McGill Journal of Law and Health ~ Revue de droit et Santé de McGill

Criminalization of the Intended Transmission or Knowing Non-Disclosure of HIV in Canada

Matthew Cornett *

The author of this article argues for a continuation of Canada's approach to criminalization of the intentional transmission or knowing non-disclosure of HIV, while suggesting certain reforms. The article begins by exploring the epidemiological aspects of HIV, competing theoretical models of sexual responsibility, and the distinctive challenges of applying criminal law in the sexual realm. Next the author presents and refutes anti-criminalization arguments based on public health concerns, stigmatization, and the emergence of HAART therapy. The article focuses on knowing non-disclosure, and proposes retaining the test for fraud set out in *R v Cuerrier*, while harmonizing its application with scientific evidence regarding transmission risk and modern sexual health guidelines; these factors are to guide judges, juries, and crown prosecutors in dealing with each offence. The article concludes by discussing areas of divergent interpretation in the current law: the definition of fraud adopted in *Cuerrier* and what constitutes "serious risk," and "significant harm." On this basis, the author critiques the recent application of *Cuerrier* in *R v Mabior* and *R v JAT*.

L'auteur défend ici l'approche canadienne de criminalisation de la transmission du VIH, intentionnelle ou selon la connaissance d'une non-divulgation, tout en suggérant certaines réformes. L'article débute par une exploration des aspects épidémiologiques du VIH, des modèles théoriques concurrents de la responsabilité sexuelle et des défis d'application du droit criminel aux affaires de nature sexuelle. Ensuite, l'auteur présente et réfute les arguments contre la criminalisation fondés sur des préoccupations de santé publique, de stigmatisation et d'émergence du traitement antirétroviral hautement actif (TAHA). L'article s'attarde sur la connaissance d'une non-divulgation et propose de retenir le test pour la fraude établi dans *R c Cuerrier* tout en harmonisant son application aux données scientifiques disponibles sur le risque de transmission et les indicateurs modernes de santé sexuelle. Ces facteurs devraient guider les juges, jurys et procureurs de la Couronne dans leur travail pour ce type d'infraction. L'article conclut en discutant des sphères où les interprétations du droit courant divergent : la définition de la fraude adoptée dans *Cuerrier* et ce qui constitue un « risque grave » et une « lésion grave ». Sur ces bases, l'auteur critique les récentes applications de *Cuerrier* dans *R v Mahior* et *R v JAT*.

---

* Matthew Cornett is a graduate of McGill Law School, B.C.L. / LL.B. (2010); he is currently a student-at-law with the City of Toronto, Legal Services Department. The author would like to thank Ted Dove, John Lennard, and Gregory Ko, as well as the anonymous reviewers for their helpful suggestions.

© Matthew Cornett 2011

Citation: Matthew Cornett, "Criminalization of the Intended Transmission or Knowing Non-Disclosure of HIV in Canada" (2011) 5:1 MJLH 61.

Référence : Matthew Cornett, « Criminalization of the Intended Transmission or Knowing Non-Disclosure of HIV in Canada » (2011) 5 : 1 RDSM 61.

Introduction **63**

I. Context: The HIV/AIDS Epidemic in Canada **63**
A. The Epidemiology of HIV *64*
B. Theoretical Models of Responsibility for Sexual Health *65*
C. Particularities and Challenges of the Sexual Realm *68*

II. The Challenge to Criminalization of Non-Disclosure **70**

III. Application of the Criminal Law **73**
A. Criminal Law as Applied to Non-Disclosure in R v Cuerrier 74
B. The Criminalization of Non-Disclosure and the Purposes of Criminal Law *76*
C. A Response to Public Health Concerns Opposing Criminalization *79*
D. Conceptions of Harm and Stigmatization *85*
E. Intentional Transmission or Exposure – R v Aziga 88
F. Reckless Transmission or Exposure *89*
1. Should Exposure Without Transmission be Criminalized? 89
2. Knowledge of Infection as a Precondition for Conviction 90

IV. Judicial Interpretation: The Thresholds of Risk and Harm **91**
A. The Split on Fraud in R v Cuerrier 91
B. How Much (Potential) Harm is Enough? *93*
1. The Elements of Fraud in *R v Cuerrier*: A Sliding Scale of Responsibility 93
2. Policy Considerations: Defining "Serious" and "Significant" 94

V. Recent Applications of *Cuerrier* ***96***
A. Condom Use and Viral Load: R v Mabior 96
B. HAART and "Serious Harm": R v JAT 99

Conclusion **101**

Introduction

Since the Supreme Court's seminal 1998 judgment in *R v Cuerrier*[1], 63 people in Canada have been criminally charged for not disclosing their HIV-positive status, including 32 from January 2006 to the beginning of 2009.[2] These prosecutions include the well-known case of *R v Aziga*, which resulted in multiple convictions for first-degree murder.[3] Nearly a dozen years after *Cuerrier*, this paper will re-examine and affirm the wisdom of criminalizing the knowing transmission or non-disclosure of HIV in the sexual context. The first Part will attempt to contextualize the decision to criminalize HIV with respect to its sociological backdrop and how one might understand "responsibility" in the sexual realm. The second Part lays out the emerging challenge by activists and academics to the *status quo* of criminalization, ultimately the motivating factor behind this work. The third Part focuses on objectives internal to criminal law and concludes that criminalization in the context of sexual transmission of HIV cannot be excluded prima facie as a valid public policy response, even in light of broader public health objectives. The fourth and final Part addresses the judgment in *Cuerrier* and suggests that the test for fraud laid out by the majority can be tailored to ensure that the criminal law is applied appropriately in circumstances that accord with both our understandings of responsibility in the sexual realm and modern public health objectives. Several of the most recent court rulings in the field are critiqued according to these guidelines, and suggestions are made for future judicial interpretation in the area of sexual HIV non-disclosure.

I. Context: the HIV/AIDS Epidemic in Canada

It is necessary to first consider the social context of any behaviour to decide whether it should be targeted for the application of the criminal law. There are many actions one might consider morally "wrong" or socially undesirable, but which are not criminalized due to Canadian social norms or the difficulty of policing them (e.g. adultery and suicide). Furthermore, beyond helping us code certain conduct "criminal," the social context of behaviour also

---

[1] [1998] 2 SCR 371, 127 CCC (3d) 1 [*Cuerrier*].

[2] See André Picard, "U.S., Canada Lead World in Prosecuting Those who Transmit AIDS Virus" The Globe and Mail (21 July 2010) A12; Alison Symington, "Criminalization Confusion and Concerns: The Decade Since the *Cuerrier* Decision" (2009) 14:1 HIV/AIDS Policy and Law Review at 5.

[3] See e.g. 2010 ONSC 3683, [2010] OJ No 2763; 164 CRR (2d) 122, 75 WCB (2d) 673, [2007] OJ No 4965 (various applications by Aziga exist, but, as Aziga opted for trial by jury, there is no "judgment").

helps determine the severity of fines or sentencing, as well as the gradation of possible charges. For example, both assault and sexual assault require the application of force without consent, but the latter occurs in the context of a sexual act and carries a significantly heavier maximum sentence. This Part examines the epidemiology of HIV in Canada, several theoretical models of sexual health and responsibility, and factors that militate for or against attributing moral blame in a sexual context.

A. The Epidemiology of HIV

HIV/AIDS is a matter of increasing public concern that merits strong intervention. More Canadians are now living with HIV–an estimated 65,000 at the end of 2008, compared with 57,000 at the end of 2005.[4] Though this number might reflect the increased lifespan of infected persons due to the introduction of highly active antiretroviral therapy ("HAART"), the number of new infections also continues to increase–between 2,300 and 4,500 new infections occurred in 2005, compared with 2,100 to 4,000 in 2002.[5] Estimates place Canada's adult prevalence rate (i.e. the percentage of the adult population aged 18-49 living with HIV/AIDS) at 0.3%, meaning 30 out of 10,000 adults are infected.[6]

However, the means we choose to reduce the number of HIV infections, and the trade-offs between the techniques employed will be shaped by fact. For example, of the HIV-positive individuals listed above, it is estimated that 27% are unaware of their status.[7] Given that this category accounts for the majority of transmissions,[8] varying policy responses might be selected to encourage testing and disclosure.

It is important to note that while HIV can and does infect individuals indiscriminately, its effects have not been experienced in a socially-proportionate manner. In Canada, men who have sex with men, ("MSM") though accounting for a decreasing proportion of recent infections, nonetheless

---

[4] Public Health Agency of Canada, *National HIV Prevalence and Incidence Estimates in Canada for 2008* (Ottawa: PHAC, 2010) at 2.

[5] Public Health Agency of Canada, *HIV/AIDS Updates, November 2007* (Ottawa: PHAC, 2007) at 10 [*PHAC Updates*].

[6] CIA World Factbook, *Country Comparison: HIV/AIDS Adult Prevalence Rate*, online: CIA World Factbook <www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html> [CIA World Factbook].

[7] *PHAC Updates*, *supra* note 5 at 10.

[8] *Ibid*.

represent 76.1% of cumulative reported AIDS cases and 68.1% of positive HIV test reports among adult males since testing began in 1985. Even starker are figures from studies listing HIV prevalence rates among MSM in large urban centres: 12.7% in Toronto, 12.4% in , and over 11% in Vancouver.[9] An increasing proportion of those with HIV-positive test results in Canada are women: 27.8% as of 2006. Individuals from HIV-endemic countries, Aboriginal peoples, and injection drug users are overrepresented in Canada's HIV/AIDS population.[10] Offenders in Canadian correctional facilities also experience a higher HIV prevalence (2%) due to patterns of drug use and high-risk sexual practices that may resume or continue after incarceration.[11]

For the purposes of this paper, several other facts are also relevant. First, in many countries, adult HIV prevalence rates are astoundingly high and caution against direct comparisons with the Canadian situation: Swaziland (26.10%), Botswana (23.9%), and Lesotho (23.20%) are among the direst examples.[12] Second, HIV-1 comprises many sub-types (A; B, predominant in Canada at 92.5% of infections; C; D; and recombinant), each of which evidences different primary- or multi-drug resistance to antiretrovirals, creating the possibility of cross-infection.[13] Finally, a national study found that 50-60% of grade 9 and 11 students believe there is a vaccine available to prevent HIV infection, and that 36% of grade 11 students believe there is a cure.[14] Prevalence rates, the possibility of cross-infection among HIV-positive individuals, and levels of sexual education will affect not only individual behaviour, but also any societal choice to criminalize sexual non-disclosure.

B. Theoretical Models of Responsibility for Sexual Health

Criminalizing the intended transmission or knowing non-disclosure of HIV, or another sexually-transmitted infection ("STI"), is a decision by the state to place a large portion of responsibility for sexual health on the diag-

---

[9] *Ibid* at 61.

[10] *Ibid* at 47.

[11] *Ibid* at 119.

[12] CIA World Factbook, *supra* note 6 (all rates refer to 2007 figures).

