HIV/AIDS INTRODUCTION

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On June 5th 1981, the Centers for Disease Control in Atlanta published its *Morbidity and Mortality Weekly Report* (MMWR) as it does every Friday.[1] It contained a brief report (reproduced on page 103) of five gay men from Los Angeles, all around the age of thirty and previously in good health, treated for a rare type of pneumonia. What puzzled their physicians was that this pneumonia is almost exclusively limited to patients with severely-weakened immune systems. The report concluded with the words, "All the above observations suggest the possibility of a cellular-immune dysfunction related to a common exposure that predisposes individuals to opportunistic infections … " That dysfunction would become known as AIDS.

Thirty years on, HIV/AIDS still presents challenging societal questions. One of those questions is: should failure to disclose one's HIV-positive status to a sexual partner attract criminal liability? If so, under what circumstances? The MJLH is fortunate enough to be publishing the following two articles on this subject by Isabel Grant and Matthew Cornett. Each offers a different analysis, and arrives at opposing conclusions to the other.

The landmark case in non-disclosure of HIV status is the Supreme Court of Canada's 1998 decision *R v Cuerrier*,[2] which established that failure to disclosure ones HIV status can be prosecuted as aggravated assault. Central to the Court's reasoning was that non-disclosure constitutes fraud vitiating consent to the sexual act. The Court's analysis of fraud centered on whether the accused acted dishonestly in obtaining consent to the sexual act, and whether the exposure to HIV resulted in a significant risk of bodily harm. On this latter point, the Court found that this threshold of significant risk was met.

Now, thirteen years later, the Supreme Court of Canada will be re-visiting non-disclosure of HIV status with the upcoming *R v Mabior*[3] appeal. Central to the appeal is the "significant risk" part of the test established by *Cuerrier*. The accused in *Mabior* had an undetectable viral load at the time of the sexual acts in question. One of the issues for the Court is whether an undetectable vi-

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[1] Centres for Disease Control and Prevention, "Pneumocystis Pneumonia – Los Angeles" (1981) 30:21 Morbidity and Mortality Weekly Report 250.

[2] [1998] 2 SCR 371.

[3] *R v Mabior*, 2010 MBCA 93.

ral load on the part of the accused sufficiently reduces the risk towards the complainant to below the significance threshold required for a conviction of aggravated sexual assault.

In an appeal that could have major repercussions for Canadian criminal law, HIV/AIDS public health initiatives, and persons living with HIV as well as their partners, the MJLH would like to reflect on what has and has not changed in the HIV/AIDS epidemic that has brought us to *Mabior*.

Advances in treatment mean that HIV/AIDS is no longer the death sentence it was in 1992, when Henry Girard Cuerrier started his sexual relationship with KM. In 1995, Dr. David Ho championed the use of combining antiretroviral medications [4] in what became known as "highly active antiretroviral therapy" (HAART) or the "AIDS cocktail". The results were dramatic: by 1998, when *Cuerrier* reached the Supreme Court of Canada, HIV/AIDS mortality rates had fallen by nearly two-thirds.[5] Life expectancy has also improved dramatically, so that now a 20-year old diagnosed with HIV having access to HAART can expect to live another 50 years.[6]

HAART therapy has also made it possible to reduce HIV to undetectable levels in infected persons' blood. Viral load refers to the number of viruses in a specific quantity of bodily fluid. With HIV, viral load is said to be "undetectable" when there are no more than 40 copies of the virus in 1 mL of blood.[7] An undetectable viral load is a medically-useful indicator that therapy is working. However, the extent to which an undetectable viral load means that the risk of transmission is low to zero on an individual per-case basis is unclear.[8]

Stigma and discrimination towards HIV-positive persons, nevertheless, remains. Such attitudes date back to when HIV/AIDS was poorly understood. Tellingly, before AIDS, the syndrome was called GRID for "gay-related immune deficiency". In 1988, almost one-third of Americans supported marking

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[4] David Ho, "Time to Hit HIV, Early and Hard" (1995) 333:7 The New English Journal of Medicine 450.

[5] Frank J Palella et al., "Declining Morbidity And Mortality Among Patients With Advanced Human Immunodeficiency Virus Infection" (1998) 338 The New English Journal of Medicine 853.

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

[7] David P Wilson et al., "Relation Between HIV Viral Load and Infectiousness: A Model-Based Analysis". (2008) 372:9635 The Lancet 314.

[8] *Ibid*.

