Review of Canada's Compliance with the *Convention on the Rights of Persons with Disabilities*

Submission to the United Nations Committee on the Rights of Persons with Disabilities

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The Canadian HIV/AIDS Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research and analysis, advocacy and litigation, public education and community mobilization.

Le Réseau juridique canadien VIH/sida fait valoir les droits humains des personnes vivant avec le VIH/sida et vulnérables à l'épidémie, au Canada et dans le monde, à l'aide de recherches et d'analyses, de plaidoyer, d'actions en contentieux, d'éducation du public et de mobilisation communautaire.

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INTRODUCTION

The Canadian HIV/AIDS Legal Network ("Legal Network") submits this briefing to the United Nations Committee on the Rights of Persons with Disabilities ("Committee") in advance of its review of the periodic report of Canada, held during its 17th session from 20 March to 12 April 2017.

The Legal Network promotes the human rights of people living with, at risk of and affected by HIV and AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization. We envision a world in which the human rights and dignity of people living with HIV and those affected by the disease are fully realized, and in which laws and policies facilitate HIV prevention, care, treatment and support.

Canadian law recognizes people living with HIV, as well as people with drug dependence, as persons with disabilities for the purposes of protection against discrimination in various contexts. Numerous court and tribunal rulings have protected people from discrimination based on their HIV status under laws prohibiting discrimination on the basis of "disability" (or "handicap," as that term remains used in some statutes). Similarly, certain jurisdictions' anti-discrimination statutes explicitly refer to drug dependence as falling within the definition of "disability," and, as a matter of well-established interpretation across the entire country, courts and tribunals (including the Supreme Court of Canada) have recognized drug dependence (or in some cases "addiction") as a disability for the purposes of protection against discrimination (including access to social benefits programs designed to provide assistance to people with disabilities).

In this submission, the Legal Network sets out some selected concerns about the implementation of the *Convention on the Rights of Persons with Disabilities* ("Convention") by Canada, including with respect to the following ongoing manifestations of discrimination based on the disabilities of HIV and drug dependence:

1) the overly broad application of the criminal law to cases of HIV non-disclosure, which operates in particularly gendered ways against women living with HIV

2) the discriminatory incarceration of persons with drug dependence and denial of harm reduction services in prisons for persons with drug dependence in prisons

3) the inability of persons living with HIV to be granted permanent or temporary residency in Canada on the basis of their HIV status

FREEDOM FROM EXPLOITATION, VIOLENCE AND ABUSE (ARTICLE 16): CONCERNS REGARDING THE OVERLY BROAD CRIMINALIZATION OF HIV

The Committee asks:
Freedom from exploitation, violence and abuse
26. Please inform the Committee about violence against women and children with disabilities, including Indigenous women and children with disabilities, and about measures to prevent and eliminate all forms of violence in different settings, including at school, and to facilitate reporting of violence by victims.

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

However, Canada's current *overly broad* approach to criminalizing alleged HIV non-disclosure to sexual partners is increasingly at odds with scientific evidence about the risk of transmission. In some instances, it amounts to criminalizing persons because they are living with HIV. In addition, the overly broad use of the criminal law in cases of HIV non-disclosure not only amounts to a form of state violence against people living with the legally recognized disability of HIV, but also has put women living with HIV, in particular, at an increased risk of violence and abuse. Currently, Canadian law allows individuals who have not disclosed their HIV-positive status before sex in certain circumstances to be prosecuted for *aggravated sexual assault* — an offence that carries a maximum penalty of life imprisonment and mandatory registration as a sexual offender for a minimum of 20 years. This provides a tool of coercion or revenge for vindictive partners who threaten to report women to the police for not disclosing their status[4] — as was the documented circumstance in one of the most recent prosecutions to reach the Supreme Court of Canada against a woman living with HIV (*R. v. DC*, 2012 SCC 48).

