Canadian HIV/AIDS Legal Network
Submission to the Global Commission on HIV and the Law

CANADA
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Introduction

The Canadian HIV/AIDS Legal Network ("Legal Network") promotes the human rights of people living with, at risk of or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization. Since the 2012 publication of the final report of the Global Commission on HIV and the Law ("Global Commission") *HIV and the Law: Risks, Rights and Health*, the Legal Network has incorporated its recommendations in our advocacy and engagement with government officials and UN bodies in pursuit of legal and policy reform to uphold the human rights of the communities that we serve, including people living with HIV, people who use drugs, prisoners and sex workers.[1]

1. Laws and practices that criminalize people living with HIV and key populations

A. Criminalization of HIV non-disclosure

People living with HIV in Canada remain at risk of prosecution for not disclosing their HIV-positive status before sex. Individuals have been charged and prosecuted even where there was no HIV transmission, the person had no intention to harm their sexual partner, and the person used a condom or had an undetectable viral load (i.e., there was effectively no risk of HIV transmission). Canada has the third-largest absolute number of recorded prosecutions for alleged HIV non-disclosure in the world, with **more than 200 separate documented prosecutions so far**, and one of the higher per capita rates of prosecution given the number of people living with HIV in the country.[2] People living with HIV accused of HIV non-disclosure are usually charged with aggravated sexual assault — an offence that carries a maximum penalty of life imprisonment and mandatory registration as sexual offender for a minimum of 20 years.

The overly broad use of the criminal law in cases of HIV non-disclosure causes considerable harm by increasing stigma and discrimination against people living with HIV, spreading misinformation about HIV, undermining public health messaging about HIV prevention, and affecting the trust between patients and their physicians and counsellors.[3] As a result, numerous HIV organizations across Canada and internationally oppose criminal charges for non-disclosure in cases of otherwise consensual sex, except

[1] Publications and submissions in which the Legal Network has cited the Global Commission's report include: Canadian HIV/AIDS Legal Network et al, *Drug policy and human rights: the Canadian context – Submission to the Office of the UN High Commissioner for Human Rights* (2015); Canadian HIV/AIDS Legal Network, *Submission to the United Nations Human Rights Council Universal Periodic Review Working Group: Third Universal Periodic Review (UPR) Of Canada* (2017); Canadian HIV/AIDS Legal Network, *Review of Canada's Compliance with the Convention on the Elimination of All Forms of Discrimination Against Women: Submission to the United Nations Committee on the Elimination of Discrimination Against Women* (2017); Canadian Alliance for Sex Work Law Reform, *Safety, Dignity, Equality: Recommendations for Sex Work Law Reform in Canada*, 2017.

[2] E. J Bernard and S. Cameron, *Advancing HIV Justice 2: Building momentum in global advocacy against HIV criminalisation* (Brighton/Amsterdam: HIV Justice Network and Global Network of People Living with HIV (GNP+), 2016).

[3] See e.g., P. O'Byrne et al., "HIV criminal prosecutions and public health: an examination of the empirical research," *Med Humanit* 39 (2013): 85–90; 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.

in limited circumstances (such as when people are aware of their status and act with malicious intent to infect others).

Scientific experts have also increasingly articulated their concerns that the over-extension of the criminal law too often rests on a poor appreciation of the best available scientific evidence (e.g., regarding per-act risk of HIV transmission — see, for example, the **scientific consensus statement published in 2014** by nearly 80 Canadian scientific experts in HIV, which addressed the criminal justice system.[4] In recent years, advocates tracking HIV criminalization in Canada have observed the positive impact that such science-based interventions can have when properly used, including by defence lawyers; the Canadian scientific consensus statement has been helpful in a number of cases known to the Legal Network in limiting the number and scope of prosecutions.

Community mobilization is increasing with the support of organizations such as the Legal Network, and community advocacy is also having some impact.

