Submission to the UN Committee on the Rights of Persons with Disabilities: Review of Canada at 32nd Session (March 3-21, 2025)

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INTRODUCTION

1. The HIV Legal Network ("Legal Network") make this submission to the Committee on the Rights of Persons with Disabilities ("Committee") in advance of its review of Canada's periodic report, detailing our concerns about Canada's implementation of the *Convention on the Rights of Persons with Disabilities* ("Convention") with respect to the rights of people living with HIV and the rights of people who use drugs.

ARTICLE 5: EQUALITY AND NON-DISCRIMINATION

In the "List of issues prior to submission of the combined second and third periodic reports of Canada" (LOI), the Committee asked of Canada:

3. Please provide information about measures taken to implement the Committee's recommendations contained in paragraph 14 of its previous concluding observations (CRPD/C/CAN/CO/1), in particular on … (c) **Measures taken at all levels of government to eliminate inequality and discrimination faced by persons with disabilities**. …

15. Please provide information on the **measures taken to address all forms of violence, including sexual violence against women and girls with disabilities, in particular indigenous women**, women with intellectual or psychosocial disabilities, persons with disabilities in family settings and in institutions….

2. Canada has recognized HIV as a disability in its jurisprudence and legislation. The *Canadian Charter of Rights and Freedoms* ("Charter"), embedded in Canada's Constitution, guarantees "the right of equal protection and equal benefit of law … without discrimination based on … physical disability."[1] Courts and tribunals have read "disability" in the context of the Charter and other legislation to apply to HIV and AIDS,[2] and all provinces and territories in Canada interpret a person's HIV-positive status as grounds on which a person is protected from disability-related discrimination.[3]

3. Despite this, **Canada continues to criminalize people living with HIV for alleged non-disclosure to sexual partners**, in an approach that is at odds with scientific evidence about the risk of transmission. With at least 225 people criminally charged to date for not disclosing their HIV-positive status to their sexual partners before sex, Canada has the dubious distinction of being a world leader in prosecuting people living with HIV.[4]

4. Based on a 2012 decision from the Supreme Court of Canada in *R v Mabior*, 2012 SCC 47, people living with HIV in Canada are at risk of prosecution and conviction for non-disclosure of their HIV-positive status even if there was no transmission, they had no intention to harm their sexual partner, and they took reasonable precautions to prevent transmission. The

decision was widely criticized for being at odds with international recommendations and human rights standards as well as scientific consensus on the risk of HIV transmission.[5]

5. Most cases of HIV non-disclosure are also prosecuted as *aggravated sexual assault* — a criminal offence that carries a maximum penalty of life imprisonment and potential registration as a sexual offender for a minimum of 20 years. Some Canadian jurisdictions provide prosecutorial guidance to limit HIV criminalization, including where a person has a suppressed viral load.[6] However, the law is applied inconsistently across Canada, fueling fear of continued threats of criminalization for people living with HIV.

6. In addition, the **criminalization of HIV non-disclosure exposes women living with HIV to an increased risk of violence and abuse**. While criminalization is often described as a tool to protect women from HIV infection and to enhance women's dignity and autonomy in relation to sexual decision-making, a gendered analysis reveals that criminalization is a blunt, punitive, and inflexible approach that does little to protect women. Rather, the criminalization of HIV non-disclosure can provide a tool of coercion or revenge for vindictive partners who threaten to report women to the police for not disclosing their status.[7] This is especially true if they face challenges due to their socioeconomic status, discrimination, insecure immigration status, or abusive or dependent relationships.[8] A disproportionate number of women convicted of HIV non-disclosure in Canada have also included Indigenous women, who continue to suffer from the effects of colonization and racism.[9]

7. Scholars have also criticized the use of sexual assault law in the HIV non-disclosure context — where the sexual activity is otherwise consensual — and contended that this could ultimately have a detrimental impact on sexual assault law more broadly as a means to advance gender equality and renounce gender-based violence.[10]