In November 2016, the UN Committee on the Elimination of Discrimination against Women recommended that Canada "limit the application of criminal law provisions to cases of intentional transmission of HIV/AIDS, as recommended by international public health standards" and noted the use of "harsh criminal sanctions (aggravated sexual assault) to women for non-disclosing their HIV status to sexual partners, even when the transmission is not intentional, when there is no transmission or when the risk of transmission is minimal." [5]

There are numerous human rights and public health concerns associated with the overly broad criminalization of HIV non-disclosure, exposure or transmission. These have led the Joint UN Programme on HIV/ AIDS (UNAIDS) and the UN Development Programme (UNDP),[6] the UN Special Rapporteur on the right to health,[7] the Global Commission on HIV and the Law,[8] and women's rights advocates (including leading Canadian feminist legal academics),[9] among others, to urge governments to limit the use of the criminal law to cases of *intentional transmission* of HIV (i.e., where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it). The UN Special Rapporteur on the right to health has pointed out that criminalizing HIV transmission infringes not only on the right to

health but also on other rights, including the rights to privacy, equality and non-discrimination.[10] In 2016, the UN Committee on the Rights of the Child noted the need to review legislation "that criminalizes the unintentional transmission of HIV and the non-disclosure of one's HIV status."[11]

With more than 180 people charged to date for not disclosing their HIV-positive status to their sexual partners, Canada has the dubious distinction of being a world leader in prosecuting people living with HIV.[12] Based on the paired 2012 Supreme Court of Canada decisions of *R. v. Mabior*, 2012 SCC 47 and *R. v D.C.,* 2012 SCC 48, people living with HIV in Canada are at risk of prosecution and conviction for non-disclosure of their HIV-positive status even if there was no transmission, they had no intention to harm their sexual partner, and they used a condom or had an undetectable viral load. The decision was widely criticized for being at odds with international recommendations and human rights standards as well as medical evidence on HIV. Indeed, when used correctly and no breakage occurs, condoms are 100% effective at preventing the transmission of HIV.[13] It is also uncontested that condomless sex with a person living with HIV under effective antiretroviral therapy poses effectively zero risk or, at most, a "negligible" risk of transmission.[14]

Criminalization is often described as a tool to protect women from HIV infection and enhance women's dignity and autonomy in relation to sexual decision-making. This perception is reinforced by the fact that the majority of people who have been charged to date are men who had sex with women and, in the Canadian context, the application of the law of sexual assault in those cases. However, a gendered analysis of the current use of the criminal law with respect to HIV reveals that criminalization is a blunt, punitive and inflexible approach to HIV prevention that does little to protect women from HIV infection, violence, coercion or sexual objectification. (Moreover, the use of sexual assault law in the HIV non-disclosure context — where the sexual activity is otherwise consensual, aside from the claim that non-disclosure renders the consent invalid — is a poor fit and can ultimately have a detrimental impact on sexual assault law more broadly as a tool to advance gender equality and renounce gender-based violence.[15])

In particular, the criminalization of HIV non-disclosure can have a serious adverse impact on women living with HIV, especially if they face challenges due to their socioeconomic status, discrimination, insecure immigration status or abusive or dependent relationships.[16] As illustrated by the *R. v. D.C.* case, where the defendant turned to the police for protection from her violent partner prior to his allegation of HIV non-disclosure (an allegation that the trial judge found was motivated by the partner's desire for revenge against the defendant),[17] the criminalization of HIV non-disclosure can affect women in abusive relationships or who occupy marginalized positions in society. Some of the women convicted of HIV non-disclosure in Canada were survivors of violence and sexual violence; some were living in socioeconomic insecurity; and some had insecure immigration status or were members of Indigenous and racialized communities who continue to suffer from the effects of colonization and racism.[18]

Research on the impact of the criminalization of HIV non-disclosure on women living with HIV is currently ongoing in Canada. In particular, researchers are studying the impact of HIV criminalization on women's access to care and women's decisions to engage in sexual relationships. Evidence already suggests that the criminalization of HIV non-disclosure may represent a structural barrier to health care engagement for some people living with HIV in Canada, discouraging access to HIV testing and linkage to HIV care services required to achieve viral suppression, which is important to promote both individual and population health.[19] Studies have also reported high rates of sexual abstinence among women living with HIV,[20]

which are partly driven by fear of the consequences of HIV disclosure on the one hand and possible criminal prosecution for non-disclosure on the other.[21]

The overly broad criminalization of HIV non-disclosure undermines the rights of women living with HIV and public health. It is time for federal and provincial authorities to take action to limit the scope and application of the criminal law, in keeping with best practice and international, evidence-based recommendations.

