Special Considerations for Advising Sexual Assault Complainants Living with HIV

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October 2022

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[2] This resource originated out of conversations with staff at the Barbra Schlifer Commemorative Clinic and the authors acknowledge and thank them for their support.

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OVERVIEW

The "Me Too" and other similar movements have brought issues surrounding sexual assault to the forefront of society's consciousness, as more and more women[3] make the brave decision to speak up about their experiences. The criminal legal system, at least in our anecdotal experiences, has seen a subsequent increase in the number of cases in Ontario relating to sexual assault charges.

The decision to report a sexual assault is fraught with uncertainty for many, but due to the criminalization of HIV non-disclosure in Canada,[4] a complainant living with HIV faces profoundly enhanced legal, physical, and emotional risks when reporting sexual violence. HIV criminalization in Canada refers mainly to the use of the criminal law in cases of alleged non-disclosure of one's HIV positive status prior to alleged exposure or transmission of HIV. In Canada, people living with HIV can be criminally charged for not disclosing their HIV positive status to a sexual partner in certain circumstances. While feminist movements have highlighted pervasive gender inequities underlying women's experiences of not being believed while a male narrative is privileged, women living with HIV may also face retaliatory allegations of HIV non-disclosure.

This unfairness is amplified by the current state of law, as Canada is the only known country to use aggravated sexual assault as the operative offence when it comes to HIV non-disclosure,[5] even when (i) there is no allegation of transmission of HIV; (ii) there is no intention to transmit; and (iii) the sexual activity in question poses negligible to zero risk of transmission. An aggravated sexual assault charge alone may lead to separation from children,[6] and a conviction attracts a maximum life sentence, presumptive lifetime inclusion on sex offender registries[7] and, for those who are not Canadian citizens, almost certain deportation. Even when charges are ultimately not pursued or there are

[3] Note this paper uses the term "women" to refer to cisgender and transgender women. We note that all people, regardless of gender or gender identity, can face intimate partner violence and sexual assault.
[4] There have been at least 224 prosecutions in relation to HIV non-disclosure between 1989 and 2020. While it is possible for people to be charged in relation to other sexually transmitted infections ("STIs"), such prosecutions are exceedingly rare in Canada. For information regarding trends and patterns of HIV-non disclosure prosecutions, see Colin Hastings et al, "HIV Criminalization in Canada: Key Trends and Patterns (1989-2020)" (HIV Legal Network, 2022), online: <www.hivlegalnetwork.ca/site/hiv-criminalization-in-canada-key-trends-and-patterns-1989-2020/?lang=en> [perma.cc/FPX7-N76B].
[5] While the overwhelming majority of prosecutions involved aggravated sexual assault, certain other offences have been used, although much less frequently. Examples are criminal negligence causing bodily harm, common nuisance, administering a noxious thing, murder and attempted murder.
[6] Lawyers are invited to seek the guidance of family lawyers who are experienced in child protection matters if this is relevant to your client.
[7] Liam Michaud et al, "Harms of Sex Offender Registries in Canada among people living with HIV" (HIV Legal Network, 2021), online: <www.hivlegalnetwork.ca/site/harms-of-sex-offender-registries-in-canada-among-people-living-with-hiv/?lang=en> [perma.cc/W2TU-BUA8].

acquittals, police may issue press releases containing identifying information of accused persons, including photographs and health information. Such disclosures have drastic consequences, ranging from loss of family, friends, employment, and housing to violence.

There have been recent (and generally welcomed) developments in the prosecutorial practice in relation to sexual assault cases involving HIV non-disclosure.[8] HIV advocates and many in the legal community, however, feel these changes should go even further. The Canadian Coalition to Reform HIV Criminalization ("CCRHC"), for example, calls for the removal of HIV non-disclosure cases from the rubric of sexual assault law. CCHRC also recommends that criminalization should be limited to cases of actual, intentional transmission of HIV.[9] Such an approach would bring the law in line with science and human rights in a manner that is supportive of HIV care, treatment, and prevention.

This paper is devoted to issues faced by a group of individuals with a unique experience: sexual assault complainants living with HIV who could potentially be transformed from complainants to accused persons. In particular, this paper will discuss some of the factors that arise in these situations and aims to provide some guidance on the advice lawyers can provide to sexual assault complainants living with HIV to assist them in navigating these potentially complex situations. Providing accurate information regarding the potential criminal repercussions for sexual assault complainants living with HIV is critical

[8] See Canada Gazette, *Directive to the Director of Public Prosecutions* by Attorney General of Canada, "Directive to Director of the Public Prosecution Service," Canada Gazette, Part I,1 Vol. 152, (Ottawa: Government of Canada, 8 December 8, 2018.), online: <http://gazette.gc.ca/rp-pr/p1/2018/2018-12-08/html/notice-avis-eng.html#nl4.> [perma.cc/NPJ4-JMLJ] [Gazette]. See also Ministry of the Attorney General, *Crown Prosecution Manual: Sexual Offences Against Adults* (Toronto: Queens Printer for Ontario, 2017) at 131, online: <www.ontario.ca/document/crown-prosecution-manual/d-33-sexual-offences-against-adults> [perma.cc/U6AH-5UUL] [Attorney General, *Crown Prosecution Manual*].

[9] See Canadian Coalition to Reform HIV Criminalization, "Community Consensus Statement" (2022), online: *HIV Criminalization* < http://www.hivcriminalization.ca/2022-consensus-statement/> > See also House of Commons, *The Criminalization of HIV Non-Disclosure in Canada: Report of the Standing Committee on Justice and Human Rights* (June 2019) (Chair: Anthony Housefather), online: <www.ourcommons.ca/DocumentViewer/en/42-1/JUST/report-28/> [perma.cc/P4Q8-STEM]. The House of Commons Standing Committee on Justice and Human Rights calls for the end of using sexual assault provisions to deal with HIV non-disclosure and to instead focus on cases of actual transmission of HIV. It also called for the creation of a new *Criminal Code* offence in relation to the non-disclosure of *all* infectious medical conditions where transmission occurs. While many organizations, including HALCO and the Legal Network, support *Criminal Code* reform, the ousting of sexual assault law, and a focus on intentional and actual transmission of HIV, there is no such support to criminalize *all* infectious medical conditions. See also Department of Justice Canada, *Criminal Justice System's Response to Non-Disclosure of HIV* (Ottawa: Government of Canada, 1 December 2017), online (pdf): <www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/hivnd-vihnd.pdf> [https://perma.cc/ET9D-JS33]. The report called for the consideration of non-criminal responses in all cases of HIV non-disclosure and especially where the level of moral blameworthiness of the person living with HIV is low, such as in cases where there was no intention to transmit, steps were taken to prevent transmission or high risk conduct is the result of lack of access to health care and other services. See also Attorney General of Canada, "Directive to Director of the Public Prosecution Service," Canada Gazette, Part I, Vol. 152, December 8, 2018. http://gazette.gc.ca/rp-pr/p1/2018/2018-12-08/html/notice-avis-eng.html#nl4.

given that some studies have shown that misinformation and misconceptions of legal standards and duties imposed by criminalization of HIV non-disclosure persists among those living with HIV and are particularly pronounced among certain subsets of women living with HIV.[10] While the law criminalizing non-disclosure of HIV (i.e., the sexual assault provisions of the *Criminal Code*) purports to protect women, it can negatively affect women living with HIV.[11]