8. In 2016, the UN Committee on the Elimination of Discrimination against Women recognized the use 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 recommended that Canada "limit the application of criminal law provisions to cases of intentional transmission of HIV/AIDS, as recommended by international public health standards."[11] In 2016, the UN Committee on the Rights of the Child also noted the need to review legislation "that criminalizes the unintentional transmission of HIV and the non-disclosure of one's HIV status."[12] Further, the UN Special Rapporteur on the right to health has pointed out that criminalizing HIV transmission infringes on the rights to health, privacy, equality, and non-discrimination.[13]

9. Additionally, there are numerous public health concerns associated with the overly broad criminalization of HIV non-disclosure, exposure, or transmission. Evidence suggests that the criminalization of HIV non-disclosure may represent a structural barrier to health care engagement for some people living with HIV in Canada, discouraging access to HIV testing

and linkage to HIV care services required to achieve viral suppression, which is important to promote both individual and population health.[14]

10. All these concerns have led the Joint UN Programme on HIV/ AIDS (UNAIDS) and the UN Development Programme (UNDP),[15] the UN Special Rapporteur on the right to health,[16] the Global Commission on HIV and the Law,[17] and women's rights advocates (including leading Canadian feminist legal academics),[18] among others, to urge governments to limit the use of the criminal law to cases of *intentional transmission* of HIV (i.e. where a person knows their HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it).

11. Despite repeated acknowledgments from Canada that HIV criminalization is problematic and requires law reform,[19] as of January 2025 no concrete legislative action has been taken.

RECOMMENDED ACTIONS

The Legal Network recommends that the Committee call on Canada to:

- **Remove HIV non-disclosure from the ambit of sexual assault law and restrict criminal penalties to cases of actual, intentional transmission.**

- **Ensures that, at the absolute minimum, the criminal law is under no circumstances used against people living with HIV for not disclosing their status to sexual partners where they use a condom (or similar latex barrier) for penetrative sex, practice oral sex, or have condomless penetrative sex with a suppressed viral load.**

- **Reviews past convictions, allowing for a conviction to be expunged if it does not fit within new limitations on the scope of criminalization.**

ARTICLE 14: LIBERTY AND SECURITY OF THE PERSON

In the LOI, the Committee asked of Canada:

13. Please inform the Committee about measures taken at the federal, provincial and territorial levels to fully implement the Committee's recommendations contained in paragraph 32 of the previous concluding observations, in particular on:

> (a) **Ending the involuntary detention and hospitalization of persons with disabilities on the basis of impairment** …

12. The Committee has previously recommended that Canada "review federal, provincial and territorial policies and practices related to involuntary detention with the aim to bringing

these policies and practices into compliance with article 14 of the Convention and the respective guidelines,"[20] yet there continue to be **increasing calls in Canada for involuntary care and detention of people who use drugs:**

- In the province of British Columbia, the government is opening "secure facilities" and contemplating new legislation to facilitate involuntary treatment for both youth and adults who have experienced repeated overdoses, despite strong evidence showing the known harms of involuntary care.[21]

- In Alberta, a proposed *Compassionate Intervention Act* would give police and family the ability to force adults and youth into involuntary drug treatment, paired with ongoing calls for involuntary treatment of homeless people who use drugs.[22]

- In Nova Scotia, a proposed *Protection of Children from Abusing Drugs Act* would ostensibly grant parents and guardians the power to obtain a court order to forcibly remove youth who "abuse" drugs (including alcohol or cannabis) from the community and to involuntarily detain them in a "safe house" facility to undergo detoxification for up to 10 days.