RECOMMENDED ACTIONS

The Legal Network recommends that Canada

- **Limits the use of the criminal law to the intentional transmission of HIV**
- **Ensures that, at the absolute minimum, the criminal law is under no circumstances used against people living with HIV for not disclosing their status to sexual partners where they use a condom (or similar latex barrier) for penetrative sex, practice oral sex, or have condomless penetrative sex with a low or undetectable viral load**
- **Does not apply the law of sexual assault to cases of alleged HIV non-disclosure as it constitutes a stigmatizing and harmful misuse of this offence**

LIBERTY AND SECURITY OF THE PERSON (ARTICLE 14): INCARCERATION OF PERSONS WITH DRUG DEPENDENCE AND DENIAL OF HARM REDUCTION SERVICES IN PRISONS

The Committee asks:
Liberty and security of the person
24. Please also provide information about the number of persons with disabilities in prison and how many of them are provided with reasonable accommodation.

The Convention acknowledges that "disability is an evolving concept" and that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others." In our submission, given the domestic legal context, Canada's obligations under the Convention extend to protecting the rights of persons with drug dependence.[22]

"Drug dependence" is recognized as a disability under Canadian anti-discrimination law. For example, section 25 of the *Canadian Human Rights Act*, which applies in the federal jurisdiction, explicitly defines "disability" as including "previous or existing dependence on alcohol or a drug." Across Canada, drug dependence has also been recognized as a disability, either explicitly in the provinces' and territories' respective anti-discrimination codes or in jurisprudence interpreting and applying those codes.[23] The need for such protection arose given that people who use drugs routinely face ongoing stigmatization, vilification and discrimination, particularly if the substances they use are criminally prohibited.

The continued criminalization of people who use drugs in Canada, including those who may experience problematic use as a result of drug dependence, is one manifestation of ongoing discrimination by the state against people with what Canadian law recognizes as a disability. In 2012, the federal government intensified that discrimination with the passage of the *Safe Streets and Communities Act*, which introduced a number of punitive reforms, including mandatory minimum sentencing for certain non-violent drug offences. Despite purporting to only target those who *traffic* in drugs while offering alternatives to incarceration for those struggling with drug dependence, the burden of harsher enforcement still falls most heavily on those with drug dependence, particularly those who may engage in small-scale dealing to support their own drug use.[24]

Criminalizing the possession of drugs for personal use also undermines efforts to address the health needs of people struggling with problematic drug use (and thereby undermines public health more broadly). An overwhelming body of evidence demonstrates that the continued overwhelming emphasis on drug prohibition — from policing to prosecution to prisons — is not only failing to achieve both the stated public health and public safety goals of prohibition, but also resulting in costly damage to the public purse, to public health and to human rights, in Canada[25] and globally.[26] The UN Special Rapporteur on the right to the highest attainable standard of health has stated that "[a]t the root of many health-related problems faced by people who use drugs is criminalization itself, which only drives issues and people underground and contributes to negative public and individual health outcomes."[27] It is worth underscoring that the UN Committee on the Elimination of Discrimination against Women, in its November 2016

Concluding Observations, recommended that Canada "[r]epeal mandatory minimum sentences for minor, non-violent drug- related offences." [28]

At the same time, the excessive use of incarceration as a drug-control measure has led to an increase in Canada's prison population, which includes a substantial number of persons with what are recognized in Canadian law as people with disabilities. According to Canada's prison ombudsperson, 80% of federal prisoners experience problematic substance use or addiction.[29] There are also significantly higher rates of HIV and hepatitis C virus (HCV) in Canadian prisons compared to the community as a whole.[30] Furthermore, the denial of equivalent health services contributes to additional inequity and risk of harm to this population: 17% of men and 14% of women in federal prisons had injected drugs with shared injection equipment — a key risk factor in the spread of HIV and HCV.[31] In provincial institutions (where people serve a sentence of less than two years), 30% of women and 15% of men have HCV, and up to 9% of women and 2% of men have HIV.[32]

However, in spite of the overwhelming evidence of the health benefits of prison-based needle and syringe programs (PNSPs) and opiate substitution therapy (OST), no Canadian prison currently permits the distribution of sterile injection equipment to prisoners and a number of provincial and territorial prisons do not offer OST to prisoners.[33] (Also of concern: safer tattooing programs do not currently exist in any prison in Canada, despite the positive evaluation of an earlier pilot project in federal prisons, and a number of provincial and territorial prisons still do not make condoms and other safer sex supplies available to prisoners.[34]) In 2009, UN Special Rapporteur on Torture, Manfred Nowak, recommended that "needle and syringe programmes in detention should be used to reduce the risk of infection with HIV/AIDS."[35] In 2013, UN Special Rapporteur on Torture, Juan Méndez, urged States to "[e]nsure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations."[36] The Committee on the Elimination of Discrimination against Women has asked Canada to "[e]xpand care, treatment and support services to women in detention living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies." [37]