PART 1: HIV AND SEXUAL VIOLENCE — BACKGROUND

While general knowledge about HIV has increased over time, people living with HIV still experience stigma and accompanying discrimination, which exacerbates social and structural vulnerabilities for women living with HIV and leads to fear of rejection, violence, and having their HIV status disclosed without their consent.[12] In addition, stigma and discrimination are known barriers to the prevention, testing, and treatment of HIV and other sexually transmitted and blood-borne infections.[13]

Treatment advances, stigma remains

Studies conducted in 2012 and 2018 found that 40% of Canadian respondents would not use the services of a dentist or doctor living with HIV[14] and 15% were fearful of HIV transmission when they know they are near someone living with HIV.[15] Twenty-four percent of respondents would not be comfortable wearing a sweater previously worn by someone with HIV, and 22% would not be comfortable shopping in a grocery store where the owner was known to have HIV.[16] Forty-eight percent say that they would feel uncomfortable using a restaurant drinking glass once used by a person living with HIV (a statistic that is relatively unchanged from 49 percent in 2006).[17] Barely half of respondents (56%) believed that HIV treatments are effective in helping people with the disease lead

[10] Andrea Krüsi et al, "Positive sexuality: HIV disclosure, gender, violence and the law-A qualitative study" (2018) 13:8 PLoS ONE e0202776 at 8, DOI: <10.1371/journal.pone.0202776> [Krüsi, "Positive Sexuality"].
[11] *Ibid* at 9.
[12] *Ibid* at 2.
[13] EKOS Research Associates Inc., *Canadians' Awareness, Knowledge and Attitudes Related to Sexually Transmitted and Blood-Borne Infections: Prepared for Public Health Agency of Canada*, Findings Report (Ottawa: EKOS, 2018) at 1, online (pdf): <epe.lac-bac.gc.ca/100/200/301/pwgsc-tpsgc/por-ef/public_health_agency_canada/2018/056-17-e/report.pdf> [perma.cc/P824-MDQ5] [EKOS 2018].
[14] *Ibid* at 41.
[15] *Ibid* at 39.
[16] *Ibid* at 66.
[17] *Ibid*.

long and "normal lives."[18] The study also found that 71% of respondents (76% in Ontario) speculate that people living with HIV may hide their status due to stigma.[19]

HIV stigma exacerbates the vulnerability of people living with HIV. It affects how they live their lives, their sexuality, and how they approach their sexual experiences. Intensely negative social attitudes toward people living with HIV can make it dangerous for people to disclose their HIV status, increasing risks of violence, affecting their ability to negotiate safer sexual practices, and escalating risks of criminal liability.

Stigma has persisted despite significant improvements in HIV treatment and advances in knowledge around HIV transmission. HIV treatment (also called antiretroviral therapy) works by suppressing HIV's ability to make copies of itself. The number of copies of HIV in a person's blood is called their "viral load." When people take HIV medications as prescribed and see their doctor regularly, many lower their viral load to a level where there are fewer than 200 copies per millilitre of blood. This is called a "suppressed" or "undetectable" viral load.[20] For most people, this occurs after taking HIV treatment for three to six months. Among people living in Canada who have been diagnosed with HIV, approximately 85% are on treatment. Among people living with HIV in Canada who are on treatment, 94% have a suppressed viral load.[21]

A suppressed viral load prevents sexual transmission of HIV, even in circumstances involving sex without a condom. Large international studies have demonstrated that when a person taking antiretroviral treatment maintains a suppressed viral load, they do not transmit HIV to their sexual partners.[22]

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[18] *Ibid* at 37. The previous report can be found at: EKOS Research Associations Inc., *2012 HIV/AIDS Attitudinal Tracking Survey: Prepared for Public Health Agency Canada*, Final Report (Ottawa: EKOS, October 2012), online (pdf): <www.catie.ca/sites/default/files/2012-HIV-AIDS-attitudinal-tracking-survey-final-report.pdf> [perma.cc/CA5E-7NKD].

[19] EKOS2018, *supra* note 12 at 43.

[20] For the purpose of the criminal law in Canada, a "low" viral load has been defined as a viral load below 1,500 copies per millilitre of blood and a "suppressed" viral load has been defined as a viral load below 200 copies per millilitre of blood. Prosecutorial directives refer to a "suppressed" viral load. By contrast, the term "undetectable" is mostly used in the medical context. This term refers to the current standard medical tests, which cannot detect the virus in the blood if it is below 40-50 copies per millilitre of blood.

[21] Public Health Agency of Canada, *Estimates of HIV Incidence, Prevalence and Canada's Progress on Meeting the 90-90-90 HIV Targets, 2018*, Pub 200271 (Ottawa: Government of Canada, December 2020), online (pdf): <www.canada.ca/content/dam/hc-sc/documents/services/publications/diseases-conditions/summary-estimates-hiv-incidence-prevalence-canadas-progress-90-90-90/national-hiv-estimates-report-2018-en.pdf> [perma.cc/TK28-F94W]. For additional information about actual risks of transmission and the science explaining undetectable = untransmittable, see Mona Loutfy et al, "Canadian Consensus Statement on HIV and its transmission in the context of criminal law" (2014) Can J Infectious Disease Medical Microbiology 1, online (pdf): <www.hivlawandpolicy.org/sites/default/files/Canadian%20Consensus%20Statement%20on%20HIV%20in%20the%20context%20of%20criminal%20Law.pdf> [perma.cc/4UNK-G45J]. See also Françoise Barré-Sinoussi et al, "Expert consensus statement on the science of HIV in the context of criminal law" (2018) 21:7 J International AIDS Society e25161, DOI: <10.1002/jia2.25161> [Barré-Sinoussi].

[22] Barré-Sinoussi, *supra* note 21.

Regardless of treatment and viral load level, clinical studies have found no instances of transmission through oral sex performed on people living with HIV.[23] The risk of transmission through oral sex is therefore estimated to be between none and negligible.

HIV cannot be transmitted when a condom is used correctly and no breakage occurs because HIV cannot pass through intact latex or polyurethane.[24]

Unfortunately, despite the advances in the treatment of HIV, stigma, discrimination and criminalization remains.

Women living with HIV and intimate partner violence

Recent studies have shown that women living with HIV experience greater exposure to intimate partner violence and sexual violence than women not living with HIV.[25] Estimates suggest that 68 to 95 percent of women living with HIV experience intimate partner or sexual violence in their lifetime, with transgender women living with HIV experiencing particularly high rates of sexual violence in their lifetimes.[26] Experiences of gender-based violence and HIV infection are closely intertwined and intersect with several other factors including poverty, Indigeneity, racialization, gender identity, unemployment, housing instability, sex work, and substance use.[27]

Fear of disclosure by a sexual partner to others or of criminalization can exacerbate the power imbalances that increase risk of intimate partner violence and sexual violence. Threats of exposure and fear of criminalization can be used by an abusive partner as a tool of control and abuse. Studies have shown that involuntary HIV disclosure is widespread and is linked to increased risk of HIV-related violence.[28] In addition, social stigma and criminalization make it more difficult for women living with HIV to leave abusive relationships because of the dangers of commencing a new relationship where further disclosure may be necessary.[29] Women living with HIV may be threatened with false non-disclosure allegations if they leave abusive relationships. In some cases, women living with HIV have not reported being sexually assaulted out of fear of facing charges themselves in relation to non-disclosure of their HIV status.[30] There is a particularly troubling trend in relation to Indigenous women. Among women who have faced charges

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[23] *Ibid* at 5.
[24] *Ibid* at 6.
[25] The Athena Network, "10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women" (January 2009) at 3, online (pdf): <www.hivlawandpolicy.org/sites/default/files/Why%20Criminalization%20Harms%20Women-Athena2009.pdf> [perma.cc/87Z2-FXKA].
[26] Krüsi, "Positive Sexuality" *supra* note 9 at 3.
[27] *Ibid* at 10-11.
[28] *Ibid*; Athena Network, *supra* note 25 at 3.
[29] Krüsi, "Positive Sexuality", *supra* note 9 at 6.
[30] *Ibid* at 7. For example, see summary of *R v D.C.*, 2012 SCC 48, in Part 2 of this paper.

for HIV non-disclosure since 1989 whose race/Indigeneity is known, 33% (5/15) are Indigenous.