[13] Public Health Agency of Canada, *HIV-1 Strain Surveillance in Canada*, online: Public Health Agency of Canada, <www.phac-aspc.gc.ca/publicat/epiu-aepi/epi_update_may_04/14-eng.php> (even if an HIV-positive person's condition is under control due to HAART therapy, that person could acquire a new, and now untreated, strain of HIV).

[14] *PHAC Updates*, *supra* note 5 at 19.

nosed individual. In fact, most crimes, such as theft or murder, require examining only the accused's agency in bringing about a harmful result; the victim's actions are largely or totally irrelevant to the initial decision to criminalize the behaviour and are implicated only in a limited way when considering excuses or defences in law, such as provocation or self-defence. Crimes of inadvertence, such as criminal negligence, also rarely require an examination of victim conduct. The injured party is subjected to harm that he has no interest in, and over which he cannot truly exercise control. Even popular discourse regarding rape (now renamed "sexual assault") largely considers victim behaviour and sexual history as irrelevant to a determination of the accused's wrongdoing. This is arguably not true in cases involving STIs. Depending on the theoretical model to which one subscribes, criminalization may reinforce the moral status quo, or constitute a situation-specific shift in accountability and blameworthiness to the HIV-diagnosed partner. How we, as individuals or as a society, conceive of this duty of healthy sexual behaviour and its strength will determine the model of choice.

The first model places responsibility for sexual health entirely on the diagnosed individual, who has deviated from the "normative" expectation of health. Because the diagnosed individual has the most complete information with respect to his condition and its potentially serious effects if transmitted, it is he who bears the ultimate burden of disclosure and of taking adequate measures to protect his partners.

The second model, which could be termed "libertarian," holds that everyone is responsible for their own health, regardless of their partner's knowledge or health status. If an individual does not wish to risk acquiring an STI, he should use adequate protection, ask appropriate questions and demand proof of health, or abstain from sexual activity entirely. As a result, if a person engages in consensual sex, protected or unprotected, he must bear the burden of its risk and any social or medical consequences. Though often described as "shared responsibility," it is this model of individual responsibility that public health campaigns have sought to establish and reinforce through social norms.

A third model emphasizes the social aspects of individual choice and the need to take collective responsibility for attitudes and behaviours that may promote infection.[15] This could also be termed the "societal" or "no-fault" model. It recognizes that powerful environmental factors including norms, economic conditions, and laws shape risk-taking choices and are "inputs" into

---

[15] Gary Marks, Scott Burris & Thomas A Peterman, "Reducing Sexual Transmission of HIV From Those Who Know They are Infected: The need for Personal and Collective Responsibility" (1999) 13:3 AIDS 297 at 301.

the cognitive process of individuals. Examples might include sexual cultures that encourage multiple partners and unprotected sex or laws that discourage long-term, stable relationships among gay men. In the past, public health programs have focused on altering community practices with regard to many health threats, including smoking, caloric intake, and binge drinking. Similar approaches have been used in an attempt to control HIV, such as the establishment of privacy and anti-discrimination laws that encourage HIV testing, or efforts to change norms of sexual behaviour in gay bars.[16] This model, taken to its extreme, operates on the premise that asking for personal responsibility on the part of either partner in the absence of these measures is to blame a helpless victim.

The key to understanding the overall responsibility for the spread of STIs in Canada is likely a blend of these models, comprehending both the diagnosed individual and putative "victim" as relevant actors, but at present placing liability on the former. However, it is conceivable that this society-wide choice of attributing criminal responsibility to one partner or the other might poorly fit specific factual circumstances or cultural factors. For example, as mentioned above, MSM experience a far higher HIV prevalence rate than other communities and make up a large majority of documented AIDS cases.[17] In addition, many MSM remember (or have learned about) the AIDS crisis of the 1980s, and they have long been the target of HIV-control and sexual education campaigns.[18] In this context, the gap between what we might expect of the infected individual and "victim" is not so great as it might be in the heterosexual community, and a gay male who chooses to have unprotected sex with a partner of unknown status could be said to be behaving just as recklessly as his non-disclosing partner. This logic was considered in *R v Edwards* and rejected as being not only antithetical to criminal law, but also contrary to the realities of sexual behaviour (discussed in the next Part):

> It is clear that Mr. X did not inquire of Mr. Edwards nor did Mr. Edwards inquire of Mr. X whether the other was infected with any disease and in particular, if the other was HIV positive. While it is easy to suggest that such an inquiry would be particularly wise and very much appropriate in the gay community when anal sexual intercourse is anticipated, *there is no such*

---

[16] *Ibid* at 302.

[17] *PHAC Updates*, *supra* note 5 at 61.

[18] Allie Lehman, "Safer Sex & Young Gay and Bisexual Men: A Focus Group Report", online: AIDS Committee of Toronto <www.actoronto.org/research.nsf/pages/focus+group+report>.

> *standard in law, and human nature and circumstances, alcohol, passion, etcetera, dictate against such a standard.*[19]

C. Particularities and Challenges of the Sexual Realm

There are many examples in which the public, private, or particular nature of an act has been of interest to the law, and has influenced whether and to what degree criminal law sanctions are invoked. These include the decriminalization of consensual "homosexual acts" (exemplified by then-Justice Minister Pierre Trudeau's famous statement that "[t]here's no place for the state in the bedrooms of the nation"), assaults permitted in sport, and the split between assault and sexual assault. However, the question of whether, or to what degree, behaviours should be criminalized must account not only for the setting in which they take place, but also the practical difficulties of enforcement or conforming one's behaviour to the ideal. For example, projects including the creation of Insite (North America's first legal, supervised drug injection site) in Vancouver's Downtown Eastside neighbourhood,[20] or Portugal's 2001 decision to decriminalize personal possession of drugs (including marijuana, cocaine, heroin, and methamphetamines), seem to acknowledge the quasi-voluntary nature of drug use, its overwhelming addictive qualities, and the need for treatment.[21]

As suggested by the above quote from *R v Edwards*, the sexual realm presents similar challenges that militate both for and against assigning criminal responsibility to diagnosed individuals. Sex is inherently bound up with emotion, physical desire, and disinhibition. In her concurring opinion in *Cuerrier*, Justice McLachlan (as she then was) stated that "[p]eople can and do cast caution to the winds in sexual situations,"[22] while Justice Cory, for the majority, added:

> It cannot be forgotten that the act of intercourse is usually far more than the mere manifestation of the drive to reproduce. It can be the culminating demonstration of love, admiration and respect. It is the most intimate of physical relations and *what ac-*

[19] *R v Edwards*, 2001 NSSC 80, 194 NSR (2d) 107 at para 18 [*Edwards*] [emphasis added].

[20] Vancouver Coastal Health, "Insite - Supervised Injection Site", online: Vancouver Coastal Health <supervisedinjection.vch.ca>.

[21] Maia Szalavitz, "Drugs in Portugal: Did Decriminalization Work?" (26 April 2009), online: Time Health and Science <www.time.com/time/health/article/0,8599,1893946,00.html>.

[22] *Cuerrier*, *supra* note 1 at para 49.

> *tions and reactions led to mutual consent to undertake it will in retrospect be complex.*[23]

Thus, the largely private negotiations that occur prior to sexual relations are often intermixed with feelings of lust, or those of love and admiration, or a mixture of all three. These emotions contribute to a discourse between partners that is not ideal for candid discussions of sexual health status. As well, some sexual acts are performed in the context of alcohol or drug use, which can impair proper judgment; they may also be negotiated in environments which implicitly discourage verbal communication between partners, such as bathhouses or loud nightclubs.

Finally, bargaining positions are rarely equal. Power dynamics that flow through society related to physical strength, gender, race, and economic advantage are reflected in an individual's micro-choices, often relating to how he perceives his own attractiveness vis-à-vis that of his partner. For example, one study has shown that girls who perceive themselves as less attractive or less self-efficacious are less likely to use a condom with their partners.[24] Similar beliefs are held with respect to race and status in the gay community, which is thought to privilege a white, upper-middle class aesthetic, and contribute to inequalities of power.[25] HIV-positive individuals may also have concerns over the potential repercussions of disclosure, including fears that all prospective partners will reject them sexually or emotionally.

The sexual realm reveals many barriers to rational and complete communication. However, most of these challenges affect the parties to a sexual act equally. That is, the diagnosed individual is confronted with the same difficulties in disclosing his status or ensuring condom use as is the "victim" in protecting his own sexual health. Thus, context does not contribute conclusively to the selection of a model attributing responsibility entirely to the diagnosed individual or to his partner. Instead, since rational behaviour in the sexual realm is often contingent on numerous factors, this alters how, or whether, we decide to criminalize the knowing transmission or non-disclosure of HIV. In an area of inherent uncertainty, it might also be the *goal* of the criminal law to definitively attribute the protective duty to one party. Physical and emotional

---

[23] *Ibid* at para 126 [emphasis added].

[24] Jean Tschann et al, "Relative Power Between Sexual Partners and Condom Use Among Adolescents" (2002) 31 Journal of Adolescent Health 1.

[25] Adam Isaiah Green, "Health and Sexual Status in an Urban Gay Enclave: An Application of the Stress Process Model" (2008) 49:4 Journal of Health and Social Behavior 436.

vulnerabilities naturally exist when performing sexual acts. Bodily penetration and physical intimacy necessitate trust and reliance, even when precautions have been taken. Applying the criminal law can clarify who will be blamed if this trust is abused.

These issues must be considered when addressing the questions raised in the Parts below: should an individual's knowledge of his HIV-positive status decisively tip what is set out above as a *balance* of responsibility among partners towards the diagnosed individual, and is criminal law the appropriate mechanism for regulating such a complex array of situations?

II. The Challenge to Criminalization of Non-Disclosure

Though criminalization of the intended transmission or knowing non-disclosure of HIV has been well-established by two rulings of the Supreme Court of Canada (*Cuerrier* and *R v Williams*[26]), the past few years have been marked by challenges to this status quo. These challenges to criminalization have come in the form of increased activism by criminalization opponents in both the popular media and academic discourse. Examples of the former include several recent newspaper articles and editorials,[27] some of which have elicited more neutral or pro-criminalization replies.[28] A large majority of law and policy documents produced recently by academics have taken an anti-criminalization stance;[29] Justice Edwin Cameron, a judge of the Constitutional Court of South Africa and scholar in the field, has produced many of these re-

[26] *R v Williams*, 2003 SCC 41, [2003] 2 SCR 134, 176 CCC (3d) 449.

[27] See André Picard, "Prevent and Treat HIV, Don't Criminalize It", *The Globe and Mail* (14 August 2008); Tracey Tyler, "Judge Slams Criminalization of HIV", *Toronto Star* (12 June 2009); Edwin Cameron, Michael Clayton, and Scott Burris, "A Tragedy, Not a Crime", *The New York Times* (7 August 2008); Mark A Wainberg,"Criminalizing HIV Transmission may be a Mistake" (2009) 180:6 Canadian Medical Association Journal 688.

