**. The examination includes a question about whether the individual has ever tested positive for HIV. It also **includes an HIV antibody test for all persons over 15 years of age**.
- At least **five Canadian provinces have legislation** allowing certain people who may be exposed to bodily fluids from another person in the course of their employment (e.g., paramedics, police, firefighters) or in other specified circumstances to apply for **a legal order authorizing that the source person be forced to undergo testing for HIV** and other communicable diseases.

> ***Though in some situations there may be benefits to health care providers more actively encouraging HIV testing, each patient's human rights must be protected and HIV tests should not be "routine."***

Recommendations for policy and law reform

- **Enshrine "the three Cs" of HIV testing — informed consent, pre- and post-test counselling, and confidentiality — in all HIV testing policies**. While the availability of treatment has dramatically changed what it means to receive an HIV-positive diagnosis, HIV remains a serious medical condition that is highly stigmatized and can have serious legal implications. Though in some situations there may be benefits to health care providers more actively encouraging HIV testing, each patient's human rights must be protected and HIV tests should not be "routine."
- **Make anonymous and rapid HIV tests available throughout the country.** Currently, these types of tests are available in some locations but not in others. In order to meet the testing needs of diverse women, both types should be available irrespective of province or territory, and in both urban and rural areas.
- **Conduct research on women's experiences of HIV testing and what testing approaches work best for women**, both in the context of pregnancy and outside of pregnancy. Special consideration should be given to the needs and experiences of adolescents and young women, women in prison, sexual assault survivors, women in abusive relationships, women from countries where HIV is endemic, lesbian and transgender women, Aboriginal women, and women living in small communities. Such research is essential to inform HIV testing policy and practice that is respectful of and effective for the full diversity of women.
- **Ensure that counselling for women who receive an HIV test during pregnancy focuses on the woman herself, not just as a "vessel" for the baby**. The availability of alternative testing methods, the benefits and risks of receiving a positive test result, and the right to accept or decline the test must be clearly communicated. This is particularly important in the context of rapid HIV testing offered to a woman who is in labour and was not screened for HIV as part of prenatal care.
- **Note on laboratory requisition forms that informed consent is required for an HIV test** following pre-test counselling suitable for the individual to make an informed decision.
- **Ensure that all efforts to increase HIV testing are linked to and coordinated with efforts to achieve universal access to prevention, treatment, care and support**. Referrals to services should be provided with all HIV testing (e.g., specialized health care, counselling and support services, etc.), including mandatory and compulsory testing. Sufficient resources must be put in place to ensure services are available.

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[7] C.M. Obermeyer and M. Osborn at 1766.

[8] Ibid.

[9] On rapid HIV testing and anonymous testing generally, see Canadian HIV/AIDS Legal Network, "Anonymous HIV testing," *HIV Testing*, info sheet 5; and "Rapid HIV testing," *HIV Testing*, info sheet 9. Available via www.aidslaw.ca/testing.

[10] Between 1985 and 2009. Public Health Agency of Canada (Surveillance and Risk Assessment Division, Centre for Communicable Diseases and Infection Control), *HIV and AIDS in Canada. Surveillance Report to December 31, 2009*, 2010, at table 4C, page 22.

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