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Chair

Mr. Anthony Housefather

Standing Committee on Justice and Human Rights

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● (0850)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Good morning, everyone. Welcome to this meeting of the Standing Committee on Justice and Human Rights as we resume our study of the criminalization of non-disclosure of HIV status.

Today we're joined by a distinguished panel of witnesses.

We have with us, as individuals, Dr. Isaac Bogoch, Physician and Scientist, Toronto General Hospital and University of Toronto; and Mr. Jonathan A. Shime, who is an attorney. As well, from the HIV & AIDS Legal Clinic Ontario, we have Mr. Ryan Peck, who is the Executive Director and also an attorney.

Welcome.

[*Translation*]

From Montreal, we will be hearing from Dr. Sarah-Amélie Mercure, from Montréal sans sida.

Dr. Mercure, you can start, since you are testifying by video conference and I do not want to lose the link. You have eight minutes, but I will not be stopping you before 10 minutes.

Dr. Sarah-Amélie Mercure (Member, Montréal sans sida): That's fine. Thank you.

Good morning, everyone.

Thank you very much for having me as a witness in your study on the criminalization of the non-disclosure of HIV status.

I have organized my testimony around the four questions that were sent to us by Mr. Girard, the clerk of this committee. I also thank him very much for his support as I prepared for this meeting.

Essentially, your first question deals with the relevance and content of the federal directive. As a public health physician and an officer of Montréal sans sida, the issue of the criminalization of the non-disclosure of HIV-positive status has often been brought to my attention.

Without doubt, the directive is relevant. In Canada, there have been around 200 prosecutions of persons living with HIV for non-disclosure of their HIV status. Internationally, if we judge by the texts that address these problems, Canada was perceived as a country with quite a debatable interpretation, given the reality of possible HIV transmission. So the directive comes at a good time, because it provides a much more up-to-date interpretation of the decision handed down by the Supreme Court in 2012. It is much more in step with the scientific advances on living with and transmitting HIV.

We know that criminalizing the non-disclosure of HIV-positive status is generally not recommended by public health authorities. It really does not reduce the risk of transmission. Nor does it lead to lasting changes in people's behaviour. It can even have an adverse effect on public health prevention efforts because criminalization can lead to those living with HIV being stigmatized. It can, in a way, harm the relationship between patients and their treatment teams. In certain cases, it can even lead to those at risk of contracting HIV being less willing to seek HIV screening.

The directive is being received with a lot of relief in the HIV-prevention field. Our impression is that it will reduce the use of criminal law in cases of non-disclosure of HIV. We are pleased that, finally, there is a better understanding of life with, and transmission of, HIV.

Without doubt, the directive is relevant, mainly because it is public. That goes a long way in reducing the stigma. The fact that it was made public and that there was media coverage sends a very clear and helpful message.

I will not spend a lot of time on the content, because the directive was preceded by a very substantial report on the state of the science. Essentially, we are pleased to see that the directive covers two advances that are very interesting from a medical point of view. First, there is the fact that HIV is now seen as a chronic disease that is managed medically, which greatly improves people's quality of life and life expectancy. The second very relevant medical consideration is that HIV is transmitted much less easily than was thought in the past. Scientific advances show us that, when people have access to effective prevention strategies, there is little or no risk of sexual transmission. This is the case when people have a suppressed viral load, when they use condoms consistently and engage in lower-risk sexual activity. These are all part of the directive's content and they are very helpful.

The directive has another relevant item, which provides an answer to your second question about best practices in the non-disclosure of HIV status. First and foremost, the directive recognizes that non-disclosure is really a public health problem, not a criminal justice problem. This is written right into the directive and we find it very helpful.

In fact, the actions that have proved effective in changing behaviour and preventing HIV in a lasting way, are those based on a public health approach generally referred to as a graduated intensity approach. In public health terms, this means that the actions that will be put to a person, with the intent of changing behaviour and reducing the likelihood of transmitting HIV, are based on the real risk of transmission and on an approach that is as voluntary as possible. That is the way to make lasting changes in behaviour that will reduce the risk of transmission.

In the great majority of cases, we determine the factors that lead a person to not take the precautions necessary to prevent the transmission of HIV. There is often a host of factors; they may be medical, social or cultural, and they are better dealt with by a public health approach than by a criminalization approach.

In the very rare cases where an approach of that kind does not result in voluntary changes in behaviour, there is legislation, the Public Health Act in Quebec, for example, that allows us to choose a little more coercive approach, such as disclosing HIV status without a person's consent. However, it is extremely rare that we have to go that far. In public health, we never really need to use criminal justice to achieve our ends in terms of preventing the transmission of HIV, when the health of the general public is threatened, for example.

In our view, the best practices are those based on a public health approach.

I would not like to talk about best practises in non-disclosure of HIV without going into a more general discussion about best practises in HIV prevention. Those best practices are based first of all on reducing the stigmatization of those living with HIV and communities at risk of contracting HIV, and also on better access to services to prevent and treat HIV. That is really how we are going to achieve our public health objectives in terms of HIV.

In Canada, the vast majority of new HIV diagnoses can be attributed to those who do not know their HIV-positive status, not to those who know that they are carrying HIV, are living with HIV, and do not take the precautions necessary to avoid transmission. Those cases are really very rare when you consider all those living with HIV.

That leads us to address your third question, about the best ways for the criminal justice system and public health authorities to work together. Certainly, closer work of that kind allows us to achieve our public health objectives to a greater extent.

Beyond the important matter of criminalizing the non-disclosure of HIV status, other aspects of criminalization can adversely affect public health efforts. Montréal sans sida has gathered comments from communities. A number have told us, among other things, that everything to do with the criminalization of sex work, drug use and drug possession is a factor that leads to the increased stigmatization of communities at risk of contracting HIV and that distances them from HIV prevention services. In public health terms, that really distances us from our objectives of eliminating local transmission of HIV.

Therefore, each step that the justice system takes to move closer to public health authorities and the communities most affected by the enforcement of criminal law helps us to achieve our public health objectives.

The Department of Justice's directive and report are excellent examples of effective collaboration between the justice system and public health authorities. The justice system called on the epidemiological and methodological expertise of public health authorities in seeking a detailed knowledge of the science and how to translate it into effective legal tools. Can we not imagine that kind of collaboration for other aspects of criminal law, such as those I mentioned earlier?

I will not say more on that point, but I am very open to your questions. I really want to keep some time so that I can talk to you about some other things.

Your final question asked about the role that the federal government could play—

● (0855)

The Chair: Forgive me for interrupting you, but you are at nine and a half minutes. So you have about one minute to wrap up.

Dr. Sarah-Amélie Mercure: I will end with the idea of how the federal level can collaborate with the province on this directive. Basically, I am not at all familiar with your levers and your interfaces with the provincial level. But, at very least, it could be about highlighting the most helpful points in the federal directive. First of all, the fact that it is public. For us, that is very important in terms of public health. There is also the fact that it is science-based. In addition, it establishes the precedence of the public health approach. It also properly defines the investigation and prosecution procedures. Those are the items that are particularly important to highlight.

● (0900)

The Chair: Thank you very much.

The other speakers have eight minutes each. Then we will move to questions.