The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) recommends that prisoners enjoy the same standards of health care that are available in the community; this necessarily includes care for persons with drug dependence.[38] A number of UN agencies, including the UNODC, UNAIDS and the World Health Organization (WHO), have also recommended that prisoners should have access to a series of key interventions, including needle and syringe programs, condoms, drug dependence treatment including opioid substitution therapy, programs to address tattooing, piercing and other forms of skin penetration, and HIV treatment, care and support.[39] Not only should these interventions be made available, but also incarcerated women should have access to gender-specific health care that is at least equivalent to that available in the community.[40] The failure to provide prisoners with equivalent access to health services, including key harm reduction measures, is a violation of their rights to life, health, equality and non-discrimination. Given that prisoners in Canada are a population that disproportionately experiences disabilities of various kinds — including drug dependence, HIV and HCV — it should be of concern to the Committee that Canada continues to over-incarcerate people with these disabilities (through punitive drug laws criminalizing possession of drugs for personal use), and then subsequently denies them equivalent health services that contributes to further harms to health.

RECOMMENDED ACTIONS

The Legal Network recommends that Canada

- **Minimizes custodial sentences for people who commit non-violent offences, including repealing all mandatory minimum prison sentences for such offences**
- **Ensures access to appropriate health and social support services, including scaling up access to evidence-based drug dependence treatment (including gender-appropriate treatment), for those who need it, and evidence-based harm reduction services**
- **Expands evidence-based alternatives to incarceration for people who use drugs, taking into account the need for culturally appropriate care, including for women, Indigenous people, racialized minorities and youth**
- **Decriminalizes the possession for personal use of all drugs**
- **Implements key health and harm reduction measures in all prisons in Canada, including prison-based needle and syringe programs, opiate substitution therapy, condoms and other safer sex supplies, and safer tattooing programs, in consultation with prisoner groups and community health organizations to ensure operational success, taking into account the need for culturally appropriate and gender-specific programs**

LIBERTY OF MOVEMENT AND NATIONALITY (ARTICLE 18): BARRIERS TO IMMIGRATION OF PERSONS LIVING WITH HIV

The Committee asks:
Liberty of movement and nationality
29. Please comment on reports according to which disability may constitute a barrier to immigrating into the State party and for citizens to leave the State party.
30. Please provide information on the situation of migrants and asylum seekers with disabilities, including detention of migrants with intellectual and/or psychosocial disabilities.

In Canada, people seeking *permanent resident* status, or *temporary residence* as students or workers, can be rejected on the basis of their HIV status because of the "excessive demand" provision of Canada's laws governing "medical inadmissibility." Relying on the purportedly neutral criterion of the cost of health services, this law renders any applicant who is "likely" to require publicly funded health or social services in excess of the average annual health expenditure per Canadian resident (currently estimated at $6450 per year by the Canadian Institute for Health Information). Given the high cost of antiretroviral medications, the health care costs of many people living with HIV are higher than the current threshold.

A person living with HIV will be medically inadmissible to Canada unless they (a) fit within one of the exceptions to the excessive demand rule (i.e., refugees and certain family members sponsored for immigration by a Canadian resident); (b) are able to reduce the public burden of their medications by switching to generic drugs or obtaining private insurance; or (c) obtain an exemption from the excessive demand rule on humanitarian and compassionate grounds.

In 2002, the *Immigration and Refugee Protection Act* (IRPA) came into force and set out, for the first time, a comprehensive definition of excessive demand. Excessive demand is now defined as

> (a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required under paragraph 16(2)(b) of the Act, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or
>
> (b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents.

The excessive demand rule is a vestige of years of immigration policies that have excluded people with disabilities with the stated goal of protecting the public purse. The regime focuses solely on alleged use of health services as grounds for exclusion and ignores the important contributions that people with HIV make to Canadian society.

The Charter guarantees equality before and under the law and the right to the equal protection and equal benefit of the law without discrimination, including on the basis of disability, whether

physical or mental.[41] Section 3 of the IRPA specifically mandates that decisions taken under the Act must be consistent with the Charter, including its principles of equality and freedom from discrimination. The excessive demand regime violates the Charter by discriminating against people with disabilities, including people who are living with HIV.