In addition, women living with HIV face numerous other barriers and risks relating to disclosure given pervasive gender inequities including fear of abandonment or loss of economic stability.[31] These and other factors have been linked to reduction in disclosure to sexual partners by women living with HIV.[32] Some women living with HIV ended their relationships upon learning of their diagnosis due to fear of disclosure, of transmitting HIV, and of legal consequences.[33]

The ongoing criminalization of HIV non-disclosure and the legal requirements imposed on people living with HIV increase vulnerability and exacerbate these issues. As well, the criminalization of HIV non-disclosure can interfere with HIV testing and the relationships between health care providers and people living with HIV.[34]

To be clear, Canadian law does not require every person living with HIV to disclose their status to every sexual partner in relation to every sex act. The Supreme Court of Canada has held that individuals living with HIV are not required to disclose their status if there is no "realistic possibility" of HIV transmission. The Supreme Court made clear that there is no realistic possibility of transmission during vaginal intercourse[35] when the person living with HIV has a low viral load and a condom is used.[36] There have been some developments post-*Mabior* which will be discussed in Part 2, below. While the law purports to clearly set out the standard required for disclosure of one's HIV status, it does not recognize the gendered imbalance that exists with respect to disclosure or the negotiation of the terms of sexual relations, including where women living with HIV are coerced or pressured not to use condoms. While men have the direct ability to decide if an external condom is used, women generally have to negotiate the use of a condom.[37] As a result, if a male sexual partner refuses to wear a condom, women living with HIV are often placed in the position of being legally required to disclose their HIV status and risk

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[31] Krüsi, "Positive Sexuality", *supra* note 9 at 3.
[32] *Ibid*.
[33] *Ibid* at 5.
[34] *Ibid* at p. 3; For information on HIV criminalization and its impact on women and gender-diverse people, see also HIV Legal Network, "HIV criminalization, women and gender-diverse people: at the margins" (2021) HIV Legal Network, "HIV Criminalization, Women, and Gender-Diverse People: At the Margins" (2021), online: <www.hivlegalnetwork.ca/site/hiv-criminalization-women-and-gender-diverse-people-at-the-margins/?lang=en> [perma.cc/8EAK-2PBW].
[35] *R v Mabior*, 2012 SCC 47 [*Mabior*]. While the Supreme Court did not discuss this issue in the context of anal intercourse, since this decision, other courts have applied the standard expressed in this case to anal intercourse.
[36] Krüsi, "Positive Sexuality", *supra* note 9 at 8; Women's Legal Education & Action Fund (LEAF), "A Feminist Approach to Law Reform on HIV Non-Disclosure" (January 2019) at 5, online (pdf): <www.leaf.ca/wp-content/uploads/2019/01/2019-01-08-LEAF-HIV-ND-Position-Paper-FINAL.pdf> [perma.cc/SQX2-LEPD] [LEAF]; *Mabior*, *supra* note 35 at paras 95-103. *Mabior* defines "low" viral load as less than 1,500 copies per millilitre of blood.
[37] Krüsi, "Positive Sexuality", *supra* note 9 at 11; LEAF, *supra* note 35 at 5-6; Athena Network, *supra* note 24 at 3.

facing rejection and violence as a result, or they must face the legal consequences of breaking the law for not disclosing before engaging in sex without a condom. Moreover, some women, especially those who are the most marginalized, face additional barriers to achieving or maintaining a low viral load, and are less likely to achieve viral suppression than men, and are therefore at higher risk for criminal liability.[38] As a result, if a male sexual partner refuses to wear a condom, a woman living with HIV **may** have to choose between three potentially unsafe options in a context of intimate partner violence: refusing sex, disclosure of her HIV status, or criminal liability.

Regardless of the choice she makes, a woman living with HIV who faces sexual violence may be reluctant to report it for fear of counter charges related to HIV non-disclosure being laid against her. Possible advice for women living with HIV in this situation is the focus of this paper and is addressed in Part 3.

PART 2: THE LAW — AGGRAVATED SEXUAL ASSAULT INVOLVING NON-DISCLOSURE OF HIV

Canadian courts have mapped HIV non-disclosure onto the law of sexual assault by characterizing non-disclosure as fraud vitiating consent to sexual activity where there is a realistic possibility of HIV transmission. Under section 265 of the *Criminal Code*, consent to physical contact is not valid if obtained by fraud. Otherwise-consensual sex is thereby turned into sexual assault, and the operative offence is section 273: aggravated sexual assault, as courts have found that exposing someone to HIV "endangers life."[39]

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[38] See Andrea Krüsi et al, "Marginalized women living with HIV at increased risk of viral load suppression failure: Implications for prosecutorial guidelines regarding criminalization of HIV non-disclosure in Canada and globally" (Paper delivered at the 22nd Internalization Aids Conference, Amsterdam, July 2018) [unpublished], online: <programme.aids2018.org/Abstract/Abstract/11316> [perma.cc/SMY6-AR6B]. Prospective data (2010-2016) drawn from SHAWNA (Sexual health and HIV/AIDS: Women´s Longitudinal Needs Assessment, a community-based participatory open cohort study with women living with HIV (cis and trans women) who access HIV services in Metro Vancouver) show that of 277 women, 48% had an unsuppressed viral load (greater or equal to 200 copies/ml) and would not meet the legal test of achieving sustained viral suppression for at least one six-month period over the seven-year period. Contrast to data from David M Moore et al, "HIV Community Viral Load and Factors Associated with Elevated Viremia Among a Community-Based Sample of Men Who Have Sex with Men in Vancouver, Canada" (2016) 72:1 JAIDS 87, DOI: <10.1097/qai.0000000000000934>, which show that only 18.6% of Gay and Bisexual men living with HIV in Vancouver had an unsuppressed viral load (greater or equal to 200 copies/ml). "In a Canadian cohort study of people starting treatment between 2000 and 2011, in B.C., Ontario and Quebec, two different analyses showed that women were less likely to be undetectable than men." See Camille Arkelle, "Getting to undetectable: Population differences in Canada" (19 July 2017), online: *Canada's Source for HIV and hepatitis C information* <www.catie.ca/prevention-in-focus/getting-to-undetectable-population-differences-in-canada> [perma.cc/RE2N-3M9E].

[39] HIV Legal Network, "The Criminalization of HIV Non-disclosure in Canada: Currents Status and the Need for Change" (2019), online: <www.hivlegalnetwork.ca/site/the-criminalization-of-hiv-non-disclosure-in-canada-report/?lang=en> [perma.cc/AF29-TXDT]. For a thorough treatment of the law to mid-2019,

A summary of principles from R v Cuerrier *and* R v Mabior

The Supreme Court of Canada held in *R v Cuerrier*[40] that withholding HIV status from a sexual partner could vitiate consent to the sexual activity and attract criminal culpability. In short, the prosecution must prove three elements to secure a conviction:

1. an act by the accused that a reasonable person would see as dishonest (i.e., non-disclosure of one's HIV positive status);
2. a deprivation in the form of a serious bodily harm or significant risk of serious bodily harm; and
3. that the complainant would not have consented but for the dishonesty by the accused.