[28] Picard, *supra* note 2; "AIDS and the Duty to Not Infect", Editorial, *The Globe and Mail* (21 July 2010); Philip B Berger, "Prosecuting for Knowingly Transmitting HIV is Warranted" (2009) 180:13 Canadian Medical Association Journal 1368.

[29] Symington, *supra* note 2; Carol L Gattely & Steven D Pinkerton, "Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV" (2006) 10 AIDS and Behaviour 451; Ralf Jügens et al, *10 Reasons to Oppose Criminalization of HIV Exposure or Transmission* (2008), online: Open Society Institute <www.soros.org/initiatives/health/focus/law/articles_publications/publications/10reasons_20080918>.

ports and has been one of the most vocal proponents of global decriminalization.[30]

At this point, it is worth summarizing the principle arguments of decriminalization advocates, arguments which have in common the idea that criminal sanctions for non-disclosure of STIs undermine public health efforts to control the spread of HIV:

1. *The criminal law is not an effective tool for reducing the spread of HIV:* The sexual behaviours targeted by HIV-disclosure provisions are not easily deterred or altered due to many of the emotional factors referred to above. In addition, the incapacitative effect of the criminal law is experienced by very few offenders, and is therefore limited at best.

2. *Criminal laws create a disclosure-based norm for promoting safety in sexual interactions and thereby undermine the public health emphasis on personal responsibility for sexual health:* This "bipartite norm" places the HIV-diagnosed partner's responsibility to disclose before the other individuals' responsibility to protect themselves. It therefore encourages those at-risk to rely on prospective sex partners to disclose their HIV status and assume that there is minimal risk absent this disclosure, creating a false sense of security. In light of the large number of people who are unaware that they are HIV-positive, and given that the majority of new infections involve this category of persons, the message that any person could carry HIV, and that protection should always be used, is essential. Thus, criminalization fails to complement public health messaging and efforts to promote presumptive condom use.

3. *Criminal prosecutions for non-disclosure promote HIV-related stigma:* The history of HIV has been one of discrimination and stigmatization. This presents a great barrier to HIV-prevention efforts

[30] See generally Scott Burris & Edward Cameron, "The Case Against Criminalization of HIV Transmission" (2008) 300:5 Journal of the American Medical Association 578; Edwin Cameron, Scott Burris & Michael Clayton, "HIV is a Virus, Not a Crime: Ten Reasons Against Criminal Statutes and Criminal Prosecutions" (2008) 11:7 Journal of the International AIDS Society; Edwin Cameron, Edwin "Criminalization of HIV Transmission: Poor Public Health Policy" (2009) 14:2 HIV/AIDS Policy & Law Review 1 [Cameron, *Criminalization*].

that revolve around voluntary compliance with public health recommendations to be tested, avoid risky behaviours, and seek treatment. Treatment has become of even greater importance as HAART is believed to reduce the risk of HIV transmission significantly, acting at once as a treatment and preventative measure.[31] Yet HIV disclosure laws punish HIV-diagnosed persons for engaging in consensual sexual activities and thus distinguish between persons with HIV and uninfected individuals. This reinforces an "us versus them" dichotomy, associates infection with criminality, and emphasizes that the trait is undesirable and dangerous. This creates an environment where the HIV-positive hide their diagnoses, and may result in an unwillingness to seek support services for fear of a loss of confidentiality, disincentives to test and definitively know one's status, and a reduction in the benefits that early medical care provides, such as a lower viral load and reduced infectiousness.

4. *Criminalization results in overzealous prosecution and the spread of misinformation about HIV-related risks:* The charges applied in cases of non-disclosure of HIV have varied considerably and, in at least two cases, the police have laid attempted murder charges based solely on an allegation of non-disclosure before unprotected sex.[32] This gives rise to what might be called the "creep of criminalization": escalating charges by police against HIV-positive persons. Charges have been laid for engaging in low-risk behaviours, such as oral sex or spitting at a police officer,[33] and this tendency to prosecute can lead to misinformation among the public, press, and judiciary about the risks of HIV-transmission, feeding back into the stigma surrounding the virus.

5. *The criminalization of non-disclosure of HIV in Canada is fraught with legal uncertainties:* The judgment in *Cuerrier* establishes two requirements for non-disclosure to amount to fraud: dishones-

---

[31] Julio SG Montaner et al, "Association of Highly Active Antiretroviral Coverage, Population Viral Load, and Yearly New HIV Diagnoses in British Columbia, Canada: A Population-based Study" (2010) 376:9740 The Lancet 532.

[32] Cameron, *Criminalization*, *supra* note 30 at 65.

[33] James Turner, "HIV-positive Man on Trial for Assaulting Officer" *CBC News* (28 March 2011), online: <www.cbc.ca/news/canada/manitoba/story/2011/03/28/man-hiv-assault-police-trial.html>.

> ty and deprivation.[34] The latter requirement is satisfied by a "significant risk of serious bodily harm."[35] Disclosure is thus not made a blanket obligation, but it remains unclear where the line is to be drawn between activities that require disclosure and those that do not. This is especially the case with respect to lower-risk practices and undetectable viral loads. In addition to the uncertainty inherent in the test, since the judgment in *Cuerrier*, considerable advances have been made in understanding HIV transmission and treatment. This challenges the ability of courts to keep pace with medical advances and apply their understanding of modern treatments to the diverse circumstances of real-life sexual encounters.

These points can be roughly categorized into two groups, as they will be dealt with in this paper: (i) those that oppose the criminalization of HIV transmission or exposure *qua* criminalization;[36] and (ii) those that object to *how* the criminal law has been interpreted and applied, particularly in light of advances in the treatment of HIV/AIDS, and better (but still inconclusive) information about the risk of HIV transmission associated with various activities.[37]

III. Application of the Criminal Law

Having examined some of the contextual factors that must inform any debate over whether and to what extent to attribute responsibility for STI transmission, this Part addresses how the problem of non-disclosure fits within the operation of the criminal law. First, this Part will turn to the reasoning of the Supreme Court in *Cuerrier*, the most significant non-disclosure ruling to date. Second, it will examine how criminalization of the intended transmission or knowing non-disclosure of HIV might fulfill the traditional purposes of the criminal law vis-à-vis contrary arguments from a public health perspective. Third, it will discuss stigma and how one might conceive of the harm and moral blameworthiness of these behaviours. Finally, this Part will analyze how provisions relating to knowing transmission or non-disclosure should be crafted in Canada in order to avoid charges of HIV exceptionalism and to maintain fairness in the application of the criminal law.

---

[34] *Cuerrier*, *supra* note 1 at paras 112-116.

[35] *Ibid* at para 128.

[36] See Part III – Application of the Criminal Law, *infra*.

[37] See Part IV – Judicial Interpretation: The Thresholds of Risk and Harm, *infra*.

A. Criminal Law as Applied to Non-Disclosure in R v Cuerrier

In *Cuerrier*, the Supreme Court unanimously ruled that HIV-positive individuals may be subject to criminal sanctions if they do not disclose their status before engaging in unprotected sex. The importance of this case merits a brief review of the facts. In August 1992, a public health nurse told Cuerrier that he was HIV-positive. Cuerrier was instructed to use condoms during sex and inform his partners of his status. Three weeks later, he began a relationship with one of the complainants, KM, and their relationship involved frequent acts of unprotected vaginal sex. Near the beginning of their relationship, KM discussed STIs with Cuerrier but did not ask specifically about HIV. Cuerrier told her that he had tested HIV-negative eight or nine months earlier, but did not mention his recent positive result. A few months later, they both had HIV antibody tests; Cuerrier tested positive, while KM tested negative and was told she might need further tests. They continued having unprotected sex for several months, though KM testified she would not have had sex with Cuerrier had she known his HIV status at the outset. A few months later, Cuerrier began a sexual relationship with BH. After their first encounter, BH told him she was afraid of diseases but did not specifically mention HIV. Again, Cuerrier did not disclose that he was HIV-positive. Condoms were not used during most of their 10 or so sexual encounters. BH then discovered Cuerrier had HIV and confronted him. At the time of the trial, neither woman had tested positive for HIV.[38]

Cuerrier was charged with two counts of aggravated assault. Section 265 of the *Criminal Code* sets out the general provision for assault:

> (1) A person commits an assault when
>
> (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly.[39]

The intentional application of force is not assault if it is consented to. Paragraph 265(3)(c), however, sets out that fraud is one of the conditions vitiating consent:

> 265 (3)(c) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of … fraud.[40]

---

[38] *Cuerrier*, *supra* note 1 at para 79; see also *R v Cuerrier* (1996), 3 CR (5th) 330 (BCCA) at para 11 (this is the appeal-level decision with a slightly different factual emphasis).

[39] *Criminal Code*, RSC 1985, c C-46, s 265(1) [*Criminal Code*].

The general assault provision is further refined by subsequent sections, which set out the specific conditions necessary to render assault aggravated or sexual. The example pertinent to *Cuerrier* is laid out in section 268 of the *Criminal Code*:

> (1) Every one commits an aggravated assault who wounds, maims, disfigures or *endangers the life of the complainant*.
>
> (2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.[41]

This provision does not mention HIV or other STIs and, in fact, there are no HIV-specific crimes in Canadian law. Rather, existing offences have been applied in prosecutions to date. This is the preferred strategy of groups who believe penalties specifically aimed at conduct that may transmit HIV will label all individuals with HIV/AIDS as potential criminals and lead to indiscriminate stigma.[42] On the other hand, HIV-specific provisions have the advantage of defining in law the exact conduct prohibited, rather than leaving this task to courts. Limiting prosecutorial or judicial discretion in this way could check over-extension and misapplication of the criminal law. It is worth noting that diverse charges, with maximum penalties ranging from five years to life imprisonment, have been laid against people with HIV whose conduct posed a risk of transmission. These include: assault, aggravated assault, sexual assault, sexual assault causing bodily harm, aggravated sexual assault, common nuisance, criminal negligence causing bodily harm, murder, attempted murder, and uttering threats. The application of such a wide range of charges is controversial. For example, charges of common nuisance–which require conduct that "endangers the lives, safety, property, or comfort of the public"[43]–have been successfully laid against HIV-positive individuals for engaging in a single act

---

[40] *Ibid* s 265(3)(c).

[41] *Ibid* s 268 [emphasis added].

[42] Richard Elliott, "Criminal Law, Public Health and HIV Transmission: A Policy Options Paper" (Geneva: UNAIDS, 2002) at 32 [Elliott, "Policy Options"]; World Health Organisation European Region, "WHO Technical Consultation on the Criminalization of HIV and Other Sexually Transmitted Infections" (Copenhagen: WHO, 2006) at 8, online: <www.euro.who.int/aids> [WHO Technical Consultation].

[43] *Criminal Code*, *supra* note 39 s 180.

of unprotected sex.[44] In general, it is best that criminalization be carried out using general provisions, subject to the existence of consistent prosecutorial guidelines and predictable judicial interpretation (as should be the case with any criminal charge). This provides both flexibility and a clear delineation of prohibited conduct while sidestepping allegations of HIV/AIDS exceptionalism and avoiding the provisions becoming a stigmatizing force.