While the excessive demand regime may appear neutral on the surface because it does not single out HIV or any other particular medical condition, focusing instead on the cost of an applicant's medical condition, cost is not a neutral factor. Federal and provincial governments incur many costs associated with immigration, such as the cost of language classes, settlement services and the education of newcomer children. These costs, however, are not considered in the immigration application process. In contrast, Immigration, Refugees and Citizenship Canada (IRCC) generally rejects residence applications from people living with HIV solely because of the cost of their life-saving medications (unless they fall into an exempted category, such as refugees or sponsored family-class members). As a result, people living with HIV are unfairly disadvantaged by a law that appears neutral. This form of indirect discrimination is still discrimination.[42]
Discrimination is inherent to the excessive demand regime itself. No amount of individualized assessments can diminish the reality that the excessive demand regime reduces an applicant living with HIV (or another disability) to a single characteristic: the cost of their medications. The reductive analysis of the excessive demand regime contributes to anti-HIV stigma. In *Hilewitz v. Canada*, the Supreme Court of Canada recognized that even "exclusionary euphemistic designations" can conceal prejudices about disability.[43] The excessive demand regime conceals outdated prejudices that people living with HIV, like other people with disabilities, are a burden on Canadian society.

By reducing people living with HIV solely to the cost of their medications, the excessive demand regime erases the many contributions that people with HIV make to Canadian society. In *Hilewitz,* the Supreme Court recognized that "no doubt" that "most immigrants, regardless of the state of their resources when they come to Canada, eventually contribute to this country in a variety of ways."[44] People living with HIV participate in the labour force, pay taxes and contribute to their communities in many ways. A medically inadmissible person could be more productive than the average Canadian, and contribute more to the gross national product than their cost in terms of health services, yet he or she would still be found to cause an "excessive demand."

UN agencies, including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM), have highlighted the positive impact of antiretroviral medication on the longevity and productivity of people living with HIV. With the falling costs of these drugs, "it is increasingly difficult to argue that people living with HIV incur greater costs to the destination country compared to the benefits they could contribute over a long-term stay."[45]

The excessive demand regime, however, offers no opportunity for decision-makers to assess the potential contributions that an applicant may make to Canadian society. Decision-makers are not permitted to assess whether applicants have the potential to make contributions that could offset their costs to the Canadian health care system. Consideration of the anticipated contributions of newcomers with HIV is particularly important given the increasingly manageable nature of the disease and longer lifespans of people living with HIV.[46]

In 2011, the UN General Assembly encouraged Member States to eliminate HIV-related restrictions on entry, stay and residence.[47] UNAIDS reiterated this call in 2014, highlighting that

countries can make a difference in the fight against HIV by ending all restrictions on the entry, stay and residence of people living with HIV.[48] These calls are in line with international law, which prohibits States from discriminating against a person in the enjoyment and exercise of their human rights on the basis of their health status (which includes HIV status).[49]

In fuelling stigma and preventing people living with HIV from becoming legal residents, the excessive demand regime prevents people living with HIV from realizing the right to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. It also prevents people living with HIV from exercising their rights to education,[50] employment[51] and the highest attainable standard of physical and mental health under the Convention.[52]

RECOMMENDED ACTIONS

The Legal Network recommends that Canada

- **Repeal the "excessive demand" provision of Canada's laws governing medical inadmissibility, which allow people seeking permanent resident status or temporary residence as students or workers to be rejected on the basis of their HIV status**

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

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

[3] Human Rights, Citizenship and Multiculturalism Act, RSA 2000, c. H-14 [Alberta]; Human Rights Code RSBC 1996, c. 210 [British Columbia]; Human Rights Code, CCSM 1987, c. H175 [Manitoba]; Human Rights Act, RSNB 1973, c. H-11 [New Brunswick]; Human Rights Code, RSNL 1990, c. H-14 [Newfoundland & Labrador]; Human Rights Act, SNWT 2002, c. 18 [Northwest Territories]; Human Rights Act, RSNS 1989, c. 214 [Nova Scotia]; Human Rights Act, SNu 2003, c. 12 [Nunavut]; Human Rights Code, RSO 1990, c. H.19 [Ontario]; Human Rights Act, RSPEI 1988, c. H-12 [Prince Edward Island]; Québec Charter of Human Rights and Freedoms RSQ 1975, c. C-12 [Québec]; Saskatchewan Human Rights Code, SS 1979, c. S-24.1 [Saskatchewan]; Human Rights Act, RSY 2002, c. 116 [Yukon]. As compiled in R. Elliott and J. Gold, "Protection against Discrimination Based on HIV/AIDS Status in Canada: The Legal Framework," *HIV/AIDS Policy & Law Review* 10,1 (2005): 20–31. Available at www.aidslaw.ca/site/protection-against-discrimination-based-on-hivaids-status-in-canada-the-legal-framework-hivaids-policy-law-review-101.