[*English*]

Dr. Bogoch.

Dr. Isaac Bogoch (Physician and Scientist, Toronto General Hospital and University of Toronto, As an Individual): Good morning everybody. My name is Isaac Bogoch. I'm an infectious disease and HIV physician and researcher based out of the Toronto General Hospital and University of Toronto. Thank you very much for inviting me to appear before the House of Commons Standing Committee on Justice and Human Rights to discuss the issue of criminalization of non-disclosure of HIV status.

Over the next few minutes, I'd like to touch on a few key points to frame how we can view the criminalization of HIV non-disclosure by focusing on updated science and data, and discussing the practical implications of this law. Specifically, I'd like to address two points: updates in our knowledge of HIV transmission in the current era; and clinical, public health and patient-level perspectives on the criminalization of HIV non-disclosure.

I want to do this all with an aim to demonstrate how criminalizing HIV non-disclosure is a counterproductive approach to reducing the burden of HIV in Canada and globally.

I'd like to preface these discussions with a comment that I have nothing but respect for those infected with HIV and those at risk of acquiring HIV. The goal here is really to discuss recent data, law and policy in a manner that is free of value judgment.

Let's start with the first issue and those are updates in HIV transmission and risk of HIV acquisition. Over the past decade and especially over the past three years, there have been tremendous advances in our understanding of the risks of HIV transmission, and how we can mitigate and essentially eliminate the risk of HIV transmission with drugs that treat HIV. I'll refer to those drugs as antiretroviral drugs.

Given our limited time, I'd like to highlight two studies that have helped transform global public health policy for HIV.

The first study was conducted by Alison Rodger and colleagues and was published in the Journal of the American Medical Association in 2016. In this study, 1,166 couples were enrolled, of which one of the two individuals in each couple was HIV-positive and on antiretroviral drugs. Couples included both heterosexual couples and men who had sex with men.

The study looked at transmission of HIV between individuals in each couple when condoms were not used, and if the HIV-positive person in the couple had an undetectable viral load. An undetectable viral load means that the antiretroviral medications are working and the virus cannot be detected in the HIV-positive person through conventional blood tests.

As a side note, we still know the virus is there. We still know the virus will return to detectable levels if the couples stop the medications. But if someone is taking their medications and they are effective, they will have an undetectable viral load.

During the roughly two-year course of the study, heterosexual couples reported 36,000 condom-less sexual acts and men who had sex with men reported 22,000 condom-less sexual acts. How many cases of HIV transmission were there within couples when the HIV-positive individual had an undetectable viral load? The answer is zero. There were zero cases of HIV transmission. That's an important number to remember. Zero cases of HIV transmission if someone is HIV-positive, taking their antiretroviral medications and has an undetectable viral load.

The second study I'd like to touch on has some Canadian content to it. It was led by Jennifer LeMessurier, and other Canadian physicians and scientists, and was published in the Canadian Medical Association Journal in 2018.

This is an interesting study, because it's a systematic review. A systematic review means that they evaluated several published studies, such as the one I just mentioned, and they combined all the findings of these prior studies into one big study for a more powerful look at the risk of HIV transmission, especially when one person has an undetectable viral load.

They included 12 studies here which gives a much larger sample size and adds tremendous validity. They tabulated the number of times the virus was transmitted from an HIV-positive person with an undetectable viral load to an HIV-negative person. They reported this as the number of HIV transmissions per person-years. Just like the study above, this one was commended for including both heterosexual couples and men who had sex with men.

In 1,327 person-years, there were zero cases of HIV transmitted from an HIV-positive person with an undetectable viral load to an HIV-negative person. Zero. Remember that important number? That number is zero.

These are just two examples of high-calibre studies published in high-impact, peer-reviewed medical journals. There are other studies that confirm these results as well.

These data and others are the impetus for what is now known as the U equals U movement. U equals U stands for “undetectable equals untransmittable”. This means that if an individual is HIV-positive, taking antiretroviral medications and has an undetectable virus for about four to six months, then that individual is untransmittable. That means that he or she can not transmit the virus to others.

● (0905)

U equals U is now adopted by major global public health bodies, such as the Joint United Nations Programme on HIV/AIDS, UNAIDS, the World Health Organization, the United States Centers for Disease Control and Prevention, the European Centre for Disease Prevention and Control, and, more locally, by the Canadian Minister of Health Ginette Petitpas Taylor and by Canada's chief public health officer, Dr. Theresa Tam.

In Canada, we have about 65,000 people living with HIV and about 2,500 new cases of HIV per year in the country. Roughly 20% of HIV-positive individuals are unaware of their diagnosis and not on treatment. These are the individuals who are at risk of transmitting the infection to others.

HIV treatment is readily available in Canada, but we must do better to reduce as many barriers as possible to enable access to HIV testing, treatment and prevention. The Canadian Criminal Code should be amended so as to not charge people if they are HIV-positive but have a zero to negligible chance of transmitting the virus to others, such as those taking their HIV medications with evidence of an undetectable viral load. There is an urgent need for Criminal Code reform in order to remove the offence from the realm of sexual assault law and have it focused on intentional and actual transmission.

The December 2018 federal directive, published in the Canada Gazette, that provides prosecutorial guidance on HIV non-disclosure highlights this and is a step in the right direction, but more needs to be done.

Given the enormous stigma that HIV continues to have in Canada and globally, our current Criminal Code is a barrier that prevents or delays people from getting tested for HIV. I hear this in my clinic at the Toronto General Hospital regularly. Many patients are scared to get tested and delay getting tested for fear of legal repercussion. Remember: those who are HIV infected and not taking medication are at greatest risk of infecting others, and this is contributing to the ongoing epidemic in Canada and globally.

Canadian law is preventing people from getting tested and placed on effective treatment that would eliminate the risk of transmitting HIV to others. It is crucial to end the use of sexual assault law as the means of criminalizing HIV non-disclosure and limit any use of the Criminal Code only to cases of intentional and actual transmission of HIV to another person.

If we're ever going to stop this epidemic—and we will—we must support law and policy that meet the needs of those who are infected with or at risk of HIV in a caring, supportive and value-judgment-free environment.

The current Canadian Criminal Code does not support these objectives. It further stigmatizes those with HIV and it's counter-intuitive. Criminalizing HIV non-disclosure may facilitate HIV transmission as it is a barrier to those who may get tested and placed on effective therapy. We can stop HIV in Canada and globally, and amending the Criminal Code would be a smart step in the right direction.

Thank you very much for your time.

The Chair: Thank you very much. You'll be very happy to know you hit 7 minutes 59 seconds.

Dr. Isaac Bogoch: I practised.

The Chair: Amazing.

Mr. Shime, the floor is yours.

Mr. Jonathan Shime (Lawyer, As an Individual): Thank you.

Good morning. My name is Jonathan Shime, and I am a criminal lawyer with Cooper, Sandler, Shime & Bergman LLP in Toronto. For the last decade a significant portion of my practice has been devoted to representing people charged with the non-disclosure of HIV. I also act as counsel for several provincial and national HIV organizations.