In November 2016, the **UN Committee on the Elimination of Discrimination Against Women** ("CEDAW Committee") issued concluding observations to Canada that expressed its concern about the "harsh criminal sanctions" being applied to women living with HIV in Canada for non-disclosure, and recommended limiting the criminal law "to cases of intentional transmission of HIV/AIDS, as recommended by international public health standards."[5]

In November 2017, after cross-country consultation, the Canadian Coalition to Reform HIV Criminalization (CCHCR) released a joint **Community Consensus Statement** endorsed by more than 150 organizations across the country, from the HIV sector and beyond.[6] Among other things, that statement recommends limiting HIV criminalization to cases of actual, intentional transmission, as recommended by the Global Commission (and others).[7]

Most recently, on December 1, 2017, the federal and Ontario governments recognized the need to limit the "overcriminalization of HIV." Both governments acknowledged that criminal prosecution for alleged HIV non-disclosure is not warranted where a person living with HIV had a "suppressed viral load" (i.e., less than 200 copies of HIV/ml of blood) for at least six months because such an individual poses no "realistic possibility" of transmitting the virus — the Supreme Court of Canada's legal test for whether a duty to disclose existed.[8] Furthermore, **Justice Canada's historic report**, responding to community advocacy, recommended that: "The criminal law should generally not apply to persons living with HIV who: are on treatment; are not on treatment but use condoms; or, engage only in oral sex (unless other risk factors are present and the person living with HIV is aware of those risks), because the realistic possibility of transmission test is likely not met in these circumstances."[9]

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[4] E.g., M. Loutfy et al., "Canadian consensus statement on HIV and its transmission in the context of criminal law," *Can J Infect Dis Med Microbiol* 25(3) (2014):135-140. Available at www.aidslaw.ca/site/download/16147/.

[5] UN Committee on the Elimination of Discrimination Against Women, Concluding observations on the combined eighth and ninth periodic reports of Canada, CEDAW/C/CAN/CO/8-9, November, 18, 2016, para. 43.

[6] Canadian Coalition to Reform HIV Criminalization, *End Unjust HIV Criminalization: Community Consensus Statement,* 2017. Available at www.hivcriminalization.ca/community-consensus-statement/.

[7] Global Commission on HIV and the Law, *Risks, Rights & Health* (July 2012), Recommendations 2.2 and 2.4; UNAIDS, *Ending overly broad criminalisation of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations*, 2013. Available at www.unaids.org/sites/default/files/media_asset/20130530_Guidance_Ending_Criminalisation_0.pdf.

[8] Government of Canada, Department of Justice, "Criminal Justice System's Response to Non-Disclosure of HIV" (December 1, 2017). Available at www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/hivnd-vihnd.pdf; Ministry of the Attorney General, *Crown Prosecution Manual – D. 33: Sexual Offences against Adults,* updated December 1, 2017. Available at www.ontario.ca/document/crown-prosecution-manual/d-33-sexual-offences-against-adults.

[9] Ibid.

While these developments have the potential to affect the lives of people living with HIV across Canada by curtailing the reach of the criminal law, much more is still needed. For example, Ontario remains the only Canadian jurisdiction to date to adopt any clear directive to prosecutors limiting HIV criminalization, but as noted, only refrains from prosecution against persons with a "suppressed viral load"; to date, it has refused to clearly rule out prosecution in other circumstances as recommended by Justice Canada (e.g., condom use, oral sex only). The steps taken by Attorneys General and prosecutors to date in Canada fall far short of limiting HIV criminalization in the manner recommended by domestic advocates and international experts such as the Global Commission.

It remains essential for the Global Commission to reiterate its original recommendation on limiting HIV criminalization — and, we suggest, it would be advisable for the Global Commission to in fact provide more specific guidance (e.g., clearly identifying activities that should be excluded from the ambit of criminalization, based on good scientific, public health and human rights grounds). In addition, we would invite the Global Commission to specifically recommend the development of guidance and training for police, prosecutors and the judiciary on limiting the application of the criminal law in line with recommendations from the Global Commission and UNAIDS.

B. People who use drugs, including in prison

With the death toll in Canada mounting from an ongoing opioid overdose crisis,[10] Canada's federal Health Minister announced in December 2016 a **new national drug strategy reinstating harm reduction as a key pillar** and reverting responsibility for this new strategy to Health Canada, rather than the Department of Justice.[11] This strategy ushered in a number of laws and policies that have enabled people who use drugs to have greater access to harm reduction and evidence-based treatment for drug dependence.