The Supreme Court found that HIV transmission is a serious bodily harm, and as a result, the court found a duty to disclose before sexual activity that poses a realistic possibility of HIV transmission (note that this test is focused on risk and not on actual transmission meaning people can be, and often are, charged even in absence of alleged transmission of the virus).[41]

The legal test was revisited almost fifteen years later in *R v Mabior* (and the companion case of *R v D.C.*[42]) which further clarified what constitutes exposure to "significant risk" of HIV transmission.

The Supreme Court found again that HIV constituted serious bodily harm and clarified that "significant risk," in the context of HIV, could be found where there was a "realistic possibility" of transmission.[43] The Court found, on the evidence before it, that a realistic possibility of transmission was negated when: (1) the accused's viral load at the time of sexual relations was low (under 1,500 copies per millilitre of blood) and (2) a condom was used.

In *D.C.*, the accused was a woman living with HIV who had sex once with her former partner before she disclosed her status to him. She had a suppressed viral load and stated that he wore a condom during sexual activity. They stayed together for several years after she disclosed her HIV status. Over time, her partner became abusive, and he was convicted for his assaultive behaviour against her and her son. He then accused her of not disclosing her HIV positive status before the first time they had sex and claimed that a condom had not been used. D.C. was convicted at trial, but the Court of Appeal of Québec set aside the conviction based on the lack of a realistic possibility of HIV transmission associated with sexual activity when a person with HIV has a suppressed

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see Joanna Radbord, *LGBTQ2+ Law: Practice Issues and Analysis* (Toronto: Emond Publishing, 2019) at ch 12: Criminal Law and Public Health.

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

[41] Statistics on the outcome of such prosecutions and the percentages of cases involving actual transmission can be found in Hastings, *supra* note 3 at 9-12.

[42] 2012 SCC 48 ["D.C."]

[43] *Mabior*, *supra* note 34 at para 104.

viral load, regardless of whether a condom is used. The Supreme Court held that condom use was required to preclude a realistic possibility of HIV transmission, based on the new standard set in *Mabior*. The Court ultimately acquitted D.C. based on an evidentiary error by the trial judge regarding whether a condom was used. However, D.C. would have been convicted based on *Mabior* if a condom was found to have not been used, even with her suppressed viral load.

Although the Court in *Mabior* indicated that the law will need to evolve in the future as medical knowledge with respect to the transmission of HIV also evolves, the legal takeaway from *Mabior* was that the combination of a low viral load (under 1,500 copies per millilitre of blood) and condom use negated the realistic possibility of transmission (and therefore criminal liability). However, dispute remains about whether *Mabior* requires the use of condoms and a low viral load in all cases. Such a strict interpretation of *Mabior* is now being revisited.

Legal changes since Mabior

Cuerrier and *Mabior* have been criticized as depending on exaggerated and misunderstood articulations of risk and harm that contradict consensus among medical experts about what circumstances lead to a realistic possibility of transmission of HIV. HIV experts and some recent lower court decisions have recognized updated scientific studies that show that there is no realistic risk of transmission if a person living with HIV has either a suppressed viral load or a condom is used.[44] These critics also include the federal and Ontario provincial governments, both of which recently announced the need to use prosecutorial discretion to refrain from prosecuting people with HIV who do not have a medically realistic possibility of transmission, particularly those with suppressed viral loads. As well, several lower court decisions (discussed in more detail below) have resulted in acquittals of people living with HIV in circumstances in which a condom was not used but where medical evidence at trial confirmed that there was no realistic possibility of transmission of HIV because the partner living with HIV had a low or suppressed viral load.[45]

i. Provincial and federal prosecution guidelines

In December 2017, Ontario's Ministry of the Attorney General issued a directive to prosecutors stating that charges relating to HIV non-disclosure will not be prosecuted where a person living with HIV:

1. is on antiretroviral therapy; and

[44] Barré-Sinoussi, *supra* note 20.
[45] The authors are unaware of any convictions in Canada since at least 2017 in circumstances where a condom was not used but the partner living with HIV had a low or suppressed viral load.

2. has maintained a suppressed viral load for a period of six months, as there is no realistic possibility of transmission in these circumstances.[46]

This means Ontario should not prosecute in the absence of condom use if the person is on antiretroviral therapy and has maintained a suppressed viral load for six months prior to the sexual activity associated with the allegation.

In December 2018, the federal Attorney General issued a directive ceasing prosecutions against people who have a suppressed viral load (i.e., under 200 copies per millilitre of blood). The directive further states that prosecutions shall "generally" not take place against persons who have not maintained a suppressed viral load but used condoms or engaged only in oral sex or were taking treatment as prescribed, unless other risk factors are present, because there is likely no realistic possibility of transmission.[47] The federal directive also calls for prosecutions to be made using non-sexual criminal offences where appropriate, and requires consideration as to whether Public Health authorities have provided services to the person in question.[48] However, the directive only applies in the three territories (Northwest Territories, Nunavut, and Yukon); it has not been adopted by Ontario, and the Ontario directive applies to cases prosecuted in Ontario criminal courts.

More recent non-disclosure case law

i. Deprivation includes exposure to harm

Mabior held that to vitiate consent in the context of sexual activity with a person living with HIV, the dishonesty on the part of the accused person must result in deprivation in the form of serious bodily harm or exposure to a "significant risk of serious bodily harm." The deprivation may take the form of harm, or exposure to harm, in the nature of "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the integrity, health or well-being of a victim."[49] While the actual transmission of HIV constitutes serious bodily harm, the exposure to a realistic possibility of transmission may also constitute harm.

This analysis expanding the concept of harm has been applied in non-HIV cases as well. In *R v Hutchinson*,[50] deprivation was found to encompass "harm" beyond the traditional sense of the term, to include the profound bodily changes, or exposure to the risk of those changes, resulting from pregnancy. The court concluded Mr. Hutchison was guilty of

[46] Attorney General, *Crown Prosecution Manual*, *supra* note 7 at 131.
[47] Canada Gazette, *supra* note 7.
[48] *Ibid*.
[49] *Mabior, supra* note 34 at para 82.
[50] 2014 SCC 19

sexual assault because his sabotage of condoms without his girlfriend's knowledge vitiated her consent to sexual activity.[51]

The Supreme Court found that in order for the "deprivation" component to be satisfied, the dishonesty-deprivation has to be "equally serious" to that which exposes the complainant to the risk of HIV transmission and which exposes a complainant, who has chosen not to become pregnant, to an increased risk of pregnancy by removing effective birth control. Lesser deprivations, including financial deprivations or mere sadness or stress from being lied to, are not sufficient.[52] However, in *R v Kirkpatrick*, the minority left the door open on the question of whether the side-effects of post-exposure prophylactic treatment for HIV ("PEP") could constitute serious bodily harm for the purpose of the deprivation analysis.[53]

The need for deprivation to be "equally serious" to the risk of HIV transmission was confirmed in *R v Thompson,* where the Court of Appeal for Nova Scotia reiterated that harm in the form of mental distress was not something that, in the absence of significant risk of serious bodily harm (i.e., risk of HIV transmission in cases of HIV non-disclosure), could vitiate consent. Psychological harm alone, even when it amounts to bodily harm for the purpose of the criminal law (which was questionable in this instance), cannot invalidate consent.[54] Importantly, the Court of Appeal did not overturn the trial judge's findings that sexual activity involving a condom or a person with a low viral load do not pose a realistic possibility of HIV transmission. Note, however, that this decision is not binding in Ontario.

ii. Suppressed (under 200 copies per millilitre of blood) viral load alone (but not condom use alone) is sufficient for acquittal if a person living with HIV does not disclose

Several cases demonstrate that if a person living with HIV has a suppressed viral load, the use of a condom is not required for an acquittal. However, if the person's viral load is not suppressed, condom use alone may not protect a person living with HIV from a conviction of aggravated sexual assault if they do not disclose their status prior to engaging in sexual activity.