- In New Brunswick, a proposed *Compassionate Intervention Act* would "empower judges and hearing officers to order treatment for Severe Substance Abuse Disorder."[23]

13. Involuntary treatment for people who use drugs includes interventions such as forced medication, institutionalization, physical restraints, isolation/solitary confinement, and other coerced behaviour, subjecting people who use drugs to deprivations of liberty and autonomy while risking their security and health. Despite the clear human rights concerns they raise, there is no evidence that involuntary treatment is effective to treat what is construed as "problematic substance use." A 2023 Canadian review of studies on the outcomes of forced treatment concluded that it has "limited benefit" — with voluntary treatment consistently outperforming involuntary treatment in terms of cost, sustained gains (such as abstaining from substance use), and risk of overdose death following treatment.[24]

14. Calls for the expansion of forced treatment are also occurring against a backdrop in which access to voluntary care remains highly inaccessible, particularly for the most marginalized people who use drugs, and options for drug treatment are unregulated, driving unpredictability in quality and safety of the services. Notably, the 2023 review also found that "involuntarily treated patients with [substance use disorder] are at a higher risk of overdose after treatment."[25] This is because individuals who resume relying on Canada's highly toxic, criminalized drug supply lose their tolerance after involuntary treatment and are more likely to overdose.

15. Forced interventions also erode trust in the health care system. With the looming threat of involuntary treatment, frontline workers are forced to make the difficult decision of calling emergency services when an overdose occurs and potentially forcing someone into

involuntary care. These interventions destroy trust and relationships and deter people from seeking medical assistance, even for issues unrelated to their substance use, for fear of forced treatment. Legislation authorizing forced treatment also has the potential to irreparably harm family relationships by giving guardians and families the false impression that such treatment is an effective way of supporting their loved ones, despite the documented risks.

16. Moreover, involuntary treatment increases stigma by perpetuating the notion that people who use drugs deserve to be forcibly removed from community and subject to medical care to which they did not consent and is likely to result in profound psychological and physical harm, including increasing their risk of death.

17. In 2013, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment called on all States to "close compulsory drug detention and 'rehabilitation' centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community."[26] Similarly, the UN Working Group on Arbitrary Detention has confirmed, "Drug treatment should always be voluntary, based on informed consent"; as such, the Working Group called on States to "Amend legislation, policy and practice so that all treatment for drug use disorders, including for drug dependency, is evidenced-based, strictly voluntary and based on informed consent."[27] In its 2024 visit to Canada, the Working Group reaffirmed that "deprivation of liberty in all settings must be an exception and substance abuse treatments must always be based on informed and voluntary consent. As an alternative to compulsory drug treatment, the Working Group urges the authorities to invest in evidence-informed, voluntary, and rights-based health and social services, as well as drug dependence treatment and rehabilitation options in the community."[28]

18. Additionally, **support for Drug Treatment Courts continues to grow, despite the numerous human rights concerns associated with these courts**. Such courts are championed as a potential alternative to incarceration for adults charged under the *Controlled Drugs and Substances Act* or the *Criminal Code* in cases where their drug dependence was a factor, but are broadly coercive in nature. To qualify, an individual is first screened by a prosecutor and must enter a guilty plea to be admitted into the program. For the duration of the program, a participant is subject to frequent, random urine screening and is compelled to submit to a rigorous treatment regime and to appear personally in court on a regular basis for highly intrusive judicial supervision. A judge can impose sanctions including jail time for drug use, breach of curfew, or missed treatment sessions, urine tests or court appearances. To graduate from the program, participants must meet criteria, including being abstinent for a certain period. Those who are expelled from or do not complete the program face the traditional criminal sentencing process. Troublingly, the most powerful tool Drug Treatment Courts have to coerce people into ending substance use and completing treatment is the threat of incarceration.[29]