Among these is a 2017 law repealing a cumbersome federal process for obtaining exemptions to open and operate **safer consumption services** without risk of criminal prosecution and replacing it with a law that eases some of these restrictions.[12] As a result, Health Canada has to date approved 29 applications for these services — a dramatic increase from the two sites operating with a legal exemption in 2016.[13] In 2017, Health Canada further developed a process to issue class exemptions for emergency **overdose prevention sites** (which provide supervised drug consumption, harm reduction supplies and naloxone) for provinces and territories that request them, for a renewable three-month period.[14] While such sites were already operating in B.C. pursuant to a provincial declaration of a public health emergency, Health Canada authorized a class exemption for the province of Ontario, where several overdose prevention sites have been approved.[15] To encourage people who use drugs to call emergency services during a drug overdose, the federal government also passed the ***Good Samaritan Drug Overdose Act***, a law that provides an exemption from charges of drug possession for people who call emergency services for

[10] Government of Canada, "Apparent opioid-related deaths," March 27, 2018. Available at www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/apparent-opioid-related-deaths.html.

[11] Government of Canada, "Canadian drugs and substances strategy," October 30, 2017. Available at www.canada.ca/en/health-canada/services/substance-abuse/canadian-drugs-substances-strategy.html.

[12] *An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts* (S.C. 2017, c. 7).

[13] Government of Canada, "Supervised consumption sites: status of applications," May 1, 2018. Available at www.canada.ca/en/health-canada/services/substance-abuse/supervised-consumption-sites/status-application.html#app.

[14] Government of Canada, "Statement from the Minister of Health Regarding the Opioid Crisis," December 7, 2017. Available at www.canada.ca/en/health-canada/news/2017/12/statement_from_theministerofhealthregardingtheopioidcrisis.html.

[15] Ontario Ministry of Health and Long-Term Care, "Ontario Moving Quickly to Expand Life-Saving Overdose Prevention Programs," March 7, 2018. Available at https://news.ontario.ca/mohltc/en/2018/03/ontario-moving-quickly-to-expand-life-saving-overdose-prevention-programs.html.

themselves or another person suffering an overdose, as well as anyone who is at the scene when emergency help arrives.[16]

Over the past three years, Health Canada has also **overturned the previous federal government's regulation banning diacetylmorphine (medically prescribed heroin**),[17] approved a **nasal-spray formulation of naloxone**,[18] and amended regulations to promote **greater access to methadone and diacetylmorphine** by allowing physicians to prescribe methadone without first applying for an exemption from federal law and allowing patients to receive diacetylmorphine outside a hospital setting.[19] In April 2017, the federal government also introduced a bill to **legalize and regulate cannabis**, which is expected to become law some time in 2018.[20]

On the international level, Canada spearheaded the adoption by the **UN Commission on Narcotic Drugs (CND) of its first-ever resolution addressing stigma against people who use drugs**, including in health and other social services.[21] This is an important development and its operational paragraphs require UNDOC to prepare a report to the CND at its 2020 session on the implementation of the resolution. The Global Commission should welcome such a development and emphasize the critical importance of countries addressing stigma and discrimination against people who use drugs as a necessary part of any effective response to HIV, viral hepatitis, overdose and other health challenges.

Despite these positive developments, which the Global Commission could highlight as such, much more needs to be done, including **repealing mandatory minimum sentences for drug offences,** which disproportionately incarcerate people who are vulnerable to HIV and HCV infection,[22] and **decriminalizing the possession of drugs for personal use**. Imposing mandatory minimum sentences for non-violent drug-related offences and criminalizing the possession of drugs for personal use undermine efforts to address the health needs of people struggling with problematic drug use. Notably, in 2016 the CEDAW Committee recommended that Canada "repeal mandatory minimum sentences for minor, non-violent drug-related offences" [23] and in 2017, the UN Committee on the Elimination of Racial Discrimination ("CERD Committee") called on Canada to "[a]ddress the root causes of over-representation of African-Canadians and Indigenous Peoples at all levels of the justice system" by "re-examining drug policies" and "providing evidence-based alternatives to incarceration for non-violent drug users."[24]

Imprisoning people who use drugs is also ill-advised from a public health perspective because of the **inadequacy of HIV and HCV prevention measures behind bars**. Research shows that the

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[16] *Good Samaritan Drug Overdose Act* (S.C. 2017, c. 4).