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[51] *R v Hutchinson*, 2014 SCC 19 at para 70 [*Hutchinson*].Mr. Hutchinson had secretly poked holes in his condoms. His girlfriend became pregnant as a result and had an abortion, leading to medical complications.

[52] *Hutchinson*, *supra* note 50 at para 72.

[53] *R v Kirkpatrick*, 2022 SCC 33 at para 305.

[54] *R v Thompson*, 2018 NSCA 13 at paras 30 – 35, 46.In this case, the trial judge had acquitted Mr. Thompson of aggravated sexual assault, holding that either a low viral load (under 1,500 copies/ml) or condom use was sufficient to avoid a realistic possibility of transmission. However, the trial judge also found that withholding one's HIV status from a sexual partner could cause psychological harm, constituting sexual assault, notwithstanding the fact that there was no realistic possibility of transmission. The Nova Scotia Court of Appeal overturned the latter aspect of the decision.

In *R v C.B.,*[55] C.B. did not disclose his HIV status to two complainants and did not use a condom. Although the Crown Attorney proved beyond a reasonable doubt that neither complainant would have consented to sexual activity with him had they known he was living with HIV, he was acquitted of aggravated sexual assault by demonstrating through expert evidence that because C.B.'s viral load had been suppressed for longer than six months, even without condom use, there was no realistic possibility of transmission.

In *R v Murphy*,[56] the Court of Appeal overturned the appellant's 2013 conviction for aggravated sexual assault on the basis of fresh evidence. The Court accepted an HIV specialist's opinion that advances in science now established that the circumstances in this case, a single episode of unprotected vaginal sex with a person on antiretroviral medication who had an undetectable viral load, posed no realistic possibility of transmission. The Court declined to go as far as establishing a new common law standard in which a suppressed viral load negated the realistic possibility of transmission, as that went beyond the fresh evidence presented in this case. However, it left the door open for such a finding on a proper evidentiary record at trial.[57]

Another recent Ontario Court of Appeal decision, *R v Rubara,* dealt with a 2016 conviction for aggravated sexual assault where the accused person was an "elite controller", meaning a person who naturally suppresses the virus without medication.[58] Based on fresh evidence, the Court held that the risk of transmission associated with multiple episodes of unprotected vaginal sex with a viral load of 143 copies/ml or less is negligible. They determined this level of risk did not meet the realistic possibility test regardless of whether the accused achieved this suppressed viral load as a result of treatment or because they were an elite controller.[59]

In two cases from Ontario, condom use alone has been found to be insufficient to prevent conviction where the person living with HIV does not have a low or suppressed viral load. In *R v N.G.*, the accused did not disclose his HIV status to three complainants. He wore a condom but did not have a low or suppressed viral load. The defence advanced the proposition at trial that condom use alone was sufficient for the court to find that there was not a realistic likelihood of the transmission of HIV and that there had been advances in science to reflect that fact since the Supreme Court of Canada decided *Mabior* in 2012. At trial, an expert testified about the effectiveness of condoms, ultimately testifying that in real-world situations, condoms were 80-85% effective at reducing the risk of transmission of HIV, accounting for instances of improper use or breakage. Ultimately, the trial judge found this level of risk was sufficient to hold that there was a realistic possibility of transmission given that N.G.'s high viral load was not low or suppressed, and enough to convict N.G. This conclusion was upheld at the Court of Appeal for Ontario, which

[55] *R v C.B.*, 2017 ONCJ 545.
[56] *R v Murphy*, 2022 ONCA 615 [*Murphy*].
[57] *Murphy* at para 40.
[58] *R. v. Rubara*, 2022 ONCA 694 [*Rubara*]
[59] *Rubara* at paras 10-13.

declined to consider fresh evidence that when used properly and no breakage occurs, condoms are 100% effective at preventing HIV transmission in an individual sexual encounter.[60]

In *R v Boone*, the Court of Appeal for Ontario held that Mr. Boone was properly convicted of aggravated sexual assault by virtue of having had anal sex with the complainant, despite wearing a condom and not ejaculating, because of his high viral load.[61] In this case, the Court found that Mr. Boone deliberately withheld his HIV status and there was evidence before the jury that he intended to transmit HIV to the complainants.[62]

PART 3: LEGAL OBLIGATIONS OF A PERSON LIVING WITH HIV TO DISCLOSE – QUESTIONS AND ANSWERS

This section addresses various issues and commonly asked questions about the legal obligations of people living with HIV to disclose their status to police and other individuals.

Before turning to specific issues and questions, it is worth noting some significant considerations when providing advice to people living with HIV in this context. The decision to disclose one's HIV positive status is deeply personal. Many individuals experience or have experienced stigma, discrimination, fear, and violence because of their status. Lawyers providing legal advice should be aware of the difficult emotional factors at play and should consider the potential need for referrals to assist with psychological support.[63] Being cognizant of your client's potential need for emotional support is particularly important given the often-challenging nature of the legal advice available in these circumstances: in order to allow individuals to make an informed decision about disclosure, the potentially negative implications of that disclosure must be explained.

Q: Does a sexual assault complainant have a legal obligation to report the sexual assault to police?

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[60] *R v Goodchild*, 2017 ONSC 6739 and *R. v. N.G.*, 2020 ONCA 494, para. 26.
[61] *R v Boone,* 2019 ONCA 652 at paras 130 – 132. However, the authors note that the legal landscape in relation to these issues is still evolving and the applicability of these lines of cases may change in the future.
[62] *Ibid* at para 82. The Court of Appeal did, however, order a new trial for Mr. Boone in relation to his convictions for attempted murder and administering a noxious thing (in this case, HIV). In doing so, the Court identified the following essential elements that must be proved beyond a reasonable doubt for a conviction of attempted murder for the deliberate attempted transmission of HIV: (1) an intention to infect the complainant with HIV; and (2) the belief that, absent medical intervention, death at some point in the future was a virtual certainty as a consequence of contracting HIV. See para. 77 of that decision.
[63] Clients living with HIV can find social, psychological, and practical supports through their local AIDS service organization. See https://whereto.catie.ca/ for listings by location or type of service.

A: No.

There is no obligation for any sexual assault complainant, regardless of their HIV status, to disclose a sexual assault to police.

Q: If they do decide to report the sexual assault to the police, does a sexual assault complainant have a legal obligation to disclose their HIV status to police?

A: No.

There is no legal obligation to tell the police about one's HIV status. The legal obligation to disclose only extends to sexual partners where the consensual sexual activity contemplated carries a "realistic possibility" that HIV will be transmitted.[64]

Q: Can a complainant's failure to disclose their HIV positive status if they are (i) sexually assaulted or (ii) engaged in sex that they were pressured into having or sex they were not totally comfortable engaging in lead to them being charged?