19. Studies by Canada's federal Department of Justice have also shown that Drug Treatment

Courts are unable to engage women, Indigenous people, sex workers, racialized people, and youth — or to retain them once they have entered the program, thus exposing them to the serious penalties associated with attrition.[30] Evaluations have shown that, compared to men, women participants experience greater degrees of poverty and mental illness and are more likely to have children and family responsibilities, which impede their ability to complete the program; in particular, lack of appropriate housing is a major factor in women's attrition.[31] As the UN Working Group on Arbitrary Detention noted in 2021, "there is considerable evidence that drug courts cause significant harm to participants and frequently violate human rights" and that "Courts should not be supervising or involved in any way with drug treatment decisions, which should be left exclusively to health professionals."[32] In its 2024 visit to Canada, the Working Group concluded that "the threat of imprisonment should not be used as a coercive tool to incentivize people into drug treatment."[33]

20. Punitive approaches to drug use are drivers of stigma, isolation, and preventable harms and death. A core principle of harm reduction is that options for care must be non-judgmental, evidence-based, and non-coercive. Human rights norms also underscore the importance of bodily autonomy and informed consent to medical treatment as a corollary of the right to health, as well as the need to consider the impact of potential human rights violations on historically marginalized people. People who use drugs, and particularly those who are racialized, visibly homeless, living in poverty, young, disabled, and of marginalized genders are likely to be subject to even greater surveillance because of forced treatment initiatives, which could lead to increased harassment, marginalization, exclusion or expulsion from voluntary health and social services, and other abuses.

21. Expansion of involuntary treatment both exacerbates existing harms and fails to address underlying systemic issues. These approaches are out of step with international human rights norms, and harms – rather than supports – people who use drugs. As UN human rights bodies have acknowledged, "All health care interventions, including drug dependence treatment, should be carried out on a *voluntary basis with informed consent."*[34]

RECOMMENDED ACTIONS

The Legal Network recommends that the Committee call on Canada to:

- **Affirm the right of people who use drugs to bodily autonomy and informed consent to treatment and denounce all forms of coercive and involuntary care, whether it be pursuant to mental health legislation, forced substance use treatment legislation, or under the auspices of Drug Treatment Courts.**

- **Recommend law and policy reforms that aim to prevent, rather than respond to, the crises that lead to involuntary detention, including robust investments in voluntary treatment options that have strict regulatory oversight, harm reduction**

programming, and safe supply programs that are culturally affirming and reflect the intersecting identities of people who use drugs.

ARTICLE 18: LIBERTY OF MOVEMENT AND NATIONALITY

In the LOI, the Committee asked of Canada:

18. Please indicate the measures taken or envisaged to:

(a) **Repeal paragraph 38 (1) (c) of the Immigration and Refugee Protection Act, which refuses a foreign national who might reasonably be expected to require health services exceeding 99,060 Canadian dollars over a five-year period**.

22. Canada has faced repeated calls to repeal s. 38(1)(c) of the *Immigration and Refugee Protection Act* (*IRPA*) – i.e., the "excessive demand" regime – as well as Concluding Observations in 2017 from this Committee to respect the rights of migrants with disabilities,[35] but Canada has yet to do so. Instead, Canada has introduced a threefold increase to the cost threshold. While this has resulted in fewer foreign nationals being denied entry or stay in Canada, **people living with HIV and other conditions continue to be processed and denied under the "excessive demand" regime, subjecting them to additional costs, delays, and stigmatizing views of disability**.

23. Until 2017, Canada defined "excessive demand" as "a demand on health service services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years […]."[36] Under this definition, applications for temporary residence (i.e., work, student, or visitor) or permanent residence of 800-1,000 people living with health conditions were denied each year. People living with HIV were among those most often caught by the provision as most antiretroviral medications exceeded the cost threshold.[37]

24. In 2017, a Parliamentary Standing Committee studied the excessive demand regime and recommended the full repeal of s. 38(1)(c), recognizing that the provision unjustifiably harms people living with disabilities.[38] In response, Canada implemented some changes, such as tripling the cost threshold, which curtailed the number of refusals under the provision, while preserving the overall regime.[39]

25. As a result, an individual applying to remain in or travel to Canada must still undergo an immigration medical examination.[40] If the individual has a health condition, Immigration, Refugees, and Citizenship Canada (IRCC, the federal authority responsible for immigration) must then assess whether the individual's expected publicly funded healthcare costs will exceed a set cost threshold. If IRCC determines that a person will pose an "excessive

demand," IRCC must give the person an opportunity to argue that they can mitigate their expected healthcare costs. IRCC then has discretion to accept or deny the person's immigration application based on their expected healthcare costs.

