Position Paper: Criminalization of HIV

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Approved: 2014

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Background:

Criminalization of HIV refers to the broad application of the criminal justice system to non-disclosure, exposure, or transmission of HIV from infected persons, regardless of intent to harm (1) (5).

The Canadian Federation of Medical Students (CFMS) believes that the existing stigma against people living with HIV presents an important barrier to their health and wellbeing, and that prevention and treatment programs need to strive to eliminate this stigma and discrimination. We believe that the criminalization of HIV increases this stigma and discrimination, undermines public health efforts to respond to HIV at a population level, and jeopardizes the health and human rights of those living with HIV.

The question of HIV criminalization requires us, as medical students and future physicians, to consider and understand an ethically complex issue from two different perspectives: our HIV-positive population and our HIV-negative population. On the one hand we are asked to reflect on the benefit of criminalizing HIV to provide protection to individuals at risk of infection, on the other hand we must explore the impact of such legal actions on the rights of those living with HIV, and the overall public health effort to decrease transmission of HIV.

To be clear, the CFMS cannot overstate the importance of the consent process. The CFMS unequivocally supports the practice of safer sex. It is important to understand that standing up against the broad criminalization of HIV is not the same as a support for non-disclosure of an individual's sexual health history. As with any infection, healthcare providers should make every effort to educate infected patients how to best care for themselves and protect their current or future partner(s) from transmission. In addition, there is mention in this position paper of the *broad application* of criminal law to HIV transmission. This is a key point of distinction; it is important to note that in rare circumstances, should there be a proven malicious intent to transmit the HIV virus, there is already a legal precedent in place that does not require specific legislation related to HIV in particular (27).

Our demand for decriminalization calls into question the value of singling out HIV infection, in particular, as requiring specific laws, especially when such an action has not been shown to decrease transmission, has detrimental effects on a vulnerable populations, and impedes the public health effort to decrease transmission on a population level.

Legal and Public Health Context in Canada

Despite important advances in prevention and treatment of HIV, public stigma rather than current scientific and medical knowledge often fuels policy decisions and interpretation of related laws (2). There are two main reasons offered for criminalizing HIV transmission: the first is to punish conduct considered harmful by imposing criminal penalties, and the second is to prevent HIV transmission by changing or deterring risk behaviors" (3) (4) (5) (6). The problem is that, except in rare cases when HIV transmission is intentional, broadly 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). It is for this reason that the CFMS is calling

for changes to the legal and public health frameworks for HIV-positive individuals and for reducing HIV transmission rates population-wide.

The Oslo Declaration[1] (2012) and the subsequent UNAIDS Report (2013) recommended that all nations focus on evidence and rights-based approaches to prevention, diagnosis, and treatment of HIV rather than the broad criminalization of HIV. They urge that the application of criminal law be limited only to cases where there is a proven intent to transmit HIV, recognizing that "the intent to transmit HIV cannot be presumed or solely derived from the knowledge of positive HIV status and/or non-disclosure of that status" (8) (9). The Oslo Declaration also states that "HIV epidemics are driven by undiagnosed HIV infections, not by people who know their HIV positive status" (9), emphasizing once again, that our efforts are better spent on education and encouraging testing to decrease transmission rather than criminalizing HIV.

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 "a significant risk of serious bodily harm" (5). The Supreme Court ruling did not present clear nor scientifically rigorous boundaries as to what constitutes "a significant risk" (5). Therefore, this ruling had implications in five different scenarios. Individuals living with HIV may have a legal obligation to disclose their HIV-positive status:

- Prior to engaging in anal intercourse with or without a condom.
- Prior to engaging in vaginal intercourse with or without a condom.
- Prior to giving or receiving oral sex without a barrier.
- Regardless of the HIV status of a sexual partner.
- If an individual suspects they may be infected with HIV but has not received a formal diagnosis of HIV (5).

The confusion is still present in more recent cases; as an example, in *R. v. Mabior* (2012) 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 (not defined), in the case of vaginal intercourse, would not present a "realistic possibility" of transmission of HIV (22).