A: It is the legal opinion of the authors of this paper that if a person living with HIV is being sexually assaulted, they do not have a legal obligation (regardless of viral load or condom use) to disclose their HIV positive status. This is because the complainant is not voluntarily engaging in sexual activity with the assailant. In other words, the agreement to engage in sexual activity by the assailant cannot be vitiated on the basis that the assailant would not have agreed to engage in the sexual activity had he or she known about the person's HIV status because there was no "agreement" in relation to the sexual activity in the first place.

This view, however, may not be shared by police officers or Crown Attorneys. If the police charge the complainant with a crime for failing to disclose their HIV status, the determination as to whether a sexual assault took place, and whether disclosure of the complainant's HIV status was required would ultimately be up to a trial judge (assuming the Crown decides to prosecute in the first place).

The answer is more difficult when it comes to sex that a person was pressured into or was not totally comfortable with, as there is a legal distinction between being sexually assaulted (which is a crime under the *Criminal Code*) and being pressured/coerced in a manner that falls short of criminal conduct.[65] One is criminal; the other is morally condemnable but not necessarily against the criminal law.

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[64] As summarized above, sexual activity that is typically understood to fall within this category includes vaginal and anal sex where the person living with HIV does not have a suppressed viral load. Activities that have been deemed to be "no risk" by health care professionals, including kissing and mutual masturbation, cannot pose a "realistic possibility" of transmission under the law. See the next question in this section for further details regarding the duty to disclose in Ontario.

[65] An exception to this would be when the assaulter is in a position of authority vis-à-vis the complainant, such as when the complainant is intellectually vulnerable or 15-16 years old.

A woman living with HIV who engages in consensual sexual activity is liable to prosecution and conviction for aggravated sexual assault if she does not disclose her status before sex that poses a realistic possibility of transmission. At the time of writing, based on Ontario prosecutorial policy[66] and recent court cases, here is guidance for people living with HIV in Ontario.

No duty to disclose:

•A person living with HIV who is on antiretroviral therapy and has a viral load of under 200 copies per millilitre of blood for at least six months does not have a duty to disclose their HIV status before anal, vaginal, or oral[67] sex. This is the case regardless of whether a condom is used.

•A person living with HIV who has a viral load between 200 and 1,500 copies per millilitre of blood does not have a duty to disclose their HIV status before anal, vaginal, or oral sex if a condom is used properly and does not break.

Duty to disclose:

•A person living with HIV who has a viral load between 200 and 1,500 copies per millilitre of blood has a duty to disclose if no condom is used. If a condom is not used properly or breaks, and there is no disclosure, they may also be prosecuted.

•A person living with HIV who has a viral load of over 1,500 copies per millilitre of blood has a duty to disclose, regardless of whether a condom is used.

Q: Is there a situation where disclosing your client's HIV status to police might help your client, or a situation where telling the police your client's HIV status may be harmful to your client?

A: Providing as much information as possible during an initial interview with police is generally considered to be beneficial when thinking about the long-term likelihood of charges being laid, prosecution being pursued, and conviction at trial.

An accused person in a criminal case has a constitutional right to receive disclosure of all the relevant evidence that the prosecution has against them. This means that the accused person will eventually be given a copy of the complainant's statement (typically on video) and usually all information the complainant shares with the police, as well as all the other relevant evidence.

At trial, the defence lawyer for the accused person will look for any changes, inconsistencies, or omissions as between the statement(s) (or information) the complainant originally gave to the police, any subsequent statements to the police

[66] Attorney General, *Crown Prosecution Manual*, *supra* note 7 at 131.

[67] The authors believe it is unlikely that a person living with HIV would be criminally charged in relation to acts of oral sex alone. The most recent case the authors are aware of where a person was charged in these circumstances took place prior to the current prosecutorial policies and resulted in an acquittal.

or other individuals, and the complainant's trial testimony. A defence lawyer may try to argue that a complainant is less credible and should not be believed because they withheld information from the police, or changed or added details to their story later on. The defence may not be successful with this strategy, but it may be attempted.

This does not mean that a person is obligated to disclose their HIV positive status to the police when reporting a crime. More practically, it means that an individual making a report to the police should never lie to the police, as this may be damaging to the individual's credibility at trial, which can undermine the likelihood of conviction. (There is also a chance that false or misleading statements can potentially open them up to criminal prosecution.)

When speaking to the police about a crime, a complainant is usually asked to either swear an oath or promise to tell the truth to the police. Complainants are not obligated to answer every question the police ask, and they can end the interview at any time. The police may or may not ask someone about their HIV status when they are being interviewed as a complainant. As a result, if the police ask a complainant about their HIV status, the complainant can decide whether to answer. If they do answer, they would be obligated to tell the truth or risk being charged with the offence of lying to police.

There may also be some strategic benefit to upfront disclosure of an individual's HIV status to the police in relation to the police interrogation of the accused person. This is because the eventual defence to an allegation of sexual assault at trial typically takes one of several forms:

1. Denial that the sexual assault ever took place at all (the complainant has completely fabricated the allegation, for a known or unknown purpose);
2. The sexual assault took place, but the accused individual is not the person who did it (the complainant is mistaken as to the identify of their assailant);
3. Sexual activity took place, but the complainant consented at the time and is only after the fact claiming that consent was not given;
4. Sexual activity took place and the complainant did not consent, but the accused person had a reasonable mistaken belief in consent (i.e., the accused person reasonably believed that the complainant was consenting, but was wrong in this belief).

In some circumstances, if the accused individual asserts either #1 or #2 with the police when confronted by the allegation of sexual assault, it *may* be of assistance to the police during the interrogation to gauge the reaction of the accused person to the disclosure of the complainant's HIV status.

It may also be beneficial to disclose an individual's HIV status to the police upfront if the complainant disclosed their HIV status to the assailant or would have had no legal obligation to do so (e.g. because there was no realistic possibility of

transmission). This may be beneficial in that it could reduce the risk of the complainant being charged if the accused later learns of the complainant's HIV status, asserts either #3 or #4, and purports to be the actual "victim" in the encounter as a result of non-disclosure.

If the complainant does decide to disclose their HIV status to the police, it would be advisable to consider providing the police with evidence of suppressed viral load, or a low viral load (between 200 and 1,500 copies per millilitre of blood) with proper condom use and no breakage, to limit the jeopardy of a criminal investigation or charges.

Ultimately, it is difficult to know exactly what, if any, effect the disclosure of one's HIV status will have in a particular investigation/circumstance. The potential downside is difficult to anticipate, and the pragmatic reality is that HIV-related stigma continues to exist, including within law enforcement. Individuals disclosing their status in the context of a sexual assault complaint may not always receive the respect, compassion, or understanding that they deserve. It may be that disclosure could result in the police charging the complainant with aggravated sexual assault (or another offence) based on non-disclosure, if the police believe that the sexual activity was voluntary.

Q: What happens if my client doesn't tell police, but their HIV status is revealed anyway?

The police have an obligation to disclose any information they obtain about a case that is not clearly irrelevant to the accused individual. This means that if the police learn about an individual's HIV status, they may disclose this information to the accused person.

As noted above, there may be implications at trial if credibility concerns can be raised by the defence from an individual's non-disclosure (assuming the non-disclosure is relevant to credibility at trial). This is a potential consequence for the ultimate viability of the criminal prosecution against the accused person, rather than a legal consequence for the person living with HIV. But there could be legal consequences for the person living with HIV if, when the accused learns about the complainant's status, they decide to attempt to pursue charges themselves.