I would like to thank the committee for inviting me here today. It is a very encouraging sign that the committee is meeting with and consulting with a broad section of people who have been affected by HIV and the overuse of the criminal law in Canada to prosecute those who do not disclose their HIV status. I hope going forward that these consultations will continue, in particular with members of the queer, black and indigenous communities.

On the topic of indigenous communities, I wish to acknowledge that we are meeting on aboriginal land that has been inhabited by indigenous people from the beginning. In particular, we acknowledge that the land on which we gather is a traditional unceded territory of the Algonquin Anishinabe people. This acknowledgement is critical as part of our responsibility to work toward reconciliation with our indigenous communities. However, it must be more than just lip service that we do at the beginning of each meeting. In this particular context, it means we must acknowledge the disproportionate impact HIV has had on indigenous communities.

In 2016, the Public Health Agency of Canada estimated that approximately 63,000 people were living with HIV including AIDS. Approximately 9.6% of those people were indigenous, whereas indigenous people only represent 4.9% of the total Canadian population. Moreover, the estimated HIV prevalence rate for indigenous people in Canada in 2016 was 362 per 100,000 members of the population, twice as high as the prevalence rate in the general population. This means that a disproportionate number of people living with HIV in Canada are indigenous and their numbers are growing rapidly, more rapidly than the general population.

This has very real implications for our discussion. It means more and more indigenous people may be subject to the criminal law for non-disclosure, exacerbating the already disproportionate number of indigenous people engaged with the criminal justice system and in our jails. This has serious implications for our efforts to extend public health to our indigenous communities. It stigmatizes those with HIV, making testing and treatment less likely. This in turn, as you've already heard, aggravates the risk of the spread of HIV.

Indigenous communities have many needs: clean water, local and effective schools, community centres, and culturally appropriate counselling to address the intergenerational trauma of the residential school system and the sixties scoop. They do not need more people from their communities living with HIV and subjected to the criminal law and incarceration.

More broadly, I've had the opportunity to work in this area for many years as counsel. I've also reviewed the testimony from the witnesses heard previously by this committee. I wish to identify several key themes that emerge, and either have been or will be addressed by panellists today. They include the following themes.

The vast majority of people living with HIV in Canada disclose their status to their sexual partners because they are tremendously responsible about their own health and the health of their partners.

We have thankfully made great progress in our understanding of the science of HIV and the statistically negligible risk associated with sexual activity with someone who is living with HIV. This includes the recognition that there is no realistic possibility—zero, to echo a theme—of transmission from people with a suppressed viral load or who use a condom. Sadly, the criminal law has been too slow in recognizing this reality and as a result people who were no risk to others have been unfairly charged, convicted, sent to jail and stigmatized as sex offenders. A mechanism is needed from this committee, a recommendation, to review those convictions and right those past wrongs.

While the December 2018 federal directive is an important step in the right direction, more work needs to be done to ensure that the law related to the non-disclosure of HIV accords with our scientific understanding and does not imperil public health initiatives in this area.

As a general rule, the criminal law is a blunt instrument that must be used sparingly to ensure that only those who are deserving of its sanction are prosecuted. A poor understanding of HIV and the negligible risk associated with sexual activity with someone living with HIV has resulted in significant over-criminalization.

● (0910)

The use of sexual assault law in particular to prosecute those who do not disclose their HIV is overly punitive, increases the stigmatization of people living with HIV, and runs contrary to important public health efforts to maximize testing and open communication with health care providers who become witnesses in criminal proceedings against their own patients. Accordingly, the use of sexual assault law in the Criminal Code to prosecute these offences must be abandoned.

Given that HIV should properly be considered a public health issue, there is no reason why public health regulatory statutes cannot be used to ensure that those people whose conduct warrants state intervention are subject to it from that statutory authority.

For example, in Ontario the Health Protection and Promotion Act allows the medical officer of health in order to decrease or eliminate the risk to health presented by a communicable disease to "require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease." This order may include "requiring the person to whom the order is directed to conduct himself or herself in such a manner as not to expose another person to infection."

For those who are concerned that this is not a significant enough statutory sanction in the circumstances, the statute allows that if a person fails to comply with such an order from the medical officer of health, they can be brought before a judge of the Ontario Court of Justice who can order, among other things, that the person conduct himself or herself in such a manner as not to expose others to infection. The judge can further order that the person be taken into custody or detained in a hospital or other appropriate facility for a period of not more than six months. In other words, the regulatory regime has all of the necessary requirements that one needs in order to address concerns about the non-disclosure of HIV without the concerns that arise from criminalization and stigmatization under the Criminal Code.

The use of regulatory public health statutes would allow for state intervention in appropriate circumstances, including arrest and detention if need be, without resorting to the heavy hand of the criminal law.

If Parliament deems that there must be some role for the criminal law, then its use should be limited to cases where there is an intentional and actual transmission of HIV, as in England, Wales and more recently in California through Senate Bill 239. This was called for in the Community Consensus Statement endorsed by 174 organizations across this country, which I know was previously provided to this committee.

Whatever offence is considered under the Criminal Code, it should not be based in sexual assault law. People who do not disclose their HIV status should not be stigmatized as sex offenders on sex offender registries in the same way as pedophiles and those who engage in coercive sexual conduct.

We would encourage Parliament to consult broadly with the interested parties to consider other options including the potential use of the charge of criminal negligence under the Criminal Code.

Thank you.

● (0915)

The Chair: Thank you very much.

Now we will go to Mr. Peck.

Mr. Ryan Peck (Executive Director and Lawyer, HIV & AIDS Legal Clinic Ontario): Thank you and good morning.

I echo the acknowledgement, recognition and commitment to reconciliation noted by my good friend Jonathan.

I thank the committee members for taking the time to consider this vital issue and for including me.

I am a lawyer and the executive director of HALCO, the HIV & AIDS Legal Clinic, the only legal clinic in the country devoted exclusively to the HIV community. In addition to providing direct services to people living with HIV throughout Ontario, we engage in public legal education and law reform activities.

The criminalization of HIV non-disclosure permeates all of our work; whether advising clients, conducting workshops, engaging with policy-makers or intervening before courts such as the Supreme Court of Canada, it is ever-present. But before getting to the law, its impacts and what is required moving forward, it's worth taking a moment to remind ourselves once again of the reality of HIV today. There is some really beautiful news about HIV. People who have access to sustained treatment and care have more or less the same life expectancy as those who are HIV-negative. That ought to be celebrated.

Knowledge of prevention strategies is better than ever, and it is much harder to transmit HIV than was generally supposed. We heard about that this morning. The risk of transmission is zero if a condom is used properly and remains intact—it's very important not to forget condoms—and of course when a person living with HIV has a suppressed viral load.

While this reality must not be ignored, it is also very important to remember that many people face significant institutional, social and economic barriers to accessing health care and life-saving medications. Moreover, social attitudes towards people living with HIV have not nearly kept pace with the science. In other words, HIV-related stigma and accompanying discrimination remain entrenched and pervasive across the land. It's shameful that, as per a 2012 Canada-wide study prepared for the Public Health Agency of Canada, 24% of those surveyed felt uncomfortable wearing a sweater once worn by a person living with HIV. Twenty-two per cent felt uncomfortable shopping at a small neighbourhood grocery store if the owner was known to be living with HIV. As per a 2018 study, just a few months ago, 15% of Canadians felt afraid of getting HIV when they were near someone living with HIV; 25% believed that individuals might not get tested because they feared that people would find them out and treat them differently; and 71% believed that someone living with HIV would hide their HIV status from others for fear of the stigma associated with HIV.