[17] *Regulations Amending Certain Regulations Made Under the Controlled Drugs and Substances Act (Access to Diacetylmorphine for Emergency Treatment)*, P.C. 2016-759 August 26, 2016. Available at www.gazette.gc.ca/rp-pr/p2/2016/2016-09-07/html/sor-dors239-eng.html.

[18] Government of Canada, "Authorized Canadian naloxone Nasal Spray (NARCAN) coming to market," July 30, 2017. Available at http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/63784a-eng.php.

[19] See www.canada.ca/en/health-canada/news/2018/03/the-honourable-ginette-petitpas-taylor-minister-of-health-announces-new-measures-to-reduce-barriers-to-treatment-and-231-m-to-address-the-o.html.

[20] Bill C-45, *An Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts*.

[21] UN Commission on Narcotic Drugs, Removing stigma as a barrier to the availability and delivery of health, care and social services for people who use drugs, UN Doc. E/CN.7/2018/L.11/Rev1 (as adopted on 16 April 2018).

[22] *Safe Streets and Communities Act*, SC 2012, c 1.

[23] UN Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Canada*, November 2016, para. 45.

[24] UN Committee on the Elimination of Racial Discrimination, *Concluding Observations: Canada*, August 2017, para. 16(d).

incarceration of people who inject drugs is a factor driving Canada's HIV and HCV epidemic.[25] In particular, studies have revealed high rates of drug use and syringe-sharing among people who use drugs in Canada's prisons,[26] leading to HIV prevalence of 1–2% of men and 1–9% of women in prison.[27]

To ensure a response to HIV that is consistent with human rights obligations in places of detention, Canada must introduce **prison-based needle and syringe programs** (PNSPs) and increase access to **opioid substitution therapy** (OST) in Canada's federal and provincial prisons, especially in light of persistent barriers to accessing OST in prison, particularly for prisoners who wish to initiate treatment[28] and increasing reports of overdose behind bars.[29] For people who use drugs, PNSPs and OST are essential health care. These programs are also in line with the Global Commission's recommendations for the provision of "comprehensive harm reduction services" and "evidence-based treatment for drug dependence" in places of detention, the CEDAW Committee's recommendation to 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"[30] and the CERD Committee's recommendation to Canada to "[i]mplement key health and harm reduction measures across all prisons."[31] On May 14, 2018, under pressure from ongoing constitutional litigation by the Legal Network and other advocates, the federal government conceded the effectiveness and value of PNSPs and announced it would phase in the implementation of PNSPs; however, essential program details remain to be determined.[32]

We suggest the Global Commission reiterate its earlier call for full decriminalization of the possession of currently illegal drugs for personal consumption. The Commission should also specifically urge countries to comply with their international human rights obligations as reflected in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) by ensuring that prisoners have access to health care services equivalent to those available outside of prison — including all recommended harm reduction measures for prevention of HIV and viral hepatitis.

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[25] See, for example, M.W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV–1 epidemic," *AIDS* 17,6 (2003): 887–893 and H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17,6 (2003): 911–913.

[26] See, for example, Zakaria et al., *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, Correctional Service of Canada, 2010; E. van der Meulen, "'It Goes on Everywhere': Injection Drug Use in Canadian Federal Prisons," *Substance Use & Misuse* 22 (February 2017); E. Wood et al., *Recent incarceration*; C. Hankins, "Confronting HIV infection in prisons," *Canadian Medical Association Journal* 151,6 (1994): 743–745; C.A. Hankins et al., "HIV infection among women in prison: An assessment of risk factors using a non-nominal methodology," *American Journal of Public Health* 84,10 (1994): 1637–1640.

[27] F. Kouyoumdjian et al., "Health status of prisoners in Canada," *Canadian Family Physician* 62 (2016): 215–222.

[28] See, for example, F. Kouyoumdjian et al., "Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey," *PLoS ONE* 13(2) (2018): e0192431.

[29] F. Pan, "'Lots of drugs' in Hamilton Barton Street jail, former inmate testifies at inquest," *CBC*, April 20, 2018. Available at www.cbc.ca/news/canada/hamilton/hamilton-jail-overdose-inquest-acheson-kenneth-albert-1.4629144.

[30] UN Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Canada*, November 2016, para. 49(c).