26. In 2025, the "excessive demand" threshold is CAD $135,810 over a five-year period. Most people living with HIV do not meet this threshold and, therefore, are not refused based on "excessive demand." However, anyone apply for temporary or permanent residence in Canada whose HIV status is confirmed at an immigration medical exam must still be assessed for "excessive demand", which entails numerous harms, including:
    - being reduced to the cost of their healthcare, and having their value and contributions negated;
    - being exposed to stigmatizing views regarding disability and migration;
    - facing application processing delays;
    - bearing additional legal costs; and
    - facing removal from, or refusal to enter, Canada if they cannot afford to respond to a determination from IRCC that they pose an "excessive demand."

27. For decades, the "excessive demand" regime has been the focus of extensive criticism, in Canada and globally, due to its violations of the rights of persons with disabilities, including people living with HIV. In 2011, the UN General Assembly encouraged states to eliminate HIV-related restrictions on entry, stay and residence.[41] UNAIDS reiterated this call in 2014.[42]

28. In 2014, this Committee found that Australia's medical inadmissibility regime, which parallels Canada's s. 38(1)(c), violated articles 4, 5 and 18 of the *Convention on the Rights of Persons with Disabilities*.[43] In that case, the complainant had been denied a visa due to a multiple sclerosis diagnosis. The Committee concluded that Australia was under an obligation to prevent similar violations in the future, requiring Australia to repeal legislation preventing people with disabilities from immigration.

29. While Canada committed to repealing s. 38(1)(c) in 2018, its failure to do so compelled the HIV Legal Network to challenge the "excessive demand" regime in Federal Court, as inconsistent with *Charter* guarantees to equality before the law and the right to equal protection and equal benefit of the law without discrimination, including based on disability.[44]

30. Canada has attempted to justify s. 38(1)(c) as an approach involving individualized cost assessments, rather than categorical exclusion. Yet, cost is not a neutral factor. S. 38(1)(c) singles out people with disabilities by assessing them for their potential "excessive" use of health services. The law is premised on stigmatizing beliefs that people with disabilities are burdens on society and that migrants abuse public services. The "excessive demand" regime ignores the reality that people with disabilities make important economic and non-economic contributions to Canada. Moreover, the evidence demonstrates that actual savings from s. 38(1)(c) are insignificant. In 2017, refusals under the provision accounted for 0.1% of provincial and territorial healthcare budgets.

31. In imposing burdens and denying benefits to people with disabilities, the "excessive demand" regime prevents people living with disabilities from realizing the right to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. It prevents people living with disabilities from exercising their rights to education,[45] employment,[46] and the highest attainable standard of health under the Convention.[47]

RECOMMENDED ACTIONS

The Legal Network recommends that the Committee calls on Canada to:

- **Repeal the "excessive demand" provision of Canada's laws governing medical inadmissibility, which allows people seeking permanent resident status or temporary residence to be rejected based on their HIV status.**
- **Amend legislation such that immigration medical examinations are not tied to immigration applications or their outcomes.**

ARTICLE 25: HEALTH

In the LOI, the Committee asked of Canada:

24. Please provide information on the steps taken to:
    (a) Address the stigma as well as the physical, financial and attitudinal barriers faced by persons with disabilities in accessing quality health-care services, to provide universal coverage of health services, including disability-specific health services, for all persons with disabilities and to provide training for health-care practitioners.