As a result of these attitudes, legal issues abound. From being denied services to being refused accommodation in the workplace, human rights concerns are widespread. Privacy is a constant worry for many, whether related to institutional actors, service providers or neighbours, and legal recourse may be difficult or impossible to obtain. And of course, as we are here to discuss today, Canada remains a world leader in prosecuting people living with HIV, with upwards of 200 such prosecutions.

It really is impossible to overstate the manner in which over-criminalization—which is a term used explicitly by the federal government—impacts the HIV community.

To begin with, people do not know what kinds of behaviours are going to land them in jail. There are quite different approaches throughout the country. Remember, the charge is almost always aggravated sexual assault; one of the most serious offences in the Criminal Code, one designed to respond to the most sickening and horrific of forced sex acts. Canada is the only country known to take such an approach.

The consequences related to a conviction are wildly serious. For example, a conviction attracts a maximum life sentence and leads to a presumptive lifetime inclusion on sex offender registries, which brings with it enormous stigma and long-term life-changing consequences, not to mention severely diminished employment opportunities. For those who are not citizens, a conviction more or less leads to deportation. To top it all off, people are prosecuted not only when there is no allegation of transmission or no intention to transmit, but in circumstances where the sexual activity in question poses negligible to zero risk of transmission.

● (0920)

Even in circumstances when charges are ultimately not pursued or there are acquittals, police forces often issue press releases containing photos and health information. Such disclosures can and do have drastic consequences, ranging from loss of family, friends, employment and housing, to violence.

The uncertainty of when over-criminalization may strike, combined with the impacts of a conviction, would be difficult for anyone, but it has particular implications for a historically stigmatized community. It also adds severe stress to immunocompromised, and oftentimes marginalized, individuals.

Moreover, we routinely hear of the fear that a vindictive ex-partner will approach the police and prosecutions will follow. We also hear of the ways in which abusive partners use the criminal law to further their abuse by threatening to go to the police unless their partner continues to do what the abusive partner wants them to do—extortion.

Sickeningly, we hear that some women living with HIV who experience sexual violence are deeply concerned about responding for fear that they will be transformed into an accused person and themselves charged with aggravated sexual assault.

Over-criminalization is also dramatic from a public health perspective. It hinders HIV prevention efforts and hampers care, treatment and support for those living with HIV by providing disincentives for testing, as we've heard, and deterring honest and open conversations with health care and other providers, including public health authorities, for legitimate fears that such conversations will be used in court.

In short, the law is way out of step with science and human rights, and hampers care, treatment, support and HIV prevention efforts. As the federal government has recognized, it also has a disproportionate impact on indigenous, African-Caribbean black and gay persons.

To be blunt, there is a feeling in the HIV community that the medical condition itself is being criminalized, not any behaviour. This is unacceptable and it must change.

We commend the federal government for the recently issued directive on limiting HIV non-disclosure prosecutions. This was a step in the right direction, but more is needed to further limit the over-criminalization of people with HIV. The federal government must bring the law in line with science and human rights in a manner that is supportive of HIV care, treatment and prevention. This can be done by removing the offence from the realm of sexual assault, and focusing on intentional and actual transmission. Such Criminal Code reform is urgently required and it must take place in consultation with the HIV community.

In conclusion, I respectfully urge you to strongly recommend that the government immediately begin work with the HIV community on Criminal Code reform.

Thank you. *Meegwetch. Merci.*

● (0925)

The Chair: Thank you very much. All of your testimony has been very helpful.

[*Translation*]

Now we move to questions.

[*English*]

We're going to start with Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Mr. Chair, thank you very much; and thank you to the witnesses.

Let me just say at the outset that I fully agree that where someone is HIV-positive, is taking antiretroviral medication and has an undetectable viral load, they shouldn't be prosecuted. I also support the directive that was issued by the Minister of Justice.

That said, I've also looked at the Supreme Court decision, the most recent one, in Mabior, where the law provides that there must be a dishonest act, and secondly, there must be a significant risk of serious bodily harm. It is further defined in that decision.

I'm in the process of going through 59 reported cases since 1998. I haven't gone through all 59 of those yet. Can you cite any cases where someone was prosecuted and convicted who didn't have intention and was at a low viral load? It is true that there have been some cases where individuals were prosecuted, but in all the cases I have seen to date, they were ultimately acquitted.

Mr. Jonathan Shime: As one of the two lawyers on the panel, I'm happy to do the first response. Ryan may have some thoughts too.

There are two components, I think. The first component, which is slightly indirect, is that doesn't take into account the impact of the criminalization on the community; second is the impact it's had on those people who have been charged and, even if they've been acquitted, have been dragged through the criminal justice system, and more broadly the consequences of that for public health initiatives.

In terms of convictions, I currently act for two people who I will not name publicly before the committee; both of them on appeals; both of them before the Court of Appeal for Ontario; both of them convicted. One we know to be what's called a "non-progressor". A non-progressor means they are able to control their body for some unknown reason, able to control their viral load in the absence of any medical intervention, so no medicine is needed. Just their bodies are able to keep the viral load basically at undetectable levels. At some point, if they eventually progress, then there can be a medical intervention with the antiretroviral therapy, but for most of these people, it's not necessary.

This gentleman had an undetectable viral load. He engaged in a sexual relationship with a woman over a few months and he was convicted at trial notwithstanding that the expert evidence at trial, called as an expert with the consent of the crown attorney, said that there was statistically a negligible risk that the non-progressor by virtue of his naturally suppressed viral load could ever pass the virus on to the complainant. Despite that, the judge convicted. That's one.

I just finished an appeal about six months ago for a gentleman on a series of offences. One of them was that he engaged in sexual activity with a partner, with a condom, and the evidence seemed to suggest he didn't even ejaculate. In the absence of ejaculation, there is no transmission of bodily fluid, and if there's no transmission of bodily fluid, there can be no risk of HIV transmission. On top of that, it was acknowledged by both parties that he wore a condom. He was convicted at trial. His appeal is currently being considered by the Court of Appeal for Ontario.

Both of those gentlemen represent circumstances where people have been convicted where there was no risk of transmission and where steps were taken through natural body protection in terms of viral load and/or condom use and non-ejaculation. Notwithstanding that, the courts convicted.

There are at least two examples on just my roster as criminal counsel where that has occurred.

● (0930)

Mr. Michael Cooper: But where it's not negligible, is there not some duty to inform the other partner, having regard for the principles enunciated at the Ewanchuk decision, for example?

Mr. Jonathan Shime: We were there on Mabior. Mabior contemplated and was well aware of Ewanchuk. It was post-Ewanchuk, and they drew the line. Where they drew the line—you're correct—was where there was a realistic possibility of transmission or a significant risk of serious bodily harm. But I think the evidence you're hearing now is that since Mabior in 2012—and frankly to some extent at the time—the science already demonstrated, and it certainly does now, that one doesn't need both a condom and a suppressed viral load.