[4] UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*, Human Rights Council, Fourteenth session, Agenda item 3, A/HRC/14/20, April 27, 2010, para. 71. Available at www.aidslaw.ca/site/wp-content/uploads/2014/02/4_R.Special2010EN.pdf.

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

[6] UNAIDS/UNDP, *Policy brief: criminalization of HIV transmission*, August 2008. Available at www.aidslaw.ca/site/wp-content/uploads/2014/02/1.UNAIDSUNDPposition.pdf.

[7] *Report of the Special Rapporteur*.

[8] Global Commission on HIV and the Law (UNDP HIV/AIDS Group), *HIV and the Law: Risks, Rights and Health* (July 2012), 24. Available via www.hivlawcommission.org.

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

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

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

[12] E. J Bernard and S. Cameron, *Advancing HIV Justice 2: Building momentum in global advocacy against HIV criminalisation*, HIV Justice Network and Global Network of People Living with HIV, April 2016.

[13] M. Loutfy et al., "Canadian Consensus Statement on HIV and its transmission in the context of the criminal law," *Canadian Journal of Infectious Diseases & Medical Microbiology* 25, 3 (2014): 135–140. Available at www.aidslaw.ca/site/wp-content/uploads/2014/06/Canadian-statement1.pdf.

[14] A.J. Rodger et al., "Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy," *JAMA* 316, 2 (July 12, 2016): pp. 171–181. Available at www.aidslaw.ca/site/download/14555/; "Canadian Consensus Statement"; Prevention Access Campaign, "Consensus Statement: Risk of sexual transmission of HIV from a person living with HIV who has an undetectable viral load." Available at www.preventionaccess.org/consensus.

[15] Canadian HIV/AIDS Legal Network, *What does consent really mean? Rethinking HIV non-disclosure and sexual assault law meeting report*, 2014. Available at www.consentfilm.org/resources-and-publications.

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

[17] B. Myles, "De bourreau à victime; de victime à criminelle," *Le Devoir*, February 15, 2008.

[18] See, for example, C. Kazatchkine and L. Gervais, "Canada's newest sex offenders", *Winnipeg Free Press*, March 8, 2016; Canadian HIV/AIDS Legal Network, "Women and the Criminalization of HIV Non-Disclosure," info sheet, 2012.

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

[20] A. Kaida et al., "Sexual inactivity and sexual satisfaction among women living with HIV in Canada in the context of growing social, legal and public health surveillance," *Journal of the International AIDS Society* 18, Suppl 5 (2015): 20284.

[21] According to preliminary results of the Canadian HIV Women's Sexual & Reproductive Health Cohort Study (CHIWOS), 240 (41%) participants personally reported recent intentional sexual abstinence: 54 (23%) reported that abstinence was driven by concerns about HIV criminalization and 84 (35%) reported that abstinence was driven by fear of HIV disclosure. These preliminary results were presented by Valerie Nicholson, one of the Peer Associate Researchers involved in CHIWOS, at a workshop being held at the *HIV is not a crime training academy*, in Huntsville, Alabama, in May 2016. It is our understanding that the results have yet to be published.

[22] UN Convention on the Rights of Persons with Disabilities, Preamble, Article 1.

[23] For example, Ontario's Human Rights Code forbids the discrimination of a person based on "mental health disabilities or addictions." Available at www.ontario.ca/laws/statute/90h19. Manitoba's Human Rights Commission Board of Commissioner's policy defines disability as including "physical or mental disability" that may include "actual or perceived previous or existing or potential dependence on alcohol, drugs, or addictive substances, and may include addiction to gambling." Available at http://legalblogs.findlaw.ca/uncommon-law/alcohol-addiction-ruled-a-disability-in-landmark-manitoba-case-481/. In Newfoundland and Labrador, the province's Employer's Guide to the Human Rights Code warns employers that alcohol and drug dependence is considered a disability and has to be treated accordingly. Available at www.justice.gov.nl.ca/hrc/Publications/GuidetotheHumanRightsCode.pdf.

[24] Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses*, 2006; Darcie Bennett and Scott Bernstein, *Throwing Away the Keys: The Human and Social Cost of Mandatory Minimum Sentences*, Pivot Legal Society, 2013.

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