In circumstances where an individual lies to, or otherwise deceives the police, it is possible to be charged with a criminal offence called "attempting to obstruct justice." It is unlikely that such a charge would result from an individual not making any representations about their HIV positive status to the police. Even if an individual is dishonest (i.e. a denial as opposed to an omission) about their HIV status, charges may not result. The decision as to whether to lay charges is up to the police.

Q: If the police learn about my client's HIV positive status, will they tell anyone about it?

A: Generally, when someone is charged with a criminal offence, the police may create a press release about the accused and the charge(s). The police generally do not (and should not) disclose any personal or identifying information about a complainant of a sexual assault, including the complainant's name, address, or relationship to an accused. This would also include the complainant's HIV status. However, unfortunately, the authors of this paper are aware of at least one instance in which a complainant's information and HIV status was disclosed in a press release.[68]

If a woman living with HIV is arrested and charged with non-disclosure, it is possible that the police could release her personal information in a press release. While they may or may not directly disclose her HIV status, the description of the charge(s) she faces could lead to an inference as to her status. This may have a disproportionate impact on certain populations, for example, women living with HIV who are engaged in sex work.[69]

Q: If my client reports the sexual assault to the police, do they need to provide medical records to police as well?

A: In many sexual assault cases, the police will ask the complainant whether they had a "rape kit" done. If so, the police will usually ask the complainant to sign a medical authorization/release form that allows the police to obtain these (and sometimes other) medical records relating to the complainant. A complainant living with HIV should carefully consider whether to sign the medical release providing these or any other medical records to the police, as these records could include the complainant's HIV positive status.

In many cases, the results of a rape kit, and other medical records, will not be relevant to the prosecution of the sexual assault. For example, if the accused admits engaging in sexual activity with the complainant and claims that it was consensual, the presence of the accused's DNA on the complainant, as determined by the complainant's rape kit, will not be relevant at trial. Therefore, obtaining this evidence is not necessary.

In many cases, the relevance of medical records will not be known at the time that the complainant discloses the sexual assault to police. While convenient to do so, it is not always necessary to disclose medical information to the police right away. All sexual assault complainants should be advised that they have the right to

[68] If you or your client are concerned about your client's private information being disclosed by the police, counsel can ask the police not to disclose their client's name, or any information that can identify the client. It may be useful for counsel to remind the police that they should not disclose this information because of the complainant's medical privacy interests and potential danger to the complainant if their HIV positive status is publicized.

[69] For additional information and resources relating to these issues, see HIV Legal Network, "Media Reporting: HIV and the Criminal Law" (2020), online: <www.hivlegalnetwork.ca/site/media-reporting-hiv-and-the-criminal-law/?lang=en> [perma.cc/QM7M-WUT5].

consult with counsel before signing any medical release/authorization for the police to access their personal medical records. Counsel can consult with the Crown on behalf of the complainant to find out what the issues are in the case and then provide advice to the complainant about whether further disclosure is necessary once this is known. One option counsel can consider is whether it is appropriate for the complainant to obtain copies of their own medical records so that any information relating to HIV status can be redacted before they are disclosed to the police or Crown.[70]

This area of law (the production of the complainant's private records such as medical records to the accused in sexual assault proceedings) is very complicated and currently evolving, largely due to recent amendments to the *Criminal Code,* which include new procedures for litigating these issues prior to trial — procedures in which the complainant has the right to participate and have counsel represent them. In addition, if police are provided with these types of records, their ability to retain them (for example, on local and national police databases) and reference them internally is unknown.

Q: Are there any legal avenues besides the criminal legal system for my client to pursue?

A: Some sexual assault complainants have initiated civil actions against the person who sexually assaulted them. Civil actions are outside of the scope of this paper, but there are lawyers who practice in this area who can assist you and your client.[71]

Q: If your client didn't tell the person who sexually assaulted them that they are living with HIV, should they tell that person after the sexual assault?

A: A complainant does not have an obligation to disclose their HIV positive status to the person who sexually assaulted them after the fact and they should not feel responsible for the health of their assailant. If there was a possibility of transmission between the complainant and the assailant, advising the assailant after the fact may decrease the risk of transmission. In particular, the assailant may choose to start post-exposure prophylaxis ("PEP") which helps prevent the transmission of HIV to a person who may have been recently exposed to the

[70] It is important for counsel to note that there are legitimate and compelling reason for a complainant (regardless of HIV status) to be hesitant to disclose their medical records to the police. Many rape kits include the taking of photos of a complainant's body, including intimate portions of it. Complainants may be understandably reluctant to have those records disclosed to the accused person in any case. These issues can be canvassed carefully with the complainant to determine ways to mitigate potential further emotional harm to the complainant by disclosing those records.

[71] Counsel can refer their clients to the Ministry of the Attorney General's Independent Legal Advice program for sexual assault complainants where they will be provided with a list of civil lawyers who can provide this advice. See Government of Ontario, "Independent legal advice for sexual assault victims" (last visited 8 June 2022), online: *Ontario* <www.ontario.ca/page/independent-legal-advice-sexual-assault-victims> [perma.cc/9MXP-FMDM].

virus.[72] PEP must be started within 72 hours after exposure to be effective. While there may be some legal benefits (in addition to public health benefits) to disclosing status after the assault,[73] disclosure may also open up the potential for criminal charges in relation to non-disclosure.

If a complainant chooses to disclose their status to their assailant after the sexual assault, they have different options to do so, all of which entail some risk.[74] The complainant could disclose personally after the assault (although in many circumstances this may not be possible). This could create a risk to the complainant's personal safety, including retaliation by the assailant. Another option is for the complainant to make an anonymous report to their local Public Health unit (see *Public Health Unit's Powers* below for more information). Public health officials could then contact the assailant to provide information about testing and PEP without identifying the complainant. This approach may reduce personal safety concerns, though the assailant may deduce that it was the complainant who made the report and their HIV status. This option also raises concerns about public health surveillance for the complainant (see *Public Health Unit's Powers* below).

PART 4: PUBLIC HEALTH UNITS' POWERS

For the purposes of this training paper, it is important to highlight that public health laws and Public Health units' procedures can interact with the criminal law, particularly with respect to the information obtained through and records produced as part of counselling and partner notification procedures conducted by Public Health units. In addition, it is worth noting some of the ways in which a person living with HIV may come under the scrutiny of Public Health authorities as a result of sexual assault.

Public Health units have the mandate and authority under Ontario's *Health Protection and Promotion Act* ("*HPPA*") to prevent the spread of sexually transmitted infections ("STIs"), including HIV. Ontario is divided into regional "health units," each of which is run by a "medical officer of health," who is responsible for case management and contact tracing processes related to individuals in their region who are diagnosed with STIs, including

[72] For more information about PEP, see Camille Arkell, "Post Exposure prophylaxis (PEP)" (2019), online: *Canada's source for HIV and hepatitis C information* <www.catie.ca/post-exposure-prophylaxis-pep> [perma.cc/B5NT-ZKMJ].

[73] If there were a future civil action brought by the assailant, the fact that the complainant disclosed to the assailant, enabling the assailant to take PEP, could be mitigating for the complainant in relation to damages. If your client has questions about potential or actual civil claims, they should consult with a civil lawyer who practices in this area. After-the-fact disclosure may also be considered a mitigating factor in sentencing if the complainant faced criminal charges in relation to non-disclosure.

[74] Given the complexity of this choice, we recommend referring clients to HALCO (www.halco.org) for legal advice as soon as possible if they are considering disclosing their HIV status after the sexual assault.