If the Supreme Court of Canada technically had used the word "or" instead of "and", those two categories would have been precluded from prosecution—condom use or a suppressed viral load. In those circumstances, that would have been more in accord with the science, even as we understood it at the time in 2011-12.

Now as we understand the science even better, there are still prosecutions going on, certainly in Ontario, of people who have suppressed viral loads and don't use condoms, or who have suppressed viral loads and may or may not use condoms.

Those prosecutions are still going on. They're still actively happening in my office.

Mr. Michael Cooper: Okay, thank you.

The Chair: Mr. Shime or Mr. Peck, can I just ask this, if you wouldn't mind? I know Mr. Cooper is going through the 59 cases, which I think is incredible. Could you at some point send us the list of cases that you would like us to look at—people who have been convicted, who either used a condom properly or who have a suppressed viral load, in recent years. I'd appreciate that so that I don't have to read 59 different cases. Thank you.

Go ahead Mr. Peck.

Mr. Ryan Peck: At least 10 cases post Mabior involved accused with lower undetectable viral load, and of those 10, nine occurred in Ontario. One of them involved a woman living with HIV. The allegation was with regard to three incidents of sex. She had an undetectable viral load. In one of the incidents of sex, the sexual partner, a man, performed oral sex on her.

She was charged, and the prosecution pursued that. She was ultimately acquitted in relation to oral sex, but it's frankly shocking that it was found to be in the public interest to pursue a prosecution for aggravated sexual assault in relation to oral sex. She was ultimately convicted in relation to vaginal sex without a condom, even though she had an undetectable viral load. What that means is that in law, she is now considered a violent rapist. Frankly, it's a travesty.

More and more feminist socio-legal scholars are recognizing and acknowledging that this is an inappropriate and in fact problematic use of sexual assault law, including the Women's Legal Education and Action Fund, which has historically been the leader when it comes to legal issues facing women. They released a paper calling for the removal of the offence from the sexual assault realm.

That's just to respond to your comments about Ewanchuk.

The Chair: Thank you very much. That was very helpful.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair.

[*Translation*]

My thanks to everyone for being here today.

Dr. Mercure, my question is for you. Could you tell us more about cases in which people do not know whether or not they are HIV-positive and do not want to know because that could have consequences for them?

Dr. Sarah-Amélie Mercure: A number of studies have been conducted about people's intentions to have an HIV screening test, because they know that not disclosing that they have HIV could land them in prison. The criminalization of the non-disclosure of HIV-positive status makes people say, according to the surveys, that they prefer not knowing whether they have HIV rather than knowing that they do and risking prosecution if they do not disclose that they are HIV-positive.

● (0935)

Mr. Colin Fraser: Do you see that problem in your practice?

Dr. Sarah-Amélie Mercure: We do see that problem in our work. The stigmatization that comes with HIV and the requirement to reveal one's HIV-positive status slows down the process of going for screening. This harms people personally, and may well harm their sexual partners.

[*English*]

Mr. Colin Fraser: Thank you very much.

Mr. Shime, you mentioned in your presentation that the committee should recommend or come up with some mechanism in order to review past convictions and right those past wrongs of people who perhaps with today's hindsight shouldn't have been put through the criminal process.

What mechanism do you think we should recommend?

Mr. Jonathan Shime: Well Mr. Cooper has read all the cases, and maybe he could assist.

Mr. Colin Fraser: We will ask him later.

Mr. Jonathan Shime: Yes.

In the past, in Ontario, for example, when there have been concerns about miscarriages of justice, public inquiries have been struck under the Public Inquiries Act. I'm not sure one needs to go so broad, but one could easily strike a committee.

In Ottawa, as you all may know, there is already a criminal conviction review committee that looks at cases. It is a cumbersome and lengthy process, which is—if I can put a plug in—severely under-resourced. It should have greater resourcing by this government, which should have concerns about the history of wrongful convictions in this country.

One could certainly enact an ad hoc review committee that would be open to hearing from individuals who have been jailed, and/or community groups, where there are concerns about individual cases and whether those convictions were justified or were miscarriages of justice, based not only on the science we may have understood at the time, which to be fair has on occasion been misinterpreted by... whether it be juries or even judges, but based on our current understanding of the science.

When the Ontario government needed to look at pediatric deaths and concerns about wrongful convictions in relation to shaken baby syndrome and what that meant, again they struck a public inquiry. I don't think that's necessary here. However, one of the things they did was to examine all those historical convictions through the lens of the current science of shaken baby syndrome and what we understood, and how properly applied, the science should have directed the outcome. As a result, a number of those cases were referred to the Ontario Court of Appeal and were reviewed either by the Court of Appeal or other courts.

Certainly the striking of a committee that could review specifically these convictions involving perhaps former judges and/or lawyers, I think would be a welcome step in that direction. I know Mr. Peck has thought about this as well, so he may have some thoughts.

Mr. Ryan Peck: We're in touch with some people who, from our perspective, have been wrongfully convicted. Ultimately, we do urge deep consideration of this.

Mr. Colin Fraser: Thank you. Those are my questions.

The Chair: Mr. Garrison.

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you very much, Mr. Chair.

Thank you to the witnesses for being here.

I particularly want to thank Mr. Peck, as a gay man of a certain age, for reminding people that there are some positive things here to work on. I think that's very important. It also helps attack stigmatization, by noting those positive things we've done. I do include the directive in that case, even though it's narrow.

Now, of course, as a gay man of a certain age, I'm always impatient with our response to HIV/AIDS. I've said before in this committee that I'm glad we're doing these hearings. My concern is that we're doing them late in the Parliament. It's important that the initiative coming out of these hearings not be lost over an election period, and that we continue this work.

Having said all that as a kind of preface, I want to go back to something that was raised indirectly a few times in the presentations. This is the justice committee. I'd like to be talking about various forms of testing, but this is probably not the forum for that, except with regard to criminalization as a barrier. All of you, or almost all of you, mentioned other barriers in the criminal justice system to combatting the HIV/AIDS epidemic. I want to go back to Dr. Mercure. You talked in particular about criminalization of sex work. Can you talk more about other aspects of using the criminal law in ways that inhibit our ability to address this crisis?

● (0940)

[*Translation*]

Dr. Sarah-Amélie Mercure: The directive rightly points out that those from backgrounds most affected by HIV are also the most marginalized. They are the same populations that are most affected by criminal law enforcement. So any measure that public authorities may take that disproportionally affects those who are more affected by HIV will have an adverse effect on the prevention of the disease. I could give you many examples: the criminalization of sex work or drug use, in which people are stigmatized more and in which their access to prevention and treatment services is negatively affected.

More broadly, public authorities have a major presence in the lives of marginalized people living with HIV. That often means that they find that their care is interrupted, that they are incarcerated or in court. They may also live a precarious existence that can have a negative impact on their relationship with their treatment team, their consistency of treatment and their ability to take the precautions necessary to prevent HIV.

Any activity that leads to those vulnerable to HIV being over-exposed to the court system will, without doubt, have a negative impact on public health efforts in prevention.

[*English*]

Mr. Randall Garrison: Would you say we should include a recommendation on decriminalization of sex work, and decriminalization of other drugs, as a way to combat HIV/AIDS?