[31] UN Committee on the Elimination of Racial Discrimination, *Concluding Observations: Canada*, August 2017, para. 16(e).

[32] Correctional Services of Canada, "Correctional Service Canada announces a Prison Needle Exchange Program," News release, 14 May 2018. Available at: https://www.newswire.ca/news-releases/correctional-service-canada-announces-a-prison-needle-exchange-program-682556901.html; Canadian HIV/AIDS Legal Network, "Advocates welcome major concessions in Government of Canada's prison needle exchange announcement," News release, 14 May 2018. Available at: http://www.aidslaw.ca/site/advocates-welcome-major-concessions-in-government-of-canadas-prison-needle-exchange-announcement/?lang=en.

C. Sex workers

In 2014, the federal government passed *the Protection of Communities and Exploited Persons Act* (PCEPA), which reflects the 'Nordic approach' to prostitution. **This law continues to criminalize sex workers,[33] as well those who purchase sex and third parties involved in sex work**.[34] As the Global Commission has noted, this approach "has not improved — indeed, it has worsened — the lives of sex workers."[35] Numerous studies of the Nordic approach have concluded that banning the purchase of sexual services has contributed to violence against sex workers, who are forced to work in isolation and in clandestine locations, as well as to rush negotiations with potential clients for fear of police detection.[36] In Canada, research has demonstrated that police targeting of clients and third parties rather than sex workers has not affected rates of violence against sex workers or enhanced sex workers' control over their sexual health and HIV prevention.[37]

At the same time, criminalizing third parties who work with, work for or employ sex workers forces sex workers to work in isolation, away from social support networks and without proven safety mechanisms. Evidence has demonstrated the role of supportive managerial and venue-based practices in reducing violence and HIV risks among sex workers.[38] Third parties can be helpful resources for other sex workers, especially migrant sex workers who may have limited resources and face language barriers.[39] A legal framework that subjects all third parties to criminal sanction without evidence of abuse or exploitation drives the sex industry underground where labour exploitation can flourish, and deters sex workers from the criminal justice system when they experience violence, because they may fear that they and/or their employer may be charged with prostitution-related offences.[40]

Moreover, since the passage of the PCEPA, criminalizing sex work has been deemed to be a central strategy to protect women from human trafficking and has resulted in inaccurately equating sex work with sex trafficking.[41] This strategy has enabled law enforcement to intensify police surveillance and other

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[33] B. Sawchuk, "Undercover cops take aim at sex trade," *St. Catharines Standard*, July 20, 2016. Available at www.stcatharinesstandard.ca/2016/07/20/undercover-cops-take-aim-at-sex-trade.

[34] S. Chu et al., *Reckless Endangerment: Q&A on Bill C-36: Protection of Communities and Exploited Persons Act*, Canadian HIV/AIDS Legal Network, June 2014.

[35] Global Commission on HIV and the Law, *Risks, Rights & Health* (July 2012), at p. 38.

[36] See, for example, J. Levy and P. Jakobsson, "Sweden's abolitionist discourse and law: Effects on the dynamics of Swedish sex work and on the lives of Sweden's sex workers," *Criminology & Criminal Justice* 1–15 (March 31, 2014); P. Östergren and S. Dodillet, "The Swedish Sex Purchase Act: Claimed success and documented effects," paper presented at the International Workshop: Decriminalizing Prostitution and Beyond: Practical Experiences and Challenges, March 3-4, 2011, The Hague, Netherlands; and U. Bjørndah, *Dangerous Liaisons: A report on the violence women in prostitution in Oslo are exposed to*, Municipality of Oslo, 2012.

[37] A. Krüsi et al., "Criminalisation of clients: reproducing vulnerabilities for violence and poor health among street-based sex workers in Canada—a qualitative study," *BMJ Open* 4 (2014); Sex Workers United Against Violence, Pivot Legal Society and Gender and Sexual Health Initiative, *My Work Should Not Cost Me My Life: The Case Against Criminalizing the Purchase of Sexual Services in Canada*, 2014; and Krüsi et al., "'They Won't Change It Back In Their Heads That We're Trash': The Intersection of Sex Work Related Stigma and Evolving Policing Strategies," *Sociology of Health & Illness* (April 26, 2016).

[38] K. Shannon et al., "Global epidemiology of HIV among female sex workers: influence of structural determinants," *Lancet* 385, 9962 (January 3, 2015): pp. 55–71.