B. The Criminalization of Non-Disclosure and the Purposes of Criminal Law

It is trite to state that the criminal law is a blunt, naked exercise of State power, used to deprive an individual of his freedom only in both serious and blameworthy circumstances. The decision to deploy the criminal law must be justified with an eye to the four main objectives of criminalization: incapacitation, rehabilitation, retribution, and deterrence.[45] Factors unique to STI transmission that militate against achieving these goals are analyzed below:

i) *Incapacitation:* Imprisoning convicted criminals is said to incapacitate offenders for the length of their jail term, preventing them from harming others. In the case of HIV transmission by a repeat offender who refuses to comply with repeated public health orders to practice safer sex and inform partners, as was the case in *Cuerrier,* this may well be true.[46] However, imprisonment could conceivably have the opposite effect on public health. Prisons are places of heightened HIV prevalence in which high-risk behaviour is common.[47] Prisoners may also receive conjugal visits from partners who live among the general public, linking the two populations. However, it is important to note the difference from a criminal law perspective between, on the one hand, reducing the spread of HIV by any method, and, on the other, targeting exposure or transmission through sexual behaviour and non-disclosure, which might be considered dishonest, and thus worthy of a criminal law response.

---

[44] Canadian HIV/AIDS Legal Network, "Criminal Law and HIV" (2008), online: <www.aidslaw.ca/publications/publicationsdocEN.php?ref=847> at Part II [Canadian HIV/AIDS Legal Network, "Criminal Law and HIV"].

[45] Elliott, "Policy Options" *supra* note 42 at 20.

[46] *Cuerrier*, *supra* note 1 at 141.

[47] *PHAC Updates*, *supra* note 5 at 119.

ii) *Rehabilitation:* There is some debate whether criminal prosecutions serve rehabilitative functions in relation to sexual risk-taking behaviours. These behaviours are complex and may be more effectively influenced in the long-term using non-coercive interventions, such as counselling or support that address the underlying reasons for engaging in them. However, the likelihood of rehabilitation during imprisonment for *any* crime has long been questioned and is largely contingent on the allocation of resources to this end, both within prisons and in outside communities. Framed in this way, any problem of rehabilitation is not one created by the criminalization of HIV transmission in particular, but is part of a larger set of questions involving the operation of the justice system as a whole.

iii) *Retribution:* A principal justification for criminalization is the punishment of morally blameworthy behaviour. This in itself could be sufficient reason for criminalization, independent of public health efforts or other consequentialist justifications. The fulfillment of this objective depends on determining which behaviours involve a "guilty mind" of sufficient moral culpability to merit retribution.

iv) *Deterrence:* Another argument in favour of criminalization is that it deters people from conduct that transmits or risks transmitting HIV. This goal is motivated by public safety concerns. However, it is not entirely clear that criminal charges are effective in changing behaviours that occur "in the heat of the moment." Some authors have compared criminalizing the intended transmission or knowing non-disclosure of HIV to failed attempts to prohibit the consumption of alcohol and other drugs, consensual homosexual sex, or prostitution. These prohibitions led to stigma, concealment, and arguably greater harm than would have occurred had less emphasis been placed on achieving a deterrent effect.[48]

Because the strongest effect of incapacitation is experienced by a few serious offenders, the retributive and deterrent functions of the criminal law offer the strongest generalizable, though qualified, points in favour of criminalizing the intended transmission or knowing non-disclosure of HIV.

---

[48] Elliott, "Policy Options" *supra* note 42 at 21.

However, it is also important to consider section 718 of the *Criminal Code,* which describes two additional purposes of sentencing: (i) providing "reparations for harm done to victims or to the community"; and (ii) promoting "a sense of responsibility in offenders, and acknowledgment of the harm done to victims and to the community."[49] A criminal prosecution for the intended transmission or knowing non-disclosure of HIV might not only satisfy a public interest in punishment, but also provide a sense of interpersonal justice to victims who feel personally targeted and violated.

A final point not often raised by anti-criminalization groups is that criminal law, much like tort law, sends messages about what society considers to be morally wrongful behaviour.[50] As the Alberta Court of Appeal said in an early non-disclosure case:

> Concern has been expressed as to the message which this sentence sends to carriers of the AIDS virus. That message is that anyone who knowingly exposes another person to the risk of contracting AIDS, having in mind the seriousness of that risk, must expect to receive a substantial period of imprisonment.[51]

In contrast to deterrence, which operates through fear of criminal sanctions, these messages can legitimate discourses that press for mutual disclosure and the use of protection among partners. Criminal law sanctions can also be a

---

[49] *Supra* note 39 ss 718 (e)-(f).

[50] Indeed, another consideration that might frame the decision of whether and how to criminalize the knowing transmission or non-disclosure of HIV and other STIs is the existence of tort remedies. Though no definitive judgment on sexual transmission of or exposure to an STI has been rendered by a Canadian court, *ter Neuzen v Korn* ([1995] 3 SCR 674) and *Pittman Estate v Bain* ((1994), 112 DLR (4th) 257, 19 CCLT (2d) 1) seem to suggest that the negligent transmission of an STI (in both of these cases, HIV) is actionable under tort law. However, until there is a case directly concerned with the transmission of, or perhaps mere exposure to, a sexually transmitted illness, this avenue of redress remains hypothetical. Potential torts which might be invoked by the plaintiff to cover physical harm include battery and assault for cases of knowing or willfully reckless transmission, while negligence would cover cases of merely negligent transmission. Mental suffering could be compensated through the tort of outrage (also known as intentional infliction of emotional distress), or perhaps the tort of harassment (also known as negligent infliction of emotional distress). For a recent review of whether the tort of harassment exists in Canadian law, see *Mainland Sawmills Ltd v IWA-Canada*, 2006 BCSC 1195 at paras 12-16, 152 ACWS (3d) 543.

[51] *R v Summer* (1989), 69 Alta LR (2d) 303 at 303, 99 AR 29, 73 CR (3d) 32 (Alta CA) (Summer was sentenced to one year in prison on a charge of creating a common nuisance).

powerful public relations tool in the hands of non-governmental organizations. Campaigns against drunk driving provide an example of how advocacy groups have used the strong condemnation of criminal law not to prohibit the consumption of alcohol itself, but to shape its behavioural expression and the discourse surrounding it to encourage safer behaviour.

C. A Response to Public Health Concerns Opposing Criminalization

To this analysis of objectives internal to the criminal law we must add an examination of countervailing policy concerns. Naturally, the criminal law seeks to provide a net moral or practical gain to society, and must, to some extent, justify and tailor its responses with reference to outcomes. It is here that the possible spread of HIV among the population may be considered. What follows are widely-cited problems criminalization is believed to create or exacerbate:[52]

i) *Disincentive to testing:* The criminal law's ability to deter risky behaviour could be outweighed by harm to public health if people are *also* deterred from testing for STIs due to the fear of criminal prosecution. Anonymous testing has been instrumental in encouraging people to test and seek treatment without risking discrimination, a breach of confidentiality, or the creation of an official record that is disclosed to public health authorities. Criminalization may provide a disincentive for STI testing if prosecution hinges on a person's knowledge of his or her HIV status. If a person remains ignorant, he might not be successfully convicted.

However, the impact of criminalization on a person's willingness to test has not been evaluated directly. Instead, the argument is made by comparison to non-anonymous testing which can result in loss of confidentiality, stigma, and discrimination.[53] In light of the lack of such evidence, the majority in *Cuerrier* was correct in preferring Professor Holland's opinion:

> Individuals will not be deterred from testing just because of the possibility that at some future stage they may face criminal liability. … People want to know whether they are infected or not and whether any treatment is available. *Fear of possible*

[52] Elliott, "Policy Options" *supra* note 42 at 24; Canadian HIV/AIDS Legal Network, "Criminal Law and HIV", *supra* note 44 at sheet 3.

[53] See Elliott, *ibid* at 25 n 37.

> *future prosecution for something which has not yet occurred is most unlikely to deter anyone from being tested.*[54]

ii) *Hindering access to counselling and support:* Criminalizing the conduct of those infected with HIV could affect their willingness to seek out social services, including counsellors who are instrumental in altering highly complex behaviour by offering psychological or psychiatric support. If ongoing criminal actions are discussed with counsellors, to what extent could records or testimony be compelled in court for use against infected individuals? The level of legal protection for the confidentiality of treatment information or communications to professionals has been mixed, and this could have a chilling effect on diagnosed individuals' willingness to seek out counselling or disclose information to others. In common law jurisdictions, only the lawyer-client relationship is absolutely privileged, while confidential medical information may be protected or compelled on a case-by-case basis, according to four policy criteria.[55] In Quebec, statutory privilege may extend to all professional relationships, but it cannot apply to criminal proceedings, since they are a federal matter.[56] Disclosure of information obtained from a counselling session in a criminal proceeding has been implicitly approved by the Supreme Court in the case of *R v RS*, which was denied leave to appeal from the Ontario Court of Appeal, despite anti-disclosure policy considerations based on confidentiality and therapeutic benefit that were set out in the judgment.[57] Though no ruling related to confidentiality in the situation of HIV non-disclosure has been made, it can be assumed that disclosure of these records might be ordered in some situations. Of course, for this to be true, the HIV-diagnosed indi-

[54] *Cuerrier*, *supra* note 1 at para 143, citing Winifred H Holland "HIV/AIDS and the Criminal Law" (1994) 36 Crim LQ 279 [emphasis added].

[55] See *R v Gruenke*, [1991] 3 SCR 263. See also *M (A) v Ryan*, [1997] 1 SCR 157; *Slavutych v Baker*, [1976] 1 SCR 254.

[56] *Charter of Human Rights and Freedoms*, RSQ c C-12, s 9; *Medical Act*, RSQ c M-9, s 42.

[57] *R v RS* (1985), 19 CCC (3d) 115, (*sub nom R v RJS*) 45 CR (3d) 116 (Ont CA). For a more thorough discussion of confidentiality, see Richard Elliott, "After *Cuerrier*: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status" (Montreal: Canadian HIV/AIDS Legal Network, 1999) at 57-64 [Elliott, "After *Cuerrier*"].

vidual would have to be facing criminal charges after discussing activities of this nature with his counsellor. It is unclear to what extent this would affect the core counselling relationship or efforts to encourage lower-risk behaviours.

iii) *Creating a false sense of security and undermining individual responsibility:* There is a danger that criminally prosecuting people for not disclosing their HIV-positive status might encourage a false sense of security among those who are, or believe themselves to be, HIV-negative, leading to overall riskier behaviour. The belief that criminal prosecutions ensure disclosure undermines the message that individuals should always practice safer sex and obtain adequate information from a partner, which is quite problematic given the number of people referred to in Part II who are unaware of their infection.