[*Translation*]

Dr. Sarah-Amélie Mercure: Yes, that would be one of a series of measures that would ultimately lead to advances in HIV prevention. That question absolutely must be asked.

[*English*]

Mr. Randall Garrison: I'm going to throw the question to any of the other witnesses, maybe starting with Dr. Bogoch.

Dr. Isaac Bogoch: I certainly would like to echo those last statements. The criminalization of HIV permeates multiple aspects of the Criminal Code, and then there are additional issues, such as criminalization of sex work and drug consumption. Again, we're working with many individuals affected by these who are already marginalized populations. They have a greater incidence of HIV.

The criminalization of these acts, and of HIV, forms greater barriers to getting people diagnosed, on appropriate treatment and in appropriate care. It also prevents preventative measures. These are all barriers, absolutely.

Mr. Randall Garrison: Thank you.

Mr. Peck or Mr. Shime may speak, in the interests of time.

Mr. Jonathan Shime: I echo the comments that have already been made. I don't think I have anything to add.

Mr. Randall Garrison: I expected you to maybe take a little more time on that one. I've been a long-time advocate of decriminalization of sex work, and also, since my days on city council, of decriminalizing small amounts of all drugs, as a way to treat these as health issues rather than criminal issues.

Mr. Ryan Peck: We intervened in the Bedford matter at the Supreme Court of Canada. We did so for a number of reasons, but the HIV-related element is that people engaging in sex work, because of the punitive laws surrounding their work, are unable to negotiate safe sex. It puts them at further risk of acquiring HIV in addition to experiencing all sorts of violence. A number of arguments can be made in relation to both sex work and drug policy.

As we know, and I'm sure people around this table saw the numbers just yesterday, over 10,000 people have died over a very short period of time because of the poisoning crisis that is going on. Decriminalizing drugs will have much broader impacts beyond HIV.

The Chair: Mr. Boissonnault.

Mr. Randy Boissonnault (Edmonton Centre, Lib.): Thanks, Mr. Chair.

I want to respond, maybe uncharacteristically, to Mr. Garrison's comments. As a gay man not of a certain age—

Voices: Oh, oh!

Mr. Randy Boissonnault:—I have lived my whole time in the non-criminalized era, post-1969. I will say, look, I'm going to work very hard to come back and represent the citizens of Edmonton Centre and keep doing this work. I want to see that the LGBTQ2 secretariat has funding into the next mandate so that we can continue to do this work.

I want to thank you for your solidarity on these matters, Randall, and thank the whole committee for putting this issue on the table. I know I don't always agree with my Conservative colleagues, but when we can put the partisan issues to the side and focus on public health, at a justice committee, that tells me there's something in this Parliament that's working. Thank you.

Now I'll go to the witnesses here.

● (0945)

[*Translation*]

Dr. Mercure, I have a question for you that has never been brought up here. Do people have to know their HIV status before they can receive treatment for HIV?

Dr. Sarah-Amélie Mercure: I am not sure I fully understand your question.

However, clearly someone who does not know his HIV status will not be receiving treatment for HIV. Yes, the first step in what we call the treatment cascade is to know one's HIV status.

Mr. Randy Boissonnault: Great.

Here is my second question.

We have heard that, here in Canada, 83% of people living with HIV know their HIV status. In Europe, however, it is 90% and more.

In your opinion, if changes were made to the Criminal Code to decriminalize the non-disclosure of HIV status, what percentage could we reach here in Canada?

Dr. Sarah-Amélie Mercure: A huge amount can be done to improve access to, and the regularity of, screening.

I could not tell you what fraction can be attributed to the fact that it is criminalized, but that it one of the things that must be done. Clearly, that will make access to screening easier. Screening has to be made available in places where people need it. We also have to encourage regular screening.

People do not go to be screened for all kinds of reasons. But the reasons are more to do with the organization of the services. There is also the stigmatization factor, and the fear of knowing one's status. Any obstacle that can be removed will help us move closer to better knowledge of HIV status.

Unfortunately, no study comes to mind that would let me tell you how many people could find out their status if at least that legal barrier were lifted. Of course, it would be a step in the right direction for us in achieving our public health objectives; no doubt about that.

Mr. Randy Boissonnault: In your opinion, in an average week, how many people are not ready to find out their HIV status because they are afraid of a trial?

Dr. Sarah-Amélie Mercure: People like that do not get to me. I work in a clinic that provides screening and treatment. Generally, the people we see have managed to get to us; they are ready to be tested, and to be treated if necessary. We do not see people who are afraid to know their HIV status for those reasons.

Sometimes, we see people who do not want to know their HIV status but want to have all the other screening tests, such as for bacterial infections, because they know that those are easily treated and fewer legal consequences are involved.

However, most people who do not get screened for HIV because they are afraid of being criminalized, simply do not seek any health services at all. At that point, they receive none of the services they need.

Mr. Randy Boissonnault: Thank you, Dr. Mercure.

[*English*]

I have a quick question for Dr. Bogoch. You said that we'll end the epidemic. How many years until we end the epidemic, and how much faster could we do it if we changed the Criminal Code on this issue?

Dr. Isaac Bogoch: The answer is that we obviously have several barriers to appropriate HIV care that are preventing diagnosis, treatment and prevention. This is but one of several barriers. Changing the Criminal Code would eliminate some of these barriers and would really send a message to people who are at risk of acquiring HIV and even those who are HIV-positive that it's okay to have HIV and, as we've heard, people can live a long, healthy, happy, normal life with HIV. This would significantly improve our goal of essentially eliminating HIV in Canada and globally, and we can do it with the tools that we have now.

Mr. Randy Boissonnault: Thank you.

Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): Thank you.

I just have a few short questions.

Mr. Shime and Mr. Peck, if I can turn to you, Mr. Peck talks a little bit about the federal directive. I'm asking basically, when it comes to provincial prosecution policies and federal prosecution policies, what's the difference and how can we align them? Would alignment have an impact?

● (0950)

Mr. Ryan Peck: That's an excellent question. We've been working for many years to encourage the Ontario government to develop sound guidance. Unfortunately, we're not there.

The directive, which as you know is applicable only in the three territories, is a really fantastic guide. We believe that it could go a little bit further. Remember, it does not remove the offence from the sexual assault realm, but in terms of reducing the harms of the current law—while we engage in hopefully the legislative process to remove it from sexual assault and focus on actual and intentional transmission—it is a really important document. Maybe through an FTP meeting there can be discussions about alignment. Frankly, I'm not quite sure how you can convince every province to do so, which is more or less why we need legislative reform.

Ms. Iqra Khalid: I think that's it. I'm out of time.

The Chair: I'm going to grab Mr. Fraser's last minute, and I have one scientific question that I want to go to Dr. Bogoch on.

I understand that the point of view is that only intentional and actual transmission of HIV, if anything, should be criminalized. I want to get to the scientific realm in case there's a different conclusion. It's clear to me from what you said that with an undetectable viral load, you can't transmit HIV. With proper use of condoms, you can't transmit HIV. You mentioned four to six months for the undetectable viral load, so I just wanted clarification on why, once you test that your viral load is undetectable, it would have to be four to six months before you would know for sure that it was not able to be passed on.