32. Canada is in the midst of an unprecedented toxic drug crisis that has resulted in the deaths of 49,105 people who use drugs between January 2016 and June 2024.[48] These include people who use drugs who are living with a disability which may be related to their substance use — recognizing that a small percentage of people who use drugs experience problematic use.[49] Driven by Canada's long-standing policy of criminalizing drugs, the unregulated drug supply has become more potent and unpredictable year-over-year, with the emergence of high-potency opioids in the drug supply driven by intense policing and other law enforcement[50] and an observed displacement/replacement effect,[51] whereby the scheduling of substances is routinely followed by the emergence of new substances often posing greater harms from consumption. **By exacerbating the toxicity of the unregulated drug supply while failing to provide adequate health care services to people who use drugs, Canada is responsible for causing a public health crisis of overdose fatalities**.

33. One key measure to respond to the worsening drug poisoning crisis is to provide a safer

supply of pharmaceutical grade medications that are of known quality and quantity to people who use drugs. Evidence indicates that safer supply programs reduce the use of drugs from the unregulated supply and the risk of death and overdose; increase engagement and retention in programs and care; improve physical and mental health, as well as social well-being and stability; and are a critical option on the continuum of care for people who use drugs.[52] In one study, there was a 55% reduced risk of overdose death in the week after receiving at least one dispensation of safe supply opioids, while four or more dispensations were associated with a 91% reduction in risk of death in the following week.[53]

34. Yet extremely limited capacity as well as barriers to entry[54] leave most people who use drugs to rely on an unregulated supply, resulting in a staggering loss of life due to overdose fatalities. Moreover, Canada has yet to expand access to a regulated supply by engaging in the legalization and regulation of controlled substances as part of a public health approach to drug policy, despite recommendations in 2021 from Canada's own Expert Task Force on Substance Use to do so.[55]

35. Another key measure to address Canada's drug poisoning crisis is supervised consumption services (SCS), which are settings that provide a safe, hygienic environment where people can use drugs under the supervision of trained staff or volunteers to prevent the transmission of infections and overdose-related deaths. Evidence demonstrate that SCS reduce the risk of accidental overdose because people are not rushing or using alone; connect people to social services; provide or connect people to healthcare and treatment; reduce public drug use and discarded drug equipment; prevent HIV and HCV transmission; reduce strain on emergency medical services; and provide space for people to connect with staff and peers.[56] SCS can also provide a refuge from various forms of violence that women who use drugs may experience on the street.[57]

36. While a growing number of SCS are being implemented across the country, significant gaps in coverage persist, driven in part by onerous requirements for every site to obtain a federal exemption to operate, hostile provincial and local governments, and limited access to funding.[58] As a result, community members have been forced to implement unsanctioned sites to save lives.[59] Restrictions on inhalation services (which in some provinces is the route of consumption that has resulted in most overdose deaths)[60] and on assisted injection (i.e. administered by SCS staff) imposed by the criminalization of trafficking also deter people from accessing the service.

37. In addition to the harms of drug prohibition outlined above, the criminalization of people who use drugs, including via prohibitions on drug possession for personal use, pushes people to use their drugs in isolation, compromises their ability to take vital safety precautions, and deters people from essential health care and harm reduction services.[61] In Canada, Black and Indigenous people in Canada are disproportionately charged, prosecuted, and incarcerated for drug offences.[62] In prison, their risk of HIV and HCV infection and overdose also increases, given that few if any prisons in Canada offer critical harm reduction and overdose prevention measures, including needle and syringe distribution programs, SCS,

and safe supply, despite far higher rates of HIV and HCV and dramatic recent increases of deaths in custody.[63]

38. The vast majority of prisons also deny people in prison immediate access to naloxone, an exceedingly safe medication that can temporarily reverse an opioid overdose.[64] Most provinces across Canada offer free, unrestricted access to naloxone through first line responders, health centres, and pharmacies.[65] Yet incarcerated people in Canada do not receive the same standard of care. In most prisons, naloxone is only accessible to prison health care or security staff and prisoners are not permitted to have naloxone kits inside their cells in the event their cellmates suffer an opioid overdose. Correctional health care staff will not always be immediately available in overdose situations, yet the time taken to respond to an opioid overdose can mean the difference between life and death.