Canadians living with HIV have been prosecuted in all the scenarios described above and not all courts have exhibited consistent rulings on the application of what constitutes a "significant risk" (6). Given inconsistent trial results across Canada, the evolution of medicine, and the ambiguous definition of what legally constitutes a "significant risk", it is difficult for healthcare providers to outline which 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. 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 (12). The use of Highly Active Antiretroviral Therapy (HAART) has re-characterized how we understand HIV infection (7). Presently, when matched against a background population for age and gender, an individual living with HIV can anticipate a life expectancy similar to someone without HIV (8). In addition, effective treatment significantly reduces the risk of transmission to sexual partner(s) (9) (15). Furthermore, the success of antiretroviral therapy has promoted the development

of prevention options such as post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP)[2] and therapy for the prevention of mother-to-child transmission.

Principles:

The Canadian Federation of Medical Students believes:

1. The broad criminalization of HIV is unjust because:
    - Punishment has occurred in the absence of harm as in the case of non-disclosure without transmission (12).
    - Assessment of "a 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 the use of a condom, a "low" viral load, non-penetrative sex or oral sex are not always considered (12).
    - Requirement for proof of transmission 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 nor the direction of transmission (12).

2. The inconsistent climate surrounding the criminalization of HIV undermines public health efforts to decrease the transmission of HIV because:
    - 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 healthcare providers 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 public health message that *everyone should practise safer-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 a risk of adverse consequences from media, society and lawmakers (18). For example, in Canada:
    - Nearly half of the cases of people living with HIV are men who have sex with men (19).
    - 17 percent of people living with HIV are injection drug users (19).

- Aboriginal populations are also highly burdened with HIV, accounting for 12 percent of new infections in 2011, 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 in particular rather than providing protection:
    - Criminalization of HIV does not address the underlying issue of gender-based violence, or the social, economic and political inequalities that disproportionally affect women and place them at risk for HIV (17).
    - Women are more likely to know their HIV status first due to more frequent healthcare visits (birth control, prenatal, etc.), which 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 by being 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 if prosecution continues in a similar manner to the present (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" and "reasonable precautions" in non-disclosure cases based on sound evidence (22).
c. Elaborate on the definition of "an intent to transmit", and then apply criminal law to HIV non-disclosure, exposure, or transmission only when a clear intent to transmit HIV is proven.

The Public Health Agency of Canada:

a. Collaborate with the legal system, and the provincial and federal government to provide a medically-sound, population-based, harm reduction-focused plan to put an end to the broad and inconsistent criminalization of HIV.
b. Recognize that the availability of PEP outside of professional exposure is an important factor in reducing the stigma and transmission of HIV (23).
c. Implement widespread assessment of the usefulness of PrEP in community settings to reduce the transmission of HIV (23).

Canadian medical schools:

a. Include curriculum for all students regarding appropriate patient counseling on HIV testing, disclosure and 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 regardless of HIV status, promote universal safer-sex practices, and minimize criminal risk and stigmatization (12).

Canadian medical students:

a. Identify gaps in our education regarding HIV/AIDS and non-disclosure.
b. Request that our schools provide opportunities to practise the application of knowledge gained about HIV/AIDS and non-disclosure.
c. Support public campaigns to end stigma and discrimination for individuals living with HIV
d. Support public campaigns promoting HIV testing and safer-sex practices.