However, it has not been demonstrated that criminalization would have this effect on decisions regarding safer sex, particularly in light of concern over other undesirable STIs. On the contrary, high-profile prosecutions might highlight the problem of non-disclosure as a serious one and carry the message that despite silence or repeated denials, any partner might be infected. In addition, as Justice Cory points out for the majority in *Cuerrier*, criminalization in this case is a situation-specific shift in responsibility: "It is true that all members of society should be aware of the danger and take steps to avoid the risk. However, the *primary responsibility* for making the disclosure must rest upon *those who are aware* they are infected."[58] Finally, there is no reason why public health campaigns promoting lower-risk behaviours, mutual disclosure, and individual responsibility for health cannot continue in the presence of criminalized non-disclosure.

iv) *Spreading misinformation about HIV/AIDS*: Inappropriate and overly-broad prosecutions can contribute to public misunderstandings about how HIV is transmitted and the level of risk presented by various sexual activities. Abroad, criminal charges have been laid and convictions obtained in cases involving biting, scratching, and spitting, despite an extraordinarily low or non-existent risk of transmission.[59] The

---

[58] *Cuerrier*, *supra* note 1 at para 144 [emphasis added].

[59] Elliott, "Policy Options" *supra* note 42 at 24.

Canadian case of *R v Thissen*[60] resulted from a similar situation: the defendant bit the complainant on the hand, causing a bleeding wound, and then disclosed that she had HIV. Thissen was convicted of aggravated assault under section 268 of the *Criminal Code*, which requires the complainant's life be endangered, and was given a two-year sentence. It is acknowledged that this type of judicial error, coupled with sensationalist media coverage, can contribute to a dangerously misinformed public. However, these occurrences have been rare and future problems may be avoided by following the judicial guidelines outlined in Part IV of this paper.

v) *Increasing stigma and discrimination:* Criminal prosecution for transmission or knowing non-disclosure of HIV, along with inflammatory media coverage, can contribute to the stigma faced by those living with HIV. Few infectious diseases are viewed with as much fear as HIV, and diseases more contagious than HIV are nonetheless treated with less repugnance. Criminal prosecution risks portraying all people living with HIV as potential criminals, and, in a disproportionate manner, those identified in the public mind with HIV and already subject to social disapproval: sex workers, MSM (recall that AIDS was originally named "Gay-Related Immune Disease" or GRID),[61] injection drug users, and certain immigrant groups. In *R v Thissen*, for example, the defendant was a transvestite with a lengthy prostitution record and the altercation occurred in the context of a police bust. Media coverage of these criminal charges has also been vigorous and, in some cases, hyperbolic. Reports on charges against one HIV-diagnosed woman in Ontario included headlines such as: "HIV Woman Strikes Again"[62] and "Woman Admits AIDS Assault; Petite Redhead Pleads Guilty to Trying to Sexually Infect CFB Bor-

---

[60] *R v Thissen*, [1996] OJ no 2074 (QL) (Ont Prov Div).

[61] Lawrence K Altman, "New Homosexual Disorder Worries Health Officials" *The New York Times* (11 May 1982), online: <www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html>.

[62] Tracy McLaughlin, "HIV Woman Strikes Again: Cops; Charged with Having Unprotected Sex", *Toronto Sun* (28 February 2007) 4.

den with HIV."[63] These reports not only suggest devious criminality, but also misrepresent the law. In this case, the accused was charged with aggravated sexual assault for non-disclosure. Intent to infect was neither alleged by the Crown nor mentioned in the original sentencing judgment in the judge's list of aggravating and mitigating factors.[64]

Misuse of prosecutorial or judicial discretion, or irresponsible reporting by the media may reflect or reinforce pre-existing stigma and discrimination against individuals living with HIV. However, this possibility applies *mutatis mutandis* to any application of the criminal law and reflects problems with the justice system that are already well-recognized, such as police over-enforcement in Black communities or media reports promoting racialized stereotypes of crime. As Justice Cory points out in *Cuerrier*, this type of stigmatization must be distinguished from the stigma attached to a criminal conviction itself:

> It was also contended that criminalization would further stigmatize all persons with HIV/AIDS. However it cannot be forgotten that the further stigmatization arises as a result of a sexual assault and not because of the disease … To proceed by way of a criminal charge for assault is not to "criminalize" the respondent's activities. Rather, it is simply to apply the provisions of the Code to conduct which could constitute the crime of assault and thereby infringe s. 265.[65]

Opponents of criminalization argue that public health law provides an alternative method of dealing with the problems of intended transmission or knowing non-disclosure of HIV. If public health policies can achieve the objectives listed above, while simultaneously doing less damage to health initiatives or other important interests, the application of the criminal law may be unnecessary and unjustified. How might public health interventions achieve these goals?

---

[63] Tracy McLaughlin, "Woman Admits AIDS Assault; Petite Redhead Rleads Guilty to Trying to Sexually Infect CFB Borden with HIV", *Toronto Sun* (26 November, 2005) 4.

[64] *R v Murphy*, 2005 CarswellOnt 8297 (Ont Sup Ct J).

[65] *Cuerrier*, *supra* note 1 at para 145.

It is likely that public health policies are better suited to achieving rehabilitation (i.e. enabling individuals to act with the proper care to avoid HIV transmission or disclose their status) than criminalization. Interventions by public health or support workers outside the penal system can be tailored to fit an individual's situation, including psychological or emotional issues, or the violence that a woman fears may occur if she informs her partner that she is infected. If less intrusive measures fail to deter conduct that places others at risk, public health legislation may also allow for detention orders (i.e. incapacitation) in locations such as hospitals, where less high-risk activity occurs than in prisons, and where health services are more readily available. Again, however, there is no reason public health interventions that encourage and enable disclosure cannot continue alongside the criminalization of non-disclosure.

Some argue that "public health orders may have a deterrent effect on the individuals to whom they apply,"[66] particularly if they are enforceable by the courts and police, while maintaining the subject's liberty in other respects. Thus, according to this view, criminalization is unnecessary. This explanation is tenuous, given the doubt expressed by many of the same advocates about the power of criminal prosecutions to deter crime. It is also crucial to separate the goals of rehabilitation and deterrence for this analysis, since deterrence looks only prospectively to the effect of enforced negative consequences on behaviour. In addition, the criminal law is better suited than public health policies to achieve the retributive function of punishing and publicly denouncing conduct that society finds morally objectionable.

Finally, public health interventions can take on a quasi-criminal character at their extreme. Health officials may have the power to compel examination and medical treatment of people suspected of carrying a transmissible disease, order them to disclose their HIV status to sexual partners, or detain a person (often using the state's police power) if this is demonstrably justified as necessary to prevent disease from being transmitted.[67] These more coercive aspects of public health are, like criminal law, subject to misuse for reasons of stigma or discrimination: "The UN has cautioned against the inappropriate application of provisions in public health laws that may be suited for casually communicable and often curable diseases, but not HIV/AIDS."[68]

Thus, despite the potential weaknesses of the criminal law and the utility of public health interventions, evidence does not support the prima facie exclusion of criminalization as a policy option. Instead, the choice to criminalize

---

[66] Elliott, "Policy Options" *supra* note 42 at 29.

[67] See e.g. *Health Protection and Promotion Act*, RSO 1990, c H.7, ss 22, 35-36.

[68] Elliott, "Policy Options" *supra* note 42 at 29.

discrete behaviours should depend on: (i) how one understands their practical and moral gravity as deserving of control or punishment; (ii) the presence of negative effects on public health outcomes or other important interests; and (iii) the possibility of crafting legal provisions and tests with enough precision to render just results.

D. Conceptions of Harm and Stigmatization

The majority in *Cuerrier* quotes Professor Holland regarding the potential for "serious bodily harm" posed by HIV infection: "The consequences of transmission are grave: at the time there is no 'cure'; a person infected with HIV is considered to be infected for life. The most pessimistic view is that without a cure all people infected with the virus will eventually develop AIDS and die prematurely."[69] Indeed, although the life expectancy and quality of life of those who receive HAART treatment has improved dramatically over the past 30 years, and significantly even since the 1998 judgment in *Cuerrier*, those diagnosed with HIV can expect to have a shorter lifespan than an uninfected individual, with higher rates of co-morbidity and mortality.[70] HIV-infected individuals can also experience a number of conditions that do not normally develop in healthy individuals, such as rare cancers and opportunistic infections.[71]

This is not to underemphasize that HIV infection, possibly leading to AIDS, is now a chronic[72] (i.e. a long-term and incurable, but treatable) condition, but simply to reinforce its potentially serious consequences. It is also important to note that the progression of the disease varies widely according to a person's susceptibility, immune function, and other factors including: viral load and CD4 cell count when treatment begins; age; the presence of other infections; and the particular strain of virus and its resistances.[73] HAART is available in Canada but presents difficulties as a collection of medications that

---

[69] *Cuerrier*, *supra* note 1 at para 128.

[70] Antiretroviral Therapy Cohort Collaboration, "Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies" (2008) 372:9635 The Lancet 293 [ATCC, "Life Expectancy"].

[71] AIDSmap, "HIV Treatment Prognosis" (February 2010), online: AIDSmap <www.aidsmap.com/cms1044536.aspx> [AIDSmap, "Prognosis"].

[72] David C Dugdale III & Jatin M Vyas, "HIV Infection" (25 January 2011), online: Medline Plus <www.nlm.nih.gov/medlineplus/ency/article/000602.htm>.

[73] AIDSmap, "Prognosis", *supra* note 71.

must be taken in some quantity at regular intervals. Common side effects include nausea, headache, malaise, and fat accumulation on the back ("buffalo hump") and abdomen; when used for a long period of time, these medications also increase the risk of heart attack.[74] Thus, infection with HIV can still be objectively qualified as a "serious bodily harm," even for Canadians receiving advanced care.

However, as one author argues, "by conceiving of HIV infection as merely a species (of serious bodily harm) within a genus (of bodily harms), the criminal law may, additionally, be thought to have avoided the charge of HIV/AIDS exceptionalism."[75] He states that the context of transmission and social meaning of infection–which are explicitly rejected by the narrative of a liberal, positivist theory of law for which legitimacy depends on neutrality and objectivity–is precisely what determines whether it is proper and appropriate to treat those who infect others as having committed a wrong deserving of moral and legal censure. In his opinion, and that of others,[76] this context and meaning form part of a legal framework "that with every conviction affirms the idea that HIV infection is something that is in and of itself harmful, and by implication, that those people who are HIV positive are somehow 'damaged,' 'abnormal' and 'lacking.'"[77] In short, finding recklessness involves a complex relationship between risk and fault and is a matter of individual and *socio-political* judgment, as the risk must be found to have been unjustifiable or unreasonable. The negative judgment of those living with HIV is contributed to by a modern society that constructs fellow human beings as "risks" to our physical, economic, and psychic security. Because infected individuals are categorized as unhealthy and abnormal, they become potential criminals and "harmers."

