

Position Paper: Criminalization of HIV

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Background:

The CFMS believes that the stigma existing against people living with HIV presents an important barrier to fulfillment of their health and wellbeing, and that all prevention programs need to strive to eliminate this stigma and discrimination. We believe that the criminalization of HIV increases stigma and discrimination, undermines public health efforts to respond to HIV, and jeopardizes the health and human rights of those living with HIV.

Legal and Public Health Context in Canada

Criminalization of HIV refers to the application of the criminal justice system to non-disclosure, exposure, or transmission of HIV from infected person(s) (1). Despite important advances in prevention and treatment of HIV, public stigma, rather than current scientific and medical knowledge, too often fuels policy decisions and interpretation of related laws (2). There are two main reasons offered for criminalizing HIV transmission, to “punish harmful conduct by imposing criminal penalties, and prevent HIV transmission by deterring or changing risk behaviors” (3) (4) (5) (6). The problem is that except in rare cases, when HIV transmission is intentional, applying criminal law to HIV transmission does not serve these goals (3). At present we are experiencing an unprecedented number of cases of criminalization of HIV within Canada, with Canada having the *highest number of prosecutions per capita in the world* (3).

The Oslo Declaration¹ (2012) and subsequent UNAIDS Report (2013) recommend that nations focus on evidence and rights-based approaches to prevention, diagnosis and treatment of HIV rather than the broad criminalization of HIV (4). They urge that we limit the application of criminal law only to cases where there is proven intent to transmit HIV; recognizing that “intent to transmit HIV cannot be presumed or solely derived from knowledge of positive HIV status and/or non disclosure of that status” (4). The Oslo declaration states that “HIV epidemics are driven by undiagnosed HIV infections, not by people who know their HIV positive status” (9).

In *R. v. Cuerrier* 1998, the Supreme Court of Canada stated that individuals with HIV-positive status have a legal obligation to disclose their status prior to engaging in activities that place another individual at “significant risk of serious bodily harm” (5). The Supreme Court ruling did not present clear boundaries as to what constitutes “significant risk” (5). Therefore, this ruling has implications in five different scenarios. Individuals living with HIV may have a legal obligation to disclose HIV-positive status (A) prior to engaging in anal intercourse with or without a condom, (B) prior to engaging in vaginal intercourse with or without a condom, (C) prior to performing or receiving oral sex without a barrier, (D) regardless of the HIV status of a sexual partner and finally, (E) if an individual has not received a formal diagnosis of HIV, however, suspects they may be HIV infected (6). More recently, in *R. v. Mabior* and *R. v. D.C.* 2012, the Supreme Court of Canada ruled that in order to prosecute, a “realistic possibility” of transmission must be present, and that the use of a condom and a low viral count (in the case of vaginal intercourse) would not present a “realistic possibility” of transmission of HIV (7).

HIV-positive Canadians have been prosecuted in all the scenarios described above and not all courts have exhibited consistent rulings on the application of what constitutes “significant risk” (6). Given inconsistent trial results across Canada, the evolution of

medicine, and the ambiguous definition of what constitutes a legally “significant risk”, it is very difficult to outline what behavior requires HIV disclosure.

Since the 1998 Supreme Court ruling there have been important advances in medicine related to diagnosis, treatment and prevention of HIV. Diagnosis of HIV can now be carried out in one of two ways, including either a rapid point-of-care test or a traditional blood test. The use of Highly Active Antiretroviral Therapy (HAART) is currently the main treatment for HIV/AIDS and its use has re-characterized how we understand HIV infection (7). An HIV infection is no longer considered a death sentence; in fact, with proper medical treatment HIV infection is now considered a chronic manageable condition (7). When matched against a background population for age and gender, an individual living with HIV can anticipate a life expectancy the same as someone without HIV (8). In addition, effective treatment significantly reduces the risk of transmission to sexual partner(s) (9). Furthermore, the success of antiretroviral therapy has promoted the development of prevention options such as post-exposure prophylaxis (PEP)² and prevention of mother-to-child transmission therapy.

Principles:

The Canadian Federation of Medical Students believes:

1. The broad criminalization of HIV is unjust:
 - Punishment can occur in the absence of harm as in the case of non-disclosure without transmission (12).
 - Assessment of “significant risk” is not informed by current scientific and medical knowledge, and may be incorrectly and unjustly amplified (15).
 - Mental culpability is not always considered (12).
 - Defenses against charges for HIV non-disclosure such as use of a condom, a low viral load, non-penetrative sex or oral sex are not always considered (12).
 - Requirement for proof falls short of the current criminal law standards; for example, HIV phylogenetic evidence, CD4 count, viral load, and recent infection testing algorithms cannot conclusively prove that HIV was transmitted from person A to B; this evidence cannot conclusively prove the timeline or the direction of transmission (12).