Works Cited

1. Burris S, Cameron E. The case against criminalization of HIV transmission. JAMA. 2008; 300(5): p. 578 - 581.
2. Mahajan A, Sayles J, Patel V, Remien R, Sawires S, Oritz D, et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS. 2008; 22(Supp 2): p. S67-79.
3. UNAIDS. Policy Brief: Criminalization of HIV Transmission. Policy Brief; 2008.
4. O'Bryne P, Bryan A, Roy M. HIV criminal prosecutions and public health: an examination of the empirical research. Med Humanit. 2013; 39(1): p. 85-90.
5. Ontario Working Group on Criminal Law and HIV Exposure. Briefing Note: Criminalizing non-disclosure of HIV Status. Briefing Note; 2012. Accessed April 18th, 2014 from http://www.hivlawandpolicy.org/resources/briefing-note-criminalizing-non%E2%80%90disclosure-hiv-status-ontario-working-group-criminal-law
6. Wainberg M. Criminalizing HIV transmission may be a mistake. CMAJ. 2009; 180(6): p. 688.
7. Milloy MJ, Kerr T, Montaner J. Ending Canada's HIV trials. CMAJ. 2012; 184(2).
8. UNAIDS. Ending overly broad criminalziation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations. 2013.
9. International Civil Society in Oslo. Oslo Declaration on HIV Criminalization. 2012 February. Accessed April 18, 2014 from http://www.hivjustice.net/oslo
10. Supreme Court of Canada. R. v. Cuerrier; 1998. Accessed April 18th, 2014 from http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1646/index.do
11. Grant I. The Prosecution of Non-disclosure of HIV in Canada: Time to Rethink. McGill Journal of Law and Health. 2011; 5(1): p. 7-59.
12. UNAIDS. Ending overly broad criminalization of HIV transmission. Policy Brief. ; 2008.
13. Gallately C, Pinkerton S. Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV. AIDS and Behavior. 2006; 10: p. 451 - 461.
14. Boily M. Heterosexual risk of HIV-1 infection per sexual act: Systematic review and meta-analysis of observational studies. Lancet Infectious Diseases. 2009; 9: p. 118-129.
15. Attia S. Sexual transmission of HIV according to viral load and antiretroviral therapy: Systematic review and meta-analysis. AIDS. 2009; 23: p. 1397-1404.
16. Azad Y. Developing guidance for HIV prosecutions: An example of harm reduction? HIV/AIDS Policy & Law Review. 2008; 13(1): p. 13-19.
17. Jürgen R, Cohen J, Cameron E, Burris S, Clayton M, Elliot R, et al. Ten reasons to oppose the criminalization of HIV exposure or transmission. Reproductive Health Matters. 2009 November; 17(34): p. 163-172.
18. Weait M, Azad Y. The criminalization of HIV transmission in England and Wales: question of law and policy. HIV/AIDS Policy & Law Review. 2005; 10(2).
19. Public Health Agency of Canada. Summary: Estimates of HIV prevalence and incidence in Canada, 2011; 2011. Accessed on April 18th, 2014 from http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat2011-eng.php

20. Csete J, Elliot R. Criminalization of HIV transmission and exposure: in search of rights-based public health alternatives to criminal law. Future Virology. 2011; 6(8).
21. Cameron E. Criminalization of HIV Transmission: poor public health policy. HIV/AIDS Policy & Law Review. 2009; 14(2).
22. Canadian HIV/AIDS Legal Network. HIV non-disclosure and the criminal law: An analysis of two recent decisions of the Supreme Court of Canada. Briefing Document; 2012. Accessed on April 18th, 2014 from http://aidslaw.ca/publications/publicationsdocEN.php?ref=1328
23. Landovitz R, Currier J. Postexposure Prophylais for HIV Infection. The New England Journal of Medicine. 2009; 361: p.1768-1775.
24. Gagnon M. Legal and clinical implications of HIV non disclosure. Canadian AIDS Treatment Information Exchange (CATIE) & Canadian Association of Nurses in AIDS Care (CANAC); 2013. Accessed on April 18th, 2014 from http://librarypdf.catie.ca/pdf/ATI-20000s/26450.pdf
25. Mykhalovskiy E. Who? What? Where? When? And with what consequence? An analysis of criminal cases of HIV non-disclosure in Canada. Canadian Journal of Law and Society. 2012; 27(1): p. 31-53.
26. Canadian HIV/AIDS Network. Criminalization of HIV transmission: poor public health policy. HIV/AIDS Policy & Law Review. 2009; 14(2).
27. Phillips, J. Associations Between the Legal Context of HIV, Perceived Social Capital, and HIV Antiretroviral Perceived Social Capital, and HIV Antiretroviral Adherence in North America. BMC Public Health, 2013:13:736.
28. Baeten J, Donnell D, Ndase P, Mugo N, Campbell J, Wangisi J, et al. Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. N Engl J Med. 2012; 367(5): p. 399-410.

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. It has been endorsed by sixteen hundred and fifty (1650) civil society organizations, health and legal experts from around the world(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).