Also, due to the negative discourses surrounding those who are associated with HIV infection–sex workers, racial minorities, and homosexuals–these groups are portrayed as constituting a threat to mainstream society's self-identify and security, as well as to the values and norms in which these are grounded. This leads to a social explanation of AIDS "which identifies its *causes* with the *practices* that define an *identity* that constitutes a *risk*."[78] As a result, those living with HIV find it impossible to resist accusations that an in-

---

[74] David C Dugdale III & Jatin M Vyas, "AIDS" (25 May 2010), online: Medline Plus <www.nlm.nih.gov/medlineplus/ency/article/000594.htm>.

[75] Matthew Weait, *Intimacy and Responsibility: The Criminalization of HIV Transmission* (New York: Glasshouse, 2007) at 113.

[76] WHO Technical Consultation, *supra* note 42 at 7.

[77] Weait, *supra* note 75 at 112.

[78] *Ibid* at 142 [emphasis added].

cident of exposure or onward transmission was *their* responsibility and no other's. HIV is taken as merely a quality of individuals and ignored as a social fact, and the relevance of specific individuals' efforts to act responsibly will be denied.[79]

However, it must be emphasized that the threshold of the legal test for transmission or exposure in Canada remains "serious bodily harm," without which there can be no conviction. If in the future the physical harm caused by HIV infection were to fall below this threshold, regardless of any social stigma, there would be no crime. What's more, one cannot be prosecuted merely for having HIV, but rather for acting in a manner that is considered criminal. It is more difficult to address the points raised by various discourses that criminalization may: construct those living with HIV as abnormal and inherently "risky" (thus constituting the moral wrong of the crime itself); create an offender-victim dyad; preclude the social nature of HIV infection; and deny the relevance of particular individuals' efforts to prevent transmission. First, the desire to avoid risk, especially the risk of contracting an STI more serious than other communicable but curable illnesses, is logical. It is also a fact that those living with HIV, though not inherently "risky," can engage in activities that do pose a heightened risk of transmission. Second, as discussed in Part II, it is difficult for both partners to take complete responsibility for each other's protection, particularly if one of them (the HIV-infected *or* the "victim") is socially marginalized. The reasoning of the law as it stands is that one's knowledge of being infected with HIV, a virus which can lead to devastating illness, creates a situation in which *any* person could realize the wrongfulness of knowingly transmitting or not disclosing. This is no different than any other crime, like theft, which, for social and economic reasons, is invariably committed more often by marginalized individuals. It is not merely having HIV that creates a duty to disclose, rather it is but knowing one is infected and choosing not to take steps to protect or obtain the consent of one's partner. Finally, the Supreme Court has explicitly recognized that the duty to disclose varies with the significance of the risk posed;[80] therefore, efforts to act responsibly, such as choosing lower-risk activities or using a condom, may well be recognized by judges in their decisions.

---

[79] *Ibid*.

[80] *Cuerrier*, *supra* note 1 at para 127.

E. Intentional Transmission or Exposure – R v Aziga

Johnson Aziga recently became the first person, perhaps in the world, to be tried and convicted of first-degree murder for the sexual transmission of HIV. He reportedly had unprotected sex with 13 women, despite knowing of his HIV-positive status and having been warned by public health authorities to use protection and disclose his illness. Seven of the women tested positive for HIV, and two later died of AIDS-related cancers. The women alleged that Aziga had infected them with the virus, had not disclosed his status to them before having unprotected sex, and in some cases had actively deceived them. The women claimed they would not have had sex with Aziga had he disclosed. A jury found him guilty of two counts of first-degree murder, 10 counts of aggravated sexual assault, and one count of attempted aggravated sexual assault.[81] Aziga was sentenced to life in prison with no possibility of parole for 25 years, as is mandatory in Canada for a conviction of first-degree murder. He has stated his intention to appeal.

The first two charges were elevated from manslaughter to first-degree murder according to paragraphs 231(5)(b) and (d) of the *Criminal Code*, which provide that in certain contexts–in this case, sexual assault or aggravated sexual assault–all murder is of the first-degree. Though elevation of the charge in the context of HIV infection is debatable, there is nonetheless consensus among many anti-criminalization groups that, should the Crown prove beyond a reasonable doubt that the defendant intended to cause bodily harm that he knew was likely to cause death or was reckless as to whether death ensued, criminal liability is warranted.[82] This fits with the highest of the three levels of mental culpability generally recognized by the criminal law: intent, recklessness, and negligence. A person intends to commit a crime when it is his *purpose* to commit it, or if he *knows* with some certainty his conduct will bring about the prohibited result; this is most clearly included in the scope of the criminal law. However, some authors have stated concern that sensational media reports lead the Crown to pursue more serious attempted murder charges–this is described as the "creep of criminalization"–based solely on the allegation that one has not disclosed his HIV-positive status before unprotected sex.[83] While it is undoubtedly necessary to develop strong prosecutorial guidelines in these cases to ensure charges are consistent (as with any criminal mat-

---

[81] Barbara Brown, "Guilty Verdict in Hamilton HIV Murder Case" *Toronto Star* (4 April 2009), online: <www.thestar.com/article/613920>.

[82] Cameron, *Criminalization*, *supra* note 30 at 65; WHO Technical Consultation, *supra* note 42 at 9.

[83] Cameron, *Criminalization*, *supra* note 30 at 65.

ter), courts are also highly sensitive to the requirements of *mens rea*, which the Crown must prove beyond a reasonable doubt. Unduly inflated charges are unlikely to be sustained at trial.

F. Reckless Transmission or Exposure

Whether the criminal law should extend to reckless or negligent conduct in the context of HIV exposure is more contentious. A person is criminally reckless who foresees that particular conduct may cause a prohibited result, but nevertheless deliberately takes the unjustified risk. Lowering the threshold of liability below intentionality raises concerns about the potential for bias in the interpretation of factors relevant to finding recklessness, such as the degree of risk that would be deemed unjustifiable, or what conduct is so far from the conduct of the reasonable person that it could be considered criminal. In spite of these concerns, this Part demonstrates that the criminal provisions for liability and the associated judicial tests can be crafted to safeguard judicial objectivity.

1. Should Exposure Without Transmission be Criminalized?

In England and Wales, criminal charges apply only when there has been HIV transmission (i.e. infection of another person). Exposure is not a ground for prosecution.[84] It is not uncommon for the criminal law to differentiate on the basis of consequence. For example, Canada has separate charges for murder and attempted murder, and for assault and aggravated assault. This is logical when the completion of the crime is thought to indicate a more culpable mental state, a higher cost to society, or the presence of greater risk-taking. By contrast, a number of crimes, such as drunk driving, do not depend on any consequence arising, even in the absence of the more culpable mental states of intention or recklessness. However, there is no provision in the *Criminal Code* that punishes only for the completion of a serious crime, but in no manner for its attempt. While it may be desirable to reduce the overall number of prosecutions dealing with HIV for pragmatic reasons, but the criminalization of transmission and not simple non-disclosure would be morally unjustifiable. Individuals who expose their partner to an unjustifiable risk of infection with recklessness (and therefore *mens rea*) greater or equal to that of other diagnosed individuals who "successfully" transmit would not be captured. Imagine a situation in which Person A repeatedly and through active deception engages partners in unprotected sex but no transmission occurs, while a single unpro-

[84] See generally Weait, *supra* note 75.

tected act without disclosure by Person B leads to HIV infection. Prosecution would depend on chance and could be seen as arbitrary. Criminalization should thus apply equally to both reckless transmission and exposure.

2. Knowledge of Infection as a Precondition for Conviction

For criminal sanctions to apply, the Crown should have to prove the accused actually knew he was infected with HIV. In other words, the Crown would have to prove the accused had positive knowledge of his infection, without which he cannot be said to have acted recklessly. Extending criminalization to those who know they *may* be infected, or who it is felt *ought* to know they are or may be infected would expose far too many to prosecution. It would also allow for constructive knowledge based on existing bias, discrimination, or identity profiling:

> This would have resulted in a significant extension of criminal liability, one from which it is but a small step towards basing liability on membership of a high-prevalence group – on the grounds that gay men, injecting drug users or people from sub-Saharan Africa ought to assume by virtue of these criteria alone that they are, or may be, HIV-positive.[85]

Comments in the recent Supreme Court ruling in *Williams*, dealing with the non-disclosure of HIV infection to a partner after a positive test, demonstrate this incorrect, overly broad approach to determining what level of knowledge is necessary for conviction: "Once an individual becomes *aware of a risk* that he or she has contracted HIV, and hence that his or her partner's consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established."[86] This language suggests that a definitive diagnosis of HIV infection is not necessary to activate the legal duty to disclose. However, this standard seems difficult to apply: "When does a person become 'aware of a risk' that they might be HIV-positive? What sort of past activities that might have carried a risk of HIV infection will mean that a person is aware of a risk that they have contracted HIV? How significant a risk does it have to

---

[85] M Weait & Y Azad, "The criminalization of HIV transmission in England and Wales: questions of law and policy" (2005) 10(2) HIV/AIDS Policy & Law Review 6.

[86] *Williams*, *supra* note 26 at 28 [emphasis added].

be before it becomes 'reckless'?"[87] Indeed, this standard invites the application of serious criminal penalties where a person was truly uncertain, and could allow courts to intensely scrutinize a person's past activities in a manner that would substantiate the fears laid out above regarding stigmatization. A requirement for successful conviction should be actual knowledge or belief of infection, obtained through a positive medical test result, or physical manifestation of disease.

It follows from this conclusion that, in order to establish guilt, an HIV-positive person must understand how HIV can be transmitted and that his conduct carries a risk of causing his partner serious bodily harm. Though for the vast majority of Canadians it might be said that one is grossly negligent for being unaware of these risks, this may not be the case in countries like South Africa, where in 2006 the health minister famously claimed that AIDS could be treated with traditional African remedies, such as garlic, lemon juice, and beetroot.[88] In Canada's multicultural society, courts must be conscious that many will have come from HIV-endemic nations where education is limited, and that even many Canadian-born youth have incorrect views about of the existence of an AIDS vaccine, or the curability of HIV/AIDS.[89] If raised as an issue by the defence, the Crown should be required to prove that an individual possessed knowledge of how HIV is transmitted and its harmful effects, or that the accused was grossly negligent as to knowledge of these facts.

IV. Judicial Interpretation: The Thresholds of Risk and Harm

A. The Split on Fraud in R v Cuerrier

The *Cuerrier* decision focuses solely on the question of whether an HIV-positive person who fails to disclose his status has committed "fraud" as defined by the assault provision of the *Criminal Code*. Seven of nine justices heard the case and all concluded that Cuerrier's failure to disclose his status constituted fraud. The split revolved around how the law should define fraud that vitiates consent to sex. In the previous (repealed) version of the provision, fraud vitiated consent only where it related to the "nature and quality of the

---

[87] Canadian HIV/AIDS Legal Network, "Notice re: Supreme Court of Canada decision in *R v Williams*" (18 September 2003), online: <aidslaw.ca/publications/interfaces/downloadFile.php?ref=22>.