2. The criminalization of HIV undermines public health efforts to decrease the transmission of HIV:
 - There is no evidence that shows criminalization of HIV to be an effective tool in HIV prevention (15).
 - Fear of prosecution may actually deter people from seeking out testing and treatment and discourage those living with HIV from disclosing their status to their health care provider and partners (16).
 - The trust between patients and healthcare providers may be impacted, particularly when medical records are made available for criminal investigations, even when this follows protocols related to the release of confidential medical information (12).
 - Criminalization of HIV detracts from the message that *everyone should practice safe-sex behaviours* and that safety is a shared responsibility; to

believe that your partner *has* to disclose HIV status creates a false sense of security (17).

- If prosecution continues public health will need to increase the availability of anonymous testing sites to aid those who wish to be tested while minimizing their risk of future prosecution (4).
3. The criminalization of HIV disproportionately impacts marginalized individuals; the double burden of belonging to a marginalized group and being HIV positive carries stigma and risk of adverse consequences from media, society and lawmakers (18). In Canada:
- Nearly half of the cases of people living with HIV are men who have sex with men (19)
 - Seventeen percent of people living with HIV are injection drug users (19)
 - Aboriginal populations are also highly burdened with HIV, accounting for thirteen percent of new infections in 2008, a rate that is 3.5 times higher than that of the non-Aboriginal Canadian populations (19).
 - In 2011, there were approximately 16,600 women living with HIV (19).
4. The criminalization of HIV endangers and oppresses women rather than providing protection:
- Criminalization of HIV does not address the underlying issue of gender-based violence, or the social, economic and political inequality that disproportionately places women at risk for HIV (17).
 - Women are more likely to know their HIV status first due to more frequent health care visits (birth control, prenatal etc.), this puts them at a higher risk for prosecution as they are more likely to correctly or incorrectly appear to have introduced the infection into the relationship (17).
 - Women living with HIV and experiencing domestic violence may increase their risk for violence and be forced to make impossible “choices” between declining sex with a partner, demanding the use of a condom and disclosing HIV positive status or risk prosecution for non-disclosure or transmission of HIV (17) (20) (21).

Recommendations:

The Canadian Federation of Medical Students recommends that:

Federal and Provincial Governments:

- a. develop and implement police and prosecutorial guidelines that limit, clarify, and harmonize the application of criminal law for transmission of HIV (12)
- b. implement anonymous HIV testing programs in all provinces and territories (4).

The Supreme Court of Canada:

- a. base its public health recommendations on sound scientific and medical information in all cases involving non-disclosure of HIV status (12)
- b. define “significant risk” in nondisclosure cases based on sound evidence (22)
- c. apply criminal law to HIV non-disclosure, exposure, or transmission only when a clear intent to transmit HIV is proven (12).

The Public Health Agency of Canada:

- a. recognize that the availability of PEP outside of professional exposure is an important factor in reducing stigma and transmission within marginalized groups (23)
- b. implement widespread assessment of the usefulness of PEP in community settings to reduce the transmission of HIV (23).

Canadian medical schools:

- a. include curriculum for all students regarding appropriate patient counselling on HIV testing, disclosure, its legal ramifications, and availability of HAART and PEP (12) (24).
- b. prepare students to counsel their patients appropriately in the face of non-disclosure laws, and explain the concept of “significant risk” in order to maximize patient understanding and minimize criminal risk (12).

Canadian medical students:

- a. identify gaps in our education regarding HIV/AIDS and non-disclosure
- b. request that our schools provide opportunities to apply knowledge gained about HIV/AIDS and non-disclosure
- c. support public campaigns to end stigma and discrimination for individuals living with HIV.

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End Notes:

¹ The Oslo Declaration was written by 20 individual experts and organizations representing civil society organizations internationally working to end overly broad criminal prosecutions for HIV non-disclosure, exposure and transmission. Sixteen hundred and fifty (1650) civil society organizations, health and legal experts from around the world have endorsed it (12).

² In Canada, PEP is primarily used for occupational exposure to HIV (23). The use of pre-exposure prophylaxis (PrEP) for those at a high risk of HIV infection is another prevention strategy that is being investigated worldwide (28). PrEP provides partial prevention of HIV infection and thus is being developed as part of a prevention strategy along with condom and clean needle usage (28).