[39] Butterfly (Asian and Migrant Sex Workers Support Network), *Stop the harm from anti-trafficking policies & campaigns: support sex workers' rights, justice and dignity*, 2016.

[40] Canadian Alliance for Sex Work Law Reform, *Pimps, Managers and Other Third Parties: Making Distinctions Between Third Parties and Exploitation*, 2014.

[41] Indeed, the *National Action Plan to Combat Human Trafficking* makes the unsubstantiated claim that the sexual exploitation of women and girls is the most common manifestation of trafficking in Canada. See Public Safety Canada, *National Action Plan to Combat Human Trafficking*, 2012.

initiatives against sex workers.[42] Greater surveillance of migrant and Indigenous women who leave their communities has undermined their relationships with those who may offer them safety or support, including in circumstances where they may be selling sex. Migrant sex workers are under constant threat of detention and deportation, thus deterring them from critical health and support services including the police for fear of being labeled victims of trafficking.[43] Such policing initiatives have not resulted in more protection or safety for trafficked persons.

Consistent with the Global Commission's recommendations in relation to sex work, Canada must **repeal the PCEPA and all sex work-specific criminal laws**, and take all measures to **stop police harassment and violence against sex workers**, including raids, detentions and deportations of sex workers by using anti-trafficking, anti–sex work and immigration laws in the name of protection.

2. Access to medicines and intellectual property law

As has been highlighted recently by the UN Secretary-General's High-Level Panel on Access to Medicines, created in response an earlier recommendation of the Global Commission on HIV and the Law, intellectual property (IP) rules can either improve or undermine the ability of some of the world's poorest to obtain lower-cost medicines.[44] Countries such as Canada should take action, domestically and internationally, to ensure their laws and policies in relation to IP facilitate access to medicines, as an essential element of realizing the right to the highest attainable standard of health.[45]

Canada should commit to ending the tragic global gap in access to medicines, which is particularly burdensome for developing countries facing multiple major public health challenges — including, but not limited to, HIV — by **remedying the deficiencies in its current legislative regime authorizing compulsory licensing of patented pharmaceuticals for export to eligible developing countries**, and similarly supporting the adoption by World Trade Organization (WTO) Members of revised mechanism that it simple and straightforward in facilitating such use of compulsory licensing. This is in keeping with the original recommendation (Recommendation 6.5) of the Global Commission, and was reiterated again most recently by the UN Secretary-General's High-Level Panel on Access to Medicines.[46] The Global Commission should underscore the continued need for action by individual countries, and by WTO Members, to address this ongoing barrier to scaling up access to lower-cost, generic medicines.

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[42] A. Rose, "Punished for Strength: Sex Worker Activism and the Anti-Trafficking Movement," *Atlantis* 37, 2 (2015): pp. 57-64; POWER (Prostitutes of Ottawa/Gatineau Work, Educate, and Resist), *Ottawa Area Sex Workers Targets of Intrusive Police Visits*, 2014.

[43] Butterfly (Asian and Migrant Sex Workers Support Network), *Stop the harm from anti-trafficking policies & campaigns: support sex workers' rights, justice and dignity*, 2016 and C. McIntyre, "Migrant sex workers caught up in Ottawa sting facing deportation, further exploitation: activists," *National Post*, May 13, 2015. Available at http://news.nationalpost.com/news/canada/migrant-sex-workers-caught-up-in-ottawa-sting-facing-deportation-further-exploitation-activists.

[44] *Report of the United Nations Secretary-General's High-Level Panel on Access to Medicines: Promoting innovation and access to health technologies* (September 2016). Available at www.unsgaccessmeds.org/final-report/.

[45] R. Elliott et al., *Background Paper: International legal norms: the right to health and the justifiable rights of inventors*, UN Secretary-General's High-Level Panel on Access to Medicines, March 2016. Available at: http://www.unsgaccessmeds.org/reports-documents/.