[88] Geoffrey York, "Radical shift in HIV-AIDS thinking" *The Globe and Mail* (15 November 2009), online: <www.theglobeandmail.com/news/world/south-africa-radically-shifts-aids-thinking/article1364340>.

[89] *PHAC Updates*, *supra* note 5.

act," or in this case, the mechanical content of the sexual act as opposed to its possible health consequences. The justices agreed that fraud covered in the past by this rule would still vitiate consent, but decided that the operative definition must be extended to cover the situation of the *Cuerrier* case.

The justices adopted three different approaches. The majority, led by Justice Cory, set out a harm-based approach for deciding what would constitute fraud vitiating consent to sex, requiring that the prosecution prove the existence of: (i) an act that a reasonable person would see as *dishonest*; (ii) *deprivation*, or a harm or risk of harm to the complainant as a result of that dishonesty; and (iii) that the complainant would not have consented to the act but for the accused's dishonesty.[90]

Writing for herself and Justice Gonthier, Justice McLachlin concluded the rule of fraud as to the "nature and quality of the act" should simply be expanded to include deceit about STIs:

> Where the person represents that he or she is disease-free, and consent is given on that basis, deception on the matter goes to the very act of assault. The complainant does not consent to the transmission of diseased fluid into his or her body. This deception in a very real sense goes to the nature of the sexual act, changing it from an act that has certain natural consequences (whether pleasure, pain or pregnancy), to a potential sentence of disease or death. It differs fundamentally from deception as to the consideration that will be given for consent, like marriage, money or a fur coat, in that it relates to the physical act itself.[91]

Justice L'Heureux-Dubé proposed that the Court go further, stating that whether the fraud in question was physically harmful or carried a risk of harm is irrelevant. The Crown would be required to prove beyond a reasonable doubt that the accused was dishonest (using an objective standard) with respect to *any* fact in a manner designed to induce the complainant to submit to activity, and that absent this dishonesty, the complainant would not have submitted.

While the two minority approaches seem easier to both define and apply than the harm approach adopted by the majority, Justice McLachlin's approach offers no principled reason for singling out HIV or any other STIs as an additional locus of fraud that potentially vitiates consent (as opposed to any other fraud), and would greatly expand criminal liability. This same problem exists with Justice L'Heureux-Dubé's approach, which her colleagues correctly not-

---

[90] *Cuerrier*, *supra* note 1 at paras 112-116.

[91] *Ibid* at para 72.

ed "vastly extends the offence of assault,"[92] and "would trivialize the criminal process by leading to a proliferation of petty prosecutions instituted without judicial guidelines or directions."[93] The approach adopted by Justice Cory–while requiring more thorough interpretation by courts–offers a principle for extending criminal liability, and is more amenable to contextual analysis, the creation of judicial safeguards against abuse, and addressing public health policy concerns. These attributes will be examined in the following Part.

B. How Much (Potential) Harm is Enough?

1. The Elements of Fraud in *R v Cuerrier*: A Sliding Scale of Responsibility

The majority reasons sets out the two requirements for fraud that would vitiate consent: (i) dishonesty and (ii) deprivation. To this first element of dishonesty, Justice Cory assimilates not only deliberate deceit, but also non-disclosure or silence regarding one's HIV-positive status. As he states, "the actions of the accused must be assessed objectively to determine whether a reasonable person would find them to be dishonest."[94] This raises the spectre of stigma and bias entering into the assessment of criminal responsibility; that is, finding an HIV-positive person to be dishonest simply because they are "risky." However, whether dishonesty vitiates consent is decided with reference to the *severity* of the possible bodily harm and the *risk* of its occurrence, creating a sliding scale of responsibility: "The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud, the greater the risk of deprivation the higher the duty of disclosure … he Crown will have to establish…a significant risk of serious bodily harm."[95] Justice Cory also added that "[t]he possible consequence of engaging in unprotected intercourse with an HIV-positive partner is death. In these circumstances there can be no basis for distinguishing between lies and a deliberate failure to disclose."[96] *Cuerrier* establishes that the severity of HIV infection creates a positive duty, but raises the following questions: what embodies a legally "significant" risk of transmission? What constitutes a "serious" bodily harm?

---

[92] *Ibid* at para 52.

[93] *Ibid* at para 131.

[94] *Ibid* at para 126.

[95] *Ibid* at para 127-28.

[96] *Ibid* at para 126.

2. Policy Considerations: Defining "Serious" and "Significant"

Most agree that HIV infection poses a risk of serious bodily harm. The most common charge laid in cases of non-consensual HIV transmission or exposure is aggravated sexual assault, which requires that the accused "endangers the life of the complainant." This point is rarely, if ever, contested. Notably, the test of serious bodily harm is not exclusive of other severe but generally curable STIs, such as Chlamydia or syphilis. As of yet, few cases have been brought to Canadian courts to test criminal charges for the transmission of or exposure to these other infections.[97] An interesting situation arose in *Williams*, in which the accused was convicted of "*attempted* aggravated assault." Though the accused was deceitful with regard to his HIV-positive status, it was possible that his partner was infected before he became aware of his diagnosis, and thus the Court ruled Williams had not endangered the life of the complainant.[98] However–though it was not accepted at the time–the possibility was raised of an accused individual cross-infecting a complainant with a different, drug-resistant viral strain and thereby further endangering his life.[99] The author believes that in the proper factual circumstances, non-disclosure of potentially cross-infecting HIV infection should be subject to a full conviction for aggravated assault as cross-infection can give rise to a new risk of serious bodily harm.

From the viewpoint of HIV transmission, what constitutes a "significant" risk in law is more complex. It is here that the test set forth by Justice Cory in *Cuerrier* demonstrates its greatest flexibility in incorporating public health goals into criminal law. Intercourse with an HIV-positive person will always present risks, but it is unclear whether lower-risk activities might be considered a "significant" risk. The following chart incorporates the number of infections per 10,000 exposures to an infected source organized by type of *unprotected* exposure route, as well as the categorization of risk with and without condom use:

---

[97] See e.g. *R v Jones*, 2002 NBQB 340 (dealing with the transmission of Hepatitis C).

[98] *R v Williams*, *supra* note 26.

[99] *Ibid* at 15.

Exposure Route	***Estimated infections per 10,000 exposures to an infected source***[100]	***Categorization of risk (unprotected)***[101]	***Categorization of risk with condom use***[102]
Blood Transfusion	9,000	-	-
Childbirth	2,500	-	-
Needle-sharing (Injection Drug Use)	67	High	-
Percutaneous Needle Stick	30	-	-
Receptive anal intercourse	50	High	Low
Insertive anal intercourse	6.5	High	Low
Receptive penile-vaginal intercourse	10	High	Low
Insertive penile-vaginal intercourse	5	High	Low
Receptive oral intercourse	1	Low	Negligible
Insertive oral intercourse	0.5	Negligible	Negligible
Kissing/Spitting	-	None – low	-

---

[100] B Varghese et al, "Reducing the Risk of Sexual HIV Transmission: Quantifying the per-act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use" (2002) 29:1 Sexually Transmitted Diseases 38 at 40.

[101] Canadian AIDS Society, *HIV Transmission: Guidelines for Assessing Risk*, 5th ed (Ottawa: CAS, 2004) at 6, online: <www.cdnaids.ca/web/repguide.nsf/Pages/cas-rep-0307> [*CAS Guidelines*].

[102] *Ibid* at 22-25.

The chart shows that in cases involving kissing or spitting, criminal charges are not appropriate in the absence of aggravating factors. In *R v Edwards*, the trial judge correctly stated that "unprotected oral sex is conduct at a low risk that would not bring it within s. 268(1) of the *Criminal Code*, and had only unprotected oral sex taken place, no charges would have been laid."[103] Indeed, as pointed out in the Canadian AIDS Society risk report, "these categories of HIV transmission are no risk, negligible risk, low risk and high risk. If these categories or levels were represented graphically on a continuous line, negligible and low risk would be much closer to the 'no risk' end of the continuum. There is no 'middle' level of risk."[104] Judicial assessments of the significance of the risk of HIV-transmission should be consistent with available epidemiological data, and thus preclude oral sex, and other low-to-no risk activities from leading to criminal prosecution. This will create consistency in the criminal law, maintain scientific objectivity, and avoid imposing penalties disproportionate to the offence. It would also allow HIV-positive individuals to choose lower-risk activities that accord with public health guidelines and send proper messages to the wider public about the risks of transmission.

V. Recent Applications of *Cuerrier*

A. Condom Use and Viral Load: R v Mabior

In *Cuerrier*, Justice McLachlan specifically mentioned that condom use would preclude a finding of fraud on the part of the accused,[105] while the majority stated that "the careful use of condoms *might* be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation."[106] This hypothetical statement was considered in the recent case of *R v Mabior*, in which the trial judge concluded that an accused who does not disclose his HIV-positive status can be convicted of aggravated sexual assault even when a condom is used, but that when an accused uses a condom *and* has an undetectable viral load, the risk of harm is so reduced that it cannot constitute fraud.[107] This case was varied on appeal and the court dismissed four of the six counts against Mabior, stating that either "careful or consistent" condom usage *or* "effective" an-

---

[103] *Edwards*, *supra* note 19 at para 6.

[104] *CAS Guidelines*, *supra* note 101 at 17.

[105] *Cuerrier*, *supra* note 1 at para 73.

[106] *Ibid* at para 129.

[107] *R v Mabior*, 2008 MBQB 201, 230 Man R (2d) 184, 78 WCB (2d) 380 [*Mabior* (QB)].

tiretroviral treatment (defined as that which renders the viral load in blood undetectable for at least six months) would be sufficient to reduce transmission risks below the level of significance required for conviction by the test in *Cuerrier*.[108] Leave to appeal to the Supreme Court of Canada has been granted as of the time of writing.

A problem with both these rulings is their reliance on viral load as an element necessary or sufficient to escape a finding of fraud. An undetectable viral load (only recently achievable as a result of HAART) significantly decreases the risk of transmission.[109] Yet, as a recent article points out, viral load poses several problems: (i) we cannot yet establish the precise transmission risk for someone with an undetectable viral load; (ii) it is unclear how often and how close to the sexual act one would have to be tested in order to establish a pattern of undetectability;[110] (iii) it is unclear on whom the burden of proof would lie–would an undetectable viral load act as a defence the accused must put forward or would the Crown be required, almost impossibly, to prove beyond a reasonable doubt that the accused's viral load was *not* undetectable at the time of sexual activity; and (iv) considering viral load in liability might open the door to HIV-positive individuals making their own risk-assessments about transmissibility and disclosure.[111] As an example of this last point, studies indicate that optimism about new HIV therapies is linked with sexual risk-taking among MSM.[112] Above all, accepting viral load as negating a finding of fraud in the current state of scientific knowledge would introduce uncertainty into the criminal law, and require courts to make arbitrary distinctions as to what level of viral load is acceptable, either as a single factor (though the trial judge in *Mabior* rejected this argument), or in combination with condom use. For the time being, courts should base any determination of fraud and criminal liability on condom use alone.