Secondly, is there not another situation? For example, let's say your partner advises you that the partner is on PrEP. Would that not be another occasion where you would not scientifically be able to transmit the virus and, at that point, you should not be criminalized for non-disclosure? Maybe you could just clarify.

Dr. Isaac Bogoch: Those are both great points.

The first issue is why the four to six months? Essentially, the medications are reducing the burden of HIV in an individual from a lot to a tiny, tiny amount. Essentially the four to six months basically ensures that someone is continuing to take their medication and is continuing to suppress their virus. If someone is not adhering to their medications or if, for whatever reason—maybe they're on the wrong medication and there's resistant virus and there's a detectable viral load—that person is at risk of transmitting. If people get tested every six-ish months, and it's consistently suppressed, we know that the risk is basically zero. That's issue number one.

The second issue is about HIV pre-exposure prophylaxis, also known as PrEP. We know that people who are HIV-negative but at risk for HIV acquisition for whatever reason—so they're HIV-negative individuals at risk for HIV acquisition—if they take a tablet that's an antiretroviral medication—and most people will take one of these tablets per day—they can almost completely reduce their probability of acquiring the infection. In medicine, just like in life, nothing is 0.0% or 100%, but with PrEP, if people are taking their PrEP, they will essentially eliminate their risk of getting HIV. That would also essentially eliminate the risk of transmitting HIV to someone else, because they can't get HIV.

Those are two excellent points to bring up in this committee. Thank you for bringing those up.

The Chair: Thanks very much.

These witnesses have all been amazing in giving us information.

[*Translation*]

I am very grateful to you for your contributions today.

[*English*]

To come back, Mr. Shime or Mr. Peck, I would appreciate also if you could send us the list of any cases you want us to read and review based on that premise.

Mr. Jonathan Shime: Sure.

Thank you for that.

The Chair: Thank you so much. I will ask the next panel to come up, and we'll just rotate. The meeting is suspended for one minute.

● (0950)

(Pause)

● (0955)

The Chair: We're resuming our meeting on our study of criminalization of non-disclosure of HIV status. We're joined by our next panel of distinguished guests. Joining us from the Canadian Aboriginal AIDS Network is Mr. Merv Thomas, Chief Operating Officer, who is joining us by video conference from Burnaby.

We're joined from the Canadian Coalition to Reform HIV Criminalization by Mr. Chad Clarke and Ms. Valerie Nicholson. From the Community-Based Research Centre we have Mr. Brook Biggin, Director, Program Development, Scale-Up and Implementation. From the Parkdale Queen West Community Health Centre we have Ms. Maureen Gans, Senior Director, Client Services. Welcome, all.

You each have eight minutes, but I will let you go up to 10 minutes before I cut you off.

Mr. Thomas, because you're on video conference and we don't want to lose you, I'm going to ask you to go first, please.

Mr. Merv Thomas (Chief Operating Officer, Canadian Aboriginal AIDS Network): My name is Merv Thomas. I'm a Nehiyaw-Cree from Saskatchewan.

I want to begin by acknowledging the Algonquin people on whose territory in Ottawa this meeting is being held. I'm video conferencing from the Coast Salish territory in Vancouver, B.C.

I want to thank this committee for the invitation to appear as a witness. I'm here as the Chief Operating Officer from the Canadian Aboriginal AIDS Network, a position I hold in a part-time capacity. I also work at the Circle Of Eagles Lodge Society as the chief executive officer, so I bring a unique perspective in working closely with indigenous people in the field of HIV as well as assisting indigenous people in reintegrating back into society.

CAAN's main mandate is HIV, but in 2013 it expanded its mandate to include hepatitis C, sexually transmitted blood-borne infections and tuberculosis, mental health and comorbidity issues. The Circle Of Eagles Lodge Society operates two halfway houses and several other cultural programs.

I was born and raised in Saskatchewan. I saw first-hand and felt the impact that colonialism, systemic discrimination, racism, the residential school system and the laws and policies of Canada have contributed to and continue to contribute to the overwhelming representation of indigenous people who are incarcerated.

In 2017, 92% of people incarcerated in Saskatchewan were indigenous. I also know that Saskatchewan has the highest rates of HIV, with approximately 80% of those living with HIV identifying as indigenous. This discussion with the House of Commons justice committee and these laws that are being discussed here are contributing to the challenges and the overwhelming representation of indigenous people incarcerated and living with HIV.

I want to discuss some of the stats as found in the Auditor General's report as they relate to indigenous peoples in the federal corrections system. That office stated:

> In the ten-year period between March 2009 and March 2018, the Indigenous inmate population increased by 42.8% compared to a less than 1% overall growth during the same period. As of March 31...Indigenous inmates represented 28% of the total federal in-custody population while comprising just 4.3% of the Canadian population.

When it relates to HIV, I want to point out that indigenous people continue to bear the burden of overrepresentation of HIV and AIDS. The trend continues to rise as indigenous people turn to substance use to address their trauma. Injection drug use is the vehicle that drives this epidemic.

In B.C. we are experiencing an opioid crisis, but this crisis is also spreading to other regions, and the time to act is now. Many indigenous people who are involved in the criminal justice system are at high risk. Most of those involved in the justice system are dealing with addictions, and they are impacted.

I want to share the story of a young man from Regina, Saskatchewan. He was a gang member, a young man, 23 years old. He had three children. He was transferred to the Pacific region because he wanted to leave the gang and start a new life for his wife and children and to make a new start with hopes of making a positive change in his life. He arrived at a Circle Of Eagles Lodge Society halfway house, but he went AWOL shortly thereafter. He came back to the halfway house, clearly under the influence of some substance, a few days afterwards. Before he could get picked up, he left once again.

I received a call stating that he was in a coma in the hospital. I went with another staff member, and we stayed with A.B. until he passed on to the spirit world that evening. Calling his mother and hearing her weep is one of the hardest things that I have had to do in my career.

It was not until much later that I found out he was also living with HIV. This brings up another point that I am hoping may be addressed. It is very difficult to be living with HIV in the community due to stigma and discrimination. Imagine what it would mean for an HIV-positive man in a federal institution. Openly disclosing your status within the prison population has dangers not experienced in a community. We also know that indigenous people are leaving their homes and reserves to access health care, but they are also fleeing persecution. Due to their HIV status, many are not allowed back home.

One of the other challenges faced by the Circle Of Eagles Lodge and by organizations that are helping indigenous people as they transition back into the community is accessing medical information. For example, we continue to see many people discharged without valid ID, but what I do question is what is happening for those who are living with HIV in terms of their ability to access an HIV doctor or specialist. How are they being assisted, thus ensuring that they continue to receive their medications once they have been released? In the case of A.B., what supports were in place to help him with HIV?

● (1000)

Research has shown that a person who's on medication and is undetectable is also untransmittable. On World AIDS Day and during last year's Aboriginal AIDS Awareness Week, the honourable health minister Ginette Petitpas Taylor reiterated Canada's position that U equals U.

I'm very concerned that Canada continues to criminalize addictions and HIV, rather than dealing with them as a health issue. I'm also concerned that the term “harm reduction” is often used, but there is no real appetite to ensure that all levels of government are working in concert.