HIV-positive individuals with a tattoo.[9] And even by 1999, one in five Americans thought that HIV-positive people "do not care" if they infect other people.[10] Part of the destructive force of HIV/AIDS is its ability to play into people's prejudices, and we thus must question whether some of our laws and policy decisions are borne of such prejudices.

That HIV/AIDS still strikes the most vulnerable of our society has only become much more apparent. When first identified, HIV/AIDS struck marginalized groups in the Western world, such as gay men and intravenous drug users. Now, however, the overwhelming majority of HIV/AIDS cases affect the world's poorest people. Sub-Saharan Africa alone has 22.4 million of the 33.4 million people living with HIV worldwide[11]—that represents 67% percent of those infected.

The number of people infected and the rate of new infections of HIV have changed radically. Prevalence of a disease measures the percentage of a given population (for example, the province of Quebec or gay men in Montreal) with the disease in question at a given time, whereas incidence measures the rate at which new cases of the disease arise during any given time period (for example, number of new infections per year).

Both prevalence and incidence must be examined to get the full picture of the changing HIV/AIDS epidemic. The prevalence of HIV in Canada was estimated at 65,000 persons in 2008,[12] which is a substantial increase over 1996 when there were 41,000 persons infected.[13] This increase is partly credited to HAART therapy and the fact that people with HIV are living longer.

However, the increase in prevalence also means that there are more and more people living with HIV, increasing the potential for non-disclosure cases

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[9] Robert J Blendon & Karen DoneLan, "Discrimination Against People with AIDS" (1988) 319:15 The New England Journal of Medicine 1022.

[10] Gregory M Herek et al., "HIV-Related Stigma and Knowledge in the US" (2002) 92:3 American Journal of Public Health 371.

[11] UN AIDS, online: World Health Organization <www.unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2009/20091124_fs_global_en.pdf>.

[12] Public Health Agency of Canada, "National HIV Prevalence and Incidence Estimates in Canada for 2008" (2010) HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/pdf/EN_Chapter1_Web.pdf>.

[13] Public Health Agency of Canada, "National HIV Prevalence and Incidence Estimates for 1999: No Evidence of a Decline in Overall Incidence" (2003) HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/publicat/epiu-aepi/hiv-vih/estima-eng.php>.

to arise. Moreover, there is also a worrying increase in the incidence of new HIV infections. In 2008, incidence was estimated from 2,300 to 4,300 new infections[14] up from 2,100 to 4,000 in 2002.[15] The largest increase in incidence is amongst heterosexuals; however, amongst men who have sex with men, incidence is also on the rise–up 34% in 13-29 year olds in the US.[16] The reasons for this increase in recent years are poorly understood.

Finally, for the first time ever, we now have the ability to stop the HIV/AIDS epidemic and eradicate the disease. A recent clinical trial–stopped early because of its success–found that starting antiretroviral therapy early resulted in a 96% reduction of transmission from the infected to the uninfected partner.[17] Conceivably, wide availability of HAART therapy combined with safer sex practices and public health initiatives could eliminate transmission. Absent transmission, HIV/AIDS would simply die out. As *The Economist* astutely opined, "The question for the world will no longer be whether it can wipe out the plague, but whether it is prepared to pay the price."[18]

Put together, what has changed and not changed in the HIV/AIDS epidemic carves a complicated path bringing us from the original MMWR article, to *Cuerrier*, and now to *Mabior*. To what extent should scientific advancement inform the criminal law in this area? Does a reduction in population transmission with HAART therapy have any bearing on the individual case brought before a court and the significant risk threshold? Should the fact that more and more people are living with HIV suggest maintaining a criminal response to deter would-be "offenders"? Is the deterrence power of criminal law really working as effective public policy in the face of increasing HIV incidence? Is the current Canadian approach under *Cuerrier* a product of the social attitudes towards HIV-positive persons at the time? Have those attitudes changed?

These are the issues that are discussed in the following pages in the articles by Grant and Cornett. They are also the issues with which the Supreme Court of Canada must grapple in the coming months. We invite you to submit comments on the articles that follow on our website (http://mjlh.mcgill.ca).

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[14] *Supra* note 12.

[15] HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/publicat/epiu-aepi/epi-06/pdf/epi06_e.pdf>.

[16] Joseph Prejean et al. "Estimated HIV Incidence in the United States, 2006–2009" (2011) 6:8 PLoS ONE.

[17] "Initiation of Antiretroviral Treatment Protects Uninfected Sexual Partners from HIV Infection" *HIV Prevention Trials Network* (12 May 2011).

[18] "The End of AIDS" (2 June 2011) *The Economist*.