39. Access to harm reduction is inherent in the right to health, and recognized in numerous international instruments.[66] As noted in the *International Guidelines on Human Rights and Drug Policy*, States have a legal obligation to provide harm reduction services such as needle and syringe programs, SCS, and naloxone "to progressively realise the right to health and to ensure that people who use drugs may equally benefit from scientific progress and its applications … Ensuring access to harm reduction services is also critical for protecting the right to life."[67] The Special Rapporteur on the right to health has also recommended that harm reduction services, including needle and syringe programs, naloxone distribution, and SCS be acknowledged as key services which are essential for the protection of the right to health of people who use drugs.[68] UN human rights treaty bodies have also repeatedly called on States to adopt and implement culturally appropriate and gender-sensitive harm reduction services and to ensure access to these services in prison in order to meet their obligations to protect the right to health.[69]

40. Notably, in 2016, the Committee on the Elimination of Discrimination against Women expressed its concerns with Canada's "excessive use of incarceration as a drug-control measure against women" and "the significant legislative and administrative barriers women face to access supervised consumption services, especially in light of the ongoing nation-wide opioid overdose crisis." In its Concluding Observations, the Committee called on Canada to "reduce the gap in health service delivery related to women's drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services," to "establish a transparent process for exemptions permitting the operation of supervised consumption services without risk of criminal prosecution of clients or service providers," and to "take measures to prevent overdose deaths across the State party."[70] The following year, the Committee on the Elimination of Racial Discrimination called on Canada to "Implement key health and harm reduction measures across all prisons."[71]

41. Moreover, in order to meaningfully undo the harms of drug prohibition, Canada must decriminalize drug possession for personal use and the sharing or selling of drugs for subsistence, to support personal drug use costs, or to provide a safer supply.[72] Several UN human rights treaty bodies have called on States to decriminalize drug possession for

personal use in order to meet their obligations to protect the right to health.[73] In 2018, the UN Chief Executives Board for Coordination also adopted a common position on drug control policy, which calls for "changes in laws, policies and practices that threaten the health and human rights of people," including "the decriminalization of drug possession for personal use."[74] As the Office of the UN High Commissioner for Human Rights recommended in 2023, States should "Adopt alternatives to criminalization, 'zero tolerance' and elimination of drugs, by considering decriminalization of usage; and take control of illegal drug markets through responsible regulation, to eliminate profits from illegal trafficking, criminality and violence."[75]

RECOMMENDED ACTIONS

The Legal Network recommends that the Committee calls on Canada to:

- **Expand access to culturally appropriate and gender-sensitive harm reduction services such as safer supply, needle and syringe and other drug equipment distribution programs, supervised consumption services, and naloxone, including in prisons, to curtail the harms of the unregulated drug market.**

- **Decriminalize the possession of all drugs for personal use and the sharing or selling of drugs for subsistence, to support personal drug use costs, or to provide a safer supply, and remove all sanctions for such activities.**

- **Commit to legalizing and regulating all controlled substances.**

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[1] *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982,* being Schedule B to the *Canada Act (1982)* UK, 1982, c. 11, s. 15.

[2] *Brown v British Columbia* (Minister of Health) (1990), 66 DLR (4th) 444 (BCSC); *Wakeford v Canada* (1998), 166 DLR (4th) 131 (Ont Ct Gen Div).