[46] *High-Level Panel, supra*, at p. 23 (referring to Canada's legislation specifically) and general Recommendations 2.6.1(b) and (c). It is worth noting the the widespread support — including from 80% of Canadians polled — for legislative proposals previously in front of the last Parliament that were aimed at fixing the flaws in Canada's Access to Medicines Regime. Such fixes remain needed if the regime is ever to deliver on Parliament's previous unanimous pledge (in 2004) to support developing countries in getting more affordable, generic medicines — rather than remaining moribund, with only one licence issued under the system, authorizing a limited quantity of just one medicine (for treating HIV) to one country (Rwanda). See Canadian HIV/AIDS Legal Network, *Fixing Canada's Access to Medicines Regime (CAMR): 20 Questions & Answers*, 2012. Available at www.aidslaw.ca/site/fixing-canadas-access-to-medicines-regime-camr-20-questions-answers.

On the domestic level, Canadians already pay some of the highest drug prices in the world and pharmaceutical products are one of the three largest elements of our overall health-care spending, year after year.[47] Meanwhile, in the absence of a national, universal pharmacare plan, available evidence indicates that a significant percentage of Canadian residents experience the cost of medication as a barrier to health care. It is against this backdrop that Canada, Mexico and the U.S. are currently renegotiating the **North American Free Trade Agreement** (NAFTA). Demands are being advanced by the U.S. to change the current treaty's IP chapter in ways that would further expand the monopoly protections of prescription drug corporations and thus thwart market competition from generic products that is often essential to bring down consumer prices. In light of the ongoing negotiation process, Canada must ensure that any provisions in a renegotiated NAFTA support, and do not further complicate, the already challenging task of developing universal, equitable pharmacare coverage across the country.[48] Given the broader global implications of the provisions of a renegotiated NAFTA, Canada must demonstrate this commitment in rejecting any intellectual property rules more stringent than those already embedded in the current NAFTA, and use the opportunity of the renegotiation to advance a more health-friendly approach to such provisions in an international trade agreement — including incorporating relevant recommendations from the Global Commission on HIV and the Law and, more recently, from the UN Secretary-General's High-Level Panel on Access to Medicines.

The **investor-state dispute settlement ("ISDS") clauses** in the previous NAFTA and other international trade deals, such as the revived (and re-named) **Comprehensive and Progressive Trans-Pacific Partnership Agreement** (CPTPP), also present concerns. Until now, ISDS provisions in trade agreements have not generally extended to defining "investment" as including intellectual property claims. However, under the terms originally provisionally agreed in the TPP, at the behest of the US in particular, there is a risk that ISDS provisions would be extended to include intellectual property rights claims, presenting a new route for pharmaceutical companies to try to derail public-interest laws or regulations that interfere with their expected profits. Those terms in the CPTPP have been "suspended" by the remaining negotiating parties in light of the U.S. withdrawal before final signature — but risk being reactivated in the CPTPP in future should the U.S. seek to re-join the agreement, and in the meantime are being advanced by the U.S. in the NAFTA renegotiation.

If problematic intellectual property rules, coupled with an extension of insidious dispute resolution regimes such as the one included in the existing NAFTA, were to make their way into a new North American trade deal, hundreds of millions of vulnerable people could face even higher drug costs. Delaying the entry of lower-cost generics into the market would devastate efforts to make medicines available to as many people as possible. The impact would be felt first in the three NAFTA countries, but history illustrates that the risk to access to medicines extends well beyond these states. The original intellectual property chapter of NAFTA became the template for the 1994 *Agreement on Trade-related Aspects of Intellectual Property Rights* (TRIPS) of the World Trade Organization (WTO). This globalized a model of IP regulation agreed to by the NAFTA negotiating parties, with little regard for the even more damaging impact on countries with fewer resources and more extensive burdens from HIV and other public health challenges. A further ratcheting up of "TRIPS-plus" rules in a renegotiated NAFTA would certainly be used as a new "floor" for demands in other forums and other trade treaty negotiations. This should be of concern to the Global Commission and provides further impetus for affirming its original recommendations and solidly endorsing those of the UN Secretary-General's High-Level Panel.

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[47] Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2015* (Ottawa: CIHI, 2015). Available at https://secure.cihi.ca/free_products/nhex_trends_narrative_report_2015_en.pdf.

[48] M. Dutt, *Affordable Access to Medicines: A Prescription for Canada* (Ottawa: Canadian Doctors for Medicare and Canadian Centre for Policy Alternatives, 2014). Available at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2014/12/Affordable_Access_to_Medicines.pdf.