The judge in *Mabior* relied on expert testimony that condoms have a failure rate of up to 20% without an explanation of what this figure means; that is, whether it describes breakage and improper use, a condom not providing

---

[108] *R v Mabior*, 2010 MBCA 93, leave to appeal to SCC granted, 33976 (5 May 2011) [*Mabior* (CA)].

[109] Julio SG Montaner et al, *supra* note 31.

[110] *Supra* note 108 at paras 111-113 (Several difficulties in this respect are acknowledged in the appeal judgment itself).

[111] Isabel Grant, "Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions" (2009) 54 McGill LJ 389 at 401-403.

[112] *Ibid*.

100% protection against HIV even when used properly, or a 20% risk of transmission. It is here that arguments for and against holding that the use of a condom negates a finding of fraud are laid bare. Condoms do have a risk of failure, so the issue becomes: who should bear this risk? On the one hand, our instinctive belief might be that the HIV-negative partner should be allowed to decide whether he wishes to run the risk of condom failure in the context of possible infection, and that disclosure would be the most honest course in preservation of his autonomy. However, short of abstinence, condom use is one of the best-known ways to prevent the transmission of HIV and is at the centre of modern public health campaigns. It is also important to keep in mind the difficulties involved with disclosure, and that the focus in criminal law after *Cuerrier* is on the risk-taking behaviour of the accused and corresponding moral blameworthiness. It would be problematic to find an HIV-positive person reckless and convict him of the serious criminal charge of aggravated (sexual) assault when he took largely effective steps recommended by public health bodies to protect his partner. On balance, this is a situation in which the sliding scale set out in *Cuerrier*, despite any moral reservations, should accommodate policy considerations and recognize the low-risk classification of protected sexual activities as a bar to criminal liability.

A final question about the duty to disclose arises with respect to low-to-no risk or protected sexual activities that are engaged in repeatedly with the same partner. Statistically, the risk of transmission associated with a single instance of these activities is small and the activity is classified as low-risk. However, over a number of such acts, the cumulative statistical risk of transmission may be more significant, and may even approach that of an unprotected, high-risk activity. In this case, the diagnosed individual would have had a number of opportunities to discuss HIV infection with his partner and disclose. Though feelings of love or attachment over the long term may make this more difficult–or on the contrary, engage our sense of obligation to protect a partner–the underlying logic favouring criminalization is unchanged. In the face of a potentially deadly virus, the diagnosed individual must bear the burden of disclosure when his activity poses a significant risk of serious bodily harm; prolonged non-disclosure should be considered dishonesty. Unlike single activities, which dichotomize neatly into high- and low-risk categories, it would be up to courts to determine at what point the ongoing behaviour should be considered reckless and attract criminal liability, which will be highly fact-specific.

B. HAART and "Serious Harm" R v JAT

On May 7, 2010 the British Columbia Supreme Court released its judgment in the case of *R v JAT*.[113] The accused was charged after engaging in three acts of unprotected anal intercourse with his partner during the latter part of their 10-month relationship and misrepresenting his HIV-positive status. Recall that the duty to disclose operates on a "sliding scale" that is proportionally responsive to both the magnitude of possible harm and the risk of its occurrence.[114] The ruling is significant, as it proposes a re-evaluation of the *Cuerrier* test of what constitutes a "significant risk of serious bodily harm," a question that goes to the elements of endangerment of life and lack of consent, both of which the Crown must prove to convict for aggravated sexual assault.

The judge began her analysis by stating that in *Cuerrier*, "Cory J. did not expressly address the likelihood of transmission of the virus on the facts of that case, focusing instead on the magnitude of potential harm,"[115] in particular, "the potentially lethal consequences of [HIV] infection."[116] The trial judge emphasized that since the ruling in *Cuerrier*, advances in treatment have altered the nature of the harm caused by HIV and tempered its severity. While acknowledging that the drugs used to treat HIV continue to have side effects that can make an HIV-positive person more susceptible to heart, liver, and kidney problems, the judge accepted medical evidence that "the side effects associated with *future* classes of drugs are expected to be even less marked than they are today … [hence] HIV is no longer synonymous with AIDS and premature death … [and] those living with HIV who receive treatment have a normal life expectancy."[117] It is clear that this conclusion had an effect on her subsequent analysis of the severity of harm required to establish deprivation.

In Part III of this paper, it was acknowledged that in many cases HIV has become a chronic, manageable condition. However, without deeply analyzing the content of scientific literature (which is beyond the scope of this work) a number of current studies on the effects of HAART still point to significantly shorter life expectancy among those infected with HIV, who also suffer ongoing detriment to health and well-being.[118] In this light, the general conclusion

---

[113] *R v JAT*, 2010 BCSC 766 [*JAT*].

[114] *Cuerrier*, *supra* note 1 at para 128.

[115] *JAT*, *supra* note 113 at para 19.

[116] *Cuerrier*, *supra* note 1 at para 95.

[117] *JAT*, *supra* note 113 at para 22-23 [emphasis added].

[118] ATCC, "Life Expectancy" *supra* note 70. See also Margaret May et al, "HIV Treatment Response and Prognosis in Europe and North America in the First Dec-

against serious bodily harm reached by the judge in *JAT* is questionable and contradicts the findings by the Manitoba Court of Appeal in *Mabior*, released later that same year.[119] Our medical understanding of HIV has allowed us to significantly delay the onset of AIDS and premature death, while its social meaning is also beginning to change, albeit more slowly. However, that contracting HIV no longer leads immediately to systemic secondary infections and swift death does not seem to contradict the statement in *Cuerrier* regarding its potentially lethal consequences. A positive health outcome remains dependent on a number of variables unique to the individual, and the manageability and day-to-day consequences of HIV infection have not yet approached those of any other STI. With this in mind, taking in to account the effects of hypothetical pharmaceuticals seems intuitively unjust and making more than minor adjustments to the sliding scale of responsibility on this basis is premature.

The judge in *JAT* then turned to the risk of infection in this particular case and determined it was insufficient to warrant a criminal conviction for aggravated sexual assault. In arriving at this outcome, she took account of the accused's viral load (which was not suppressed at the time), the fact that the complainant was uncircumcised (which slightly increases the risk of transmission), and that the accused was exclusively the receptive partner and the complainant, the insertive partner. The accepted risk of transmission to the complainant was 4 in 10,000 per act of anal intercourse for a cumulative risk of 12 in 10,000 or 0.12% over the three unprotected acts.[120] This rate is slightly lower than that prescribed by the risk chart set out above.[121] The judge then went on to consider the risk of transmission in other cases. In *Cuerrier*, with respect to the second complainant, the accused was convicted after engaging in 10 acts of intercourse, four or five of which were without a condom. According to the chart presented in Part IV.B(2), this would amount to a 0.4-0.5% risk;[122] in *R v Wright*, a recent decision of the British Columbia Court of Appeal, a 0.5% risk was held to be significant.[123] Meanwhile, several cases such as *Mabior*,[124]

---

ade of Highly Active Antiretroviral Therapy: A Collaborative Analysis" (2006) 368: 9534 Lancet 451; Elisa Lloyd-Smith et al, "Impact of HAART and Injection Drug Uses on Life Expectancy of two HIV-Positive Cohorts in British Columbia" (2006) 20:3 AIDS 445; Viviane D Lima et al, "Continued Improvement in Survival Among HIV-Infected Individuals with Newer Forms of High Active Antiretroviral Therapy" (2007) 20:6 AIDS 685.

[119] *Mabior* (CA), *supra* note 108 at para 64.

[120] *JAT*, *supra* note 113 at 29.

[121] Varghese, *supra* note 100.

[122] *Ibid* at 40.

[123] *R v Wright*, 2009 BCCA 514, 256 CCC (3d) 254.

Cuerrier,[125] and *R v Thornton*[126] seem to indicate–without referring to specific rates of transmission–that any risk beyond the *de minimis* level might be considered significant enough to attract liability.[127]

The finding that a 0.12% risk of transmission over three acts of insertive anal intercourse should not attract criminal liability has far-ranging consequences. On this standard, a number of acts categorized as high-risk by sexual health organizations, including several acts of insertive anal or any type of penile-vaginal intercourse, would not be captured even if transmission occurs.[128] A dichotomy in legal treatment might also emerge between receptive and insertive partners to anal sex. The insertive HIV-diagnosed partner would be subject to criminal charges after a single sex act, while the receptive partner would avoid them after engaging in several unprotected acts. It is the opinion of the author that the judgment in *JAT* goes too far, in that it is not consistent with current sexual health risk guidelines, particularly with respect to condom use as a primary risk-reduction method, and it overstates the positive effects of HAART on the life expectancy and quality of life of HIV-infected individuals. As a result, the decision raises the threshold of risk significance to a level that does not criminalize morally-blameworthy behaviour. Future rulings in this area might more carefully adjust the level of risk required to attract criminal liability to accord with updated public health guidelines.

Conclusion

The overall thrust of this paper has been that criminalizing the intended transmission or knowing non-disclosure of HIV can be appropriate Canadian criminal law policy. In so doing, it is important to contextualize HIV as an infection that affects social groups disproportionately; recall that the criminal law must account for our indeterminate understanding of responsibility for sexual health and the particular difficulties faced when attempting to disclose or self-protect in the sexual realm. Criminalization in this context can nonetheless satisfy several legal goals without denying the importance or undermining

---

[124] *Mabior* (QB), *supra* note 107.

[125] *Cuerrier*, *supra* note 1.

[126] (1991), 82 CCC (3d) 530.

[127] It is interesting at this point to compare these developments with the Supreme Court's approach to tort law causation, specifically its treatment of the material contribution test and *de minimis* risks of harm: *Athey v Leonati*, [1996] 3 SCR 458. See also *Hanke v Resurfice*, 2007 SCC 7, [2007] 1 SCR 333.

[128] Varghese, *supra* note 100; *CAS Guidelines*, *supra* note 101.

the realization of wider public health objectives, and thus it should not be excluded prima facie as a valid public policy response. Instead, criminalization should be tailored to reflect our understandings of moral culpability, advances of medical science, the realities of sexual behaviour, and the ongoing efforts of public health campaigns. This tailoring can be achieved in most conceivable situations through successful judicial interpretation of the tests for risk and harm set out a dozen years ago by the majority in *Cuerrier* and by establishing strong prosecutorial guidelines. Doing so will ensure that criminalizing the intended transmission or knowing non-disclosure of HIV remains proportionate to the possible harm created and achieves a balance between public objectives. Finally, though this paper limited itself to criminalization in the context of sexual transmission of HIV, the judgment in *Cuerrier* and related suggestions may have implications with regard to other STIs and situations ranging from injection drug use, *in utero* mother-to-child transmission, breastfeeding, and blood transfusion to disclosure requirements in healthcare settings.[129] The impact of the criminalization of non-disclosure in each of these scenarios presents an important avenue for future study.

[129] For a discussion of some of these issues, see Elliott, "*After* Cuerrier", *supra* note 57 at 32-50.