HIV.[75] Individuals may come to the attention of health units because the *HPPA* mandates that testing laboratories report the names and contact information of individuals who test positive nominally[76] for HIV to the appropriate health unit. The *HPPA* also mandates reporting of positive diagnoses for other STIs, such as gonorrhoea and syphilis. In certain situations, other individuals, including physicians, nurse practitioners, hospital administrators, and superintendents of certain institutions, also have a duty to report to the names and contact information of people living with HIV to the Public Health authorities.

When a person tests positive for HIV nominally, or positive for another STI that is reportable to Public Health authorities in Ontario, the result of that test will be reported to the person's health unit by the laboratory that processed the test result.[77] The Public Health unit will then contact the person for counselling, support, and referrals. Public Health units also communicate measures to the diagnosed person to reduce or eliminate the risk of transmission to others. In addition, Public Health units use a method known as "contact tracing" (sometimes referred to as "partner notification" or "partner counselling") to reach those at risk of infection because of interactions with a known "case" (i.e., a newly diagnosed person) of a reportable medical condition. As a result, a person who tests positive nominally for HIV (or another reportable medical condition) will be asked to disclose names and contact information so that the contacts can be notified and urged to get tested.

The *Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations 2009*[78] and *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol 2019*[79] both stress that contact tracing is to

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[75] For a list of public health units in Ontario, see: Public Health Unit Locations.

[76] Nominal testing means that positive HIV test results will be reported to the health unit with identifying information, including the person's name and contact information. The *HPPA* allows designated anonymous testing clinics to test without using a person's name. If the anonymous test is positive for HIV, the doctors and nurse practitioners at anonymous testing clinics are not required to report names and contact information to Public Health. The testing laboratory will inform the applicable public health unit about the positive test result but will not share the person's name or contact information because they do not collect that information. However, the information may later come to the attention of a Public Health unit through various other means. There is no option to be tested anonymously for other STIs. For additional information about anonymous testing, please contact the HIV & AIDS Legal Clinic Ontario (HALCO) at www.halco.org.

[77] The test result is reported by the laboratory as a matter of course but may also be reported by the person's physician, nurse practitioner, or other regulated health care professional.

[78] Ontario Ministry of Health and Long-Term Care: Provincial Infectious Diseases Advisory Committee, *Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations* (Toronto: Queens Printer for Ontario, April 2009), online (pdf): <www.publichealthontario.ca/-/media/documents/S/2009/sti-case-management-contact-tracing.pdf> [perma.cc/64PN-KE6V] [MOHLTC, *Best Practice Recommendations*].

[79] Ontario Ministry of Health and Long-Term Care, *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2019* (Toronto: Queens Printer for Ontario, 2019), online (pdf):

be done in a manner that preserves the confidentiality of the known case.[80] Depending on the circumstances, the Public Health unit may let the diagnosed person or their doctor or nurse practitioner notify their partners, and may require proof that the partners were notified. Many Public Health units, however, do the partner notification directly. While the Public Health unit should not disclose the name of the diagnosed person to the partners, the partners might determine the identity of the diagnosed person.

There are rare circumstances in which a person known to have HIV is not compliant with public health measures to reduce transmission and obtain treatment. Public Health units may become aware of continued noncompliance through third party or physician reports including mandatory reporting of positive test results for other STIs. In these situations, the Medical Officer of Health is empowered to order compliance under section 22 of the *HPPA* to ensure that the risk of transmission is minimized. However, prior to using order-making powers, Public Health units have protocols to assess and supplement gaps in counselling, education, and care.[81] Orders are a last resort for the few people who do not respond to less intrusive interventions.

If a person living with HIV tests positive for another STI, Public Health units have the authority under the *HPPA* to conduct contact tracing. Because contact tracing under *HPPA* is permissive rather than mandatory, Public Health units have discretion to determine how or whether contact tracing should take place. In the case of STI transmission related to an assault, considerations of public interest and personal safety should militate toward not pursuing a contact (i.e., not contacting the assailant). Although public health guidance does not appear to address this issue directly, contact tracing guidelines do encourage sensitivity to concerns around domestic violence.[82]

In the case of a sexual assault, if the assailant tests positive for HIV or another STI and the complainant is named as a sexual contact, Public Health units may take measures to ensure that the complainant is taking adequate precautions against HIV transmission. (Public Health units would more than likely already be aware that the complainant is living with HIV as positive nominal tests are reported, as noted above.) Public Health units should not take further action if the complainant living with HIV discloses to public health authorities that the sexual contact was the result of an assault. Provincial public health

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<www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Sexual_Health_STIBBI_Protocol_2019_en.pdf> [perma.cc/W9SZ-6JN3].

[80] In addition, see *Health Protection and Promotion Act*, RSO 1990, c H.7, s 39, which prohibits disclosure of personal health information that is likely to identify a person who is the subject of a public health intervention, except in limited circumstances.

[81] Council of Ontario Medical Officers of Health HIV Workgroup, *Public Health Approach to HIV case management*, (Toronto: Association of Local Public Health Agencies, 2017), online (pdf): <cdn.ymaws.com/www.alphaweb.org/resource/collection/822EC60D-0D03-413E-B590-AFE1AA8620A9/COMOH_Position_HIV_Case_Management_190417.pdf> [perma.cc/QZ6Z-V6ET].

[82] See e.g., MOHLTC, *Best Practice Recommendations*, *supra* note 73 at 53.

best practice guidelines recommend considering barriers to compliance with public health advice, including violence, before resorting to a section 22 order.[83]

Public Health and criminal law also interact directly with respect to evidence in a criminal proceeding. The substance and records of the counselling provided by Public Health units (or by health care providers) are routinely adduced as evidence by the Crown in the context of prosecutions for HIV non-disclosure, in order to support the establishment of *mens rea* or other elements of the charged offence (i.e., to seek to establish that the accused person is living with HIV, was aware of their HIV status, and is aware of so-called safer sex practices that can reduce the risk of HIV transmission). In the context of sexual assault, where the person living with HIV is the complainant, it may be possible that records of a contact by a Public Health unit for one of the reasons listed above could be scrutinized as being corroborative or inconsistent with the statements and testimony of the complainant in a criminal trial.

The use of public health records can be limited by section 7 *Charter* protections against self-incrimination. Statements have been excluded from use in a subsequent criminal trial where the concerns underlying this *Charter* right are engaged (existence of coercion, adversarial relationship, risk of unreliable confessions if their statements could be used against them in criminal proceedings, and abuse of power). [84] As a result, there is an argument that statements made to a health unit following the imposition of coercive measures (i.e., a section 22 order) ought not to be admissible in subsequent criminal proceedings. Even in the absence of a section 22 order, there might still be aspects of the communications that could create an honest and reasonably held belief by the individual that they were obligated to provide information.

CONCLUSION

Providing advice to sexual assault complainants who are living with HIV is complex and emotionally fraught. Counsel should approach these conversations with sensitivity and with an awareness of the deep vulnerability their clients are likely experiencing. We have endeavoured to include key information to help inform legal advice, but each circumstance is unique, and counsel should take care to explore the personal, emotional, and legal considerations specific to each client. The approach taken in this paper may seem overly conservative or pessimistic, but it is the opinion of the authors that when providing advice to individuals who are contemplating interacting with the police, especially when they may have been historically disadvantaged due to their HIV positive status, it is important to provide advice that gives individuals the power to make informed choices.

[83] *Ibid* at 38.
[84] See *R v Aziga*, 2006 CanLII 38236 (ON SC).