[3] *Human Rights, Citizenship and Multiculturalism Act*, RSA 2000, c. H-14 [Alberta]; *Human Rights Code* RSBC 1996, c. 210 [British Columbia]; *Human Rights Code*, CCSM 1987, c. H175 [Manitoba]; *Human Rights Act*, RSNB 1973, c. H-11 [New Brunswick]; *Human Rights Code*, RSNL 1990, c. H-14 [Newfoundland & Labrador]; *Human Rights Act*, SNWT 2002, c. 18 [Northwest Territories]; *Human Rights Act*, RSNS 1989, c. 214 [Nova Scotia]; Human Rights Act, SNu 2003, c. 12 [Nunavut]; *Human Rights Code*, RSO 1990, c. H.19 [Ontario]; *Human Rights Act*, RSPEI 1988, c. H-12 [Prince Edward Island]; *Québec Charter of Human Rights and Freedoms* RSQ 1975, c. C-12 [Québec]; *Saskatchewan Human Rights Code*, SS 1979, c. S-24.1 [Saskatchewan]; *Human Rights Act*, RSY 2002, c. 116 [Yukon].

[4] C. Hastings et al., *HIV Criminalization in Canada: Key Trends and Patterns (1989–2020)*, HIV Legal Network, 2022.

[5] See, e.g., M. Loutfy et al., "Canadian Consensus Statement on HIV and its transmission in the context of the criminal law," *Canadian Journal of Infectious Diseases & Medical Microbiology* 25, 3 (2014): 135–140; and A.J. Rodger et al., "Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy," *JAMA* 316, 2 (July 12, 2016): pp. 171–181.

[6] HIV Legal Network, *Prosecuting HIV-related criminal cases in Canada: A Model Policy*, March 2022.

[7] UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*, Human Rights Council, Fourteenth session, Agenda item 3, A/HRC/14/20, April 27, 2010, para. 71.

[8] P. Allard, C. Kazatchkine and A. Symington, "Criminal prosecutions for HIV non-disclosure: Protecting women from infection or threatening prevention efforts?" in. J. Gahagan (ed.), *Women and HIV Prevention in Canada: Implications for Research, Policy, and Practice* (Toronto: Women's Press, 2013): 195–218.

[9] See, for example, *HIV Criminalization in Canada: Key Trends and Patterns (1989-2020)*, supra.

[10] Canadian HIV/AIDS Legal Network, *What does consent really mean? Rethinking HIV non-disclosure and sexual assault law meeting report*, 2014.

[11] UN Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Canada* (November 2016).

[12] UN Committee on the Rights of the Child, General Comment No. 20 (2016).

[13] *Report of the Special Rapporteur*, paras 2, 51, supra.

[14] S. Patterson et al., "The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence," *Journal of the International AIDS Society* 18 (2015): 20572.

[15] UNAIDS/UNDP, *Policy brief: criminalization of HIV transmission*, August 2008.

[16] *Report of the Special Rapporteur*, supra.

[17] Global Commission on HIV and the Law, *HIV and the Law: Risks, Rights and Health,* July 2012.

[18] See the perspectives articulated in the documentary film, *Consent: HIV non-disclosure and sexual assault law* (Goldelox Productions & Canadian HIV/AIDS Legal Network, 2015).

[19] See, e.g., Statement by Minister of Justice Jody Wilson-Raybould on World AIDS Day, December 1, 2016; Report by the House of Commons Standing Committee on Justice and Human Rights on the Criminalization of HIV Non-Disclosure in Canada, June 2019; News Release from Justice Canada on the launch of consultations on modernizing the criminal justice system's response to HIV non-disclosure, July 27, 2022.

[20] Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Canada*, CRPD/C/CAN/CO/1, 12 April 2017, para. 32.

[21] See Pivot Legal Society, *Involuntary Treatment: Criminalization by another name*, March 23, 2023; J. Hunter, "Behind the push to expand mandatory treatment for mental health and addictions in B.C.," *The Globe and Mail*, February 1, 2023; and K. DeBeck and P. Kendall, *B.C.'s plan for involuntary addiction treatment is a step back in our response to the overdose crisis*, *The Conversation*, September 25, 2024.

[22] See "Alberta weighing involuntary treatment law for people with addiction," *CBC News*, April 19, 2023.

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