I want to point out the Portugal model as a consideration for this committee and the federal government. By decriminalizing addictions, they lowered their incarceration rates and lowered their HIV rates considerably.

At the Aboriginal AIDS Awareness Week harm reduction day last year, CSC reported that they had distributed seven needles since they began handing out clean needles in prison. This needs to improve.

The Truth and Reconciliation Commission has several key calls to action. This committee can assist in answering those calls. There are several for health, such as recommendation 19, which states, “We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities...”. That part also addresses mental health, chronic diseases, illness and injury incidence and availability of appropriate health services.

As it relates to justice, they call on the federal and territorial governments to provide sufficient and stable funding to implement and evaluate community sanctions that will provide realistic alternatives to imprisonment for aboriginal offenders and respond to the underlying causes of offending.

In the interests of time, I'll save a few of those other ones, but if you want to check them, numbers 30, 31, 32 and 33 of the Truth and Reconciliation Commission's calls to action relate to what we're discussing today.

Criminalization of HIV is not a just law. There are alternatives.

● (1005)

The Chair: I'm sorry, Mr. Thomas. We just had an indication that there's going to be a vote in 30 minutes.

Can I have unanimous consent to continue for 15 minutes, then break 15 minutes before the vote? I'd ask as many of us as possible to come back after the vote to hear the rest of the witnesses.

We're going to have to break at some point, probably after the first two, and come back for the last two.

Please continue, Mr. Thomas.

Mr. Merv Thomas: I have a few more things.

There are alternatives. I totally agree that those who are intentionally spreading the virus should be dealt with, but we need to find alternatives that will assist indigenous communities that are experiencing and bearing the burden of HIV, overrepresentation in the justice system, and other immediate concerns such as the opioid crisis. We cannot continue to treat people who are in addictions and those who are living with HIV as criminals.

I want to end on a promising note. We have found that it is possible for people to change. We need to allocate resources to helping people deal with their traumas, rather than opening more jails. We need to help indigenous people survive another day by providing cultural supports.

The CAAN board chair, Val Nicholson—I'm happy to see her here—said it best that addictions go away when you deal with your trauma. There is hope in culture, elders, ceremonies, protocols and traditions. Implementing the Truth and Reconciliation calls to action for more healing lodges will provide cultural supports for people who have been dealt with very harshly by this government, by the churches and by all levels of the colonial system.

Thank you for listening.

The Chair: Thank you very much.

We'll go to the Canadian Coalition to Reform HIV Criminalization, please.

Mr. Clarke and Ms. Nicholson.

Mr. Chad Clarke (Member, Canadian Coalition to Reform HIV Criminalization): Thank you to the committee for having me today. I stand before you first as a warrior, secondly as a survivor of HIV non-disclosure.

The Right Honourable Pierre Elliott Trudeau once famously said, “There's no place for the state in the bedrooms of the nation”, and yet Canada is a world leader in convicting people for HIV non-disclosure.

I am one of those 200 plus people who were convicted, sentenced. My life came to a stop on February 12, 2009. That was the day I received a life-changing phone call telling me I had a Canada-wide warrant for aggravated sexual assault. My knees buckled.

I'm a father. I'm a grandfather. I'll get to that after because right now, with what's going on, I don't get to see my grandson. How do I tell a 22-year-old who googles everything that I don't have that vulnerable person...? I'm a family man.

I want to take you back to who I was before these charges were brought into my life. I worked for Parker-Construction in Windsor, Ontario, where I had recently been promoted to fire tear out lead hand. I worked 60 hours a week, at $22.50 an hour, with company benefits and a gas allowance card. I was set in my life, a father of two kids, Tyler and Kayla, who were 14 and 13 at the time, the important time in a teenager's life. How was I going to break the news to them that their dad was leaving?

I turned myself in on this charge the next day. I was denied bail, and we know in Canada that when you're denied bail you have to wait 90 days before you can go to high court bail. I got myself a lawyer. I went to high court bail. I was once again denied bail.

I would attend court over the next 13 months while I was being held in custody. I want to bring you back to when I turned myself in and I was denied bail. Upon going into the correctional system, I did not receive my medication for two weeks. The only time I've ever become detectable is when I was in the prison system. I'm now going on 15 years living with HIV and I'm undetectable. I was undetectable at the time that these charges were brought against me.

I would attend court over the next 13 months while I was being held in custody. I was told I was facing 10 to 15 years. I didn't have my blood tested for 28 months, so how were they assuring me that I was getting the best health care while I was in the prison system?

You may not know this but when you're on the remand side, awaiting trial or waiting to be set free, there is no health care. I couldn't see a dentist until I was sentenced, so I sat there with an infection to the point where the dentist inside the prison could not go any further without going into my nasal cavity.

I'm now figuring out life after prison as Chad Clarke, the convicted sex offender. I've been given a second chance in life. I'm the proud grandfather to a four-year-old grandson named Gavin, which is Gaelic for “hawk of battle”. When I first met the round table, I was told I would get to see my grandson because we were going to do something. I'll keep going and going even to my last breath to tell you guys that we need to do something.

I don't even need to look at this; I'm just going to talk from my heart. If I went through this, and the 200 people we were able to connect with in Canada went through this, how many others are there out there?

● (1010)

There have been many times when my PTSD has gotten to me, when I wish I would have gotten the 25 years and walked out with a clean slate rather than having to walk into society as a registered sex offender. That's the part I have a problem with—the part where the mental health issues I had before going into prison have accelerated since being in prison.

I isolate myself a lot. I've lost a lot of family members. I have one brother, out of three brothers, who gets it, who is willing to sit and forgive and forget what I did to the rest of the family. As I said, I'm a family man. My family is well known in the southwestern Ontario area. I live five minutes up the road from my family—my mom and dad. They don't wave to me when they drive by. They won't even acknowledge me.

I'm sorry I'm taking so much time. This is my life. I live every day with that title of aggravated sexual assault. My son is 24. He has a mild intellectual disorder, but he gets it. My son has come to me many times saying, Dad, if I could drain all my blood out today and give it to you so that we could all forget about this once and for all, I would do that for you. That's why I'm going to sit at this table and many more tables until we get this right.

I had the opportunity to speak in Amsterdam at the International AIDS Conference. One of the things that was asked of me was what Canada can do. I'll be honest with all of you in this room that I was a little upset. I wanted to say what I really felt we could do. I said if Canada is serious about getting to 90-90-90, stop criminalizing people for HIV and become the test block.

Second, why are there only four provinces in Canada where antiretroviral medication is readily available? That tells me right there that we have an issue.

We heard the federal health minister in Amsterdam after I said if Canada is serious about doing this, don't endorse U equals U; sign on, since Canada is a world leader in convicting people. That's the first step. The science proves that after three months.... I became undetectable after being on medication for three months when the charge was brought before me. I was on medication for only eight months. I didn't know the longevity of HIV. I had no clue what was coming next. What I did know was that I was going to jail because there was the phone call.

I reached out to the Byng clinic, and got on medication and I've adhered to my medication all the time. I speak to intravenous drug users. I've given them an entity, because you have to build trust with them. I've been there myself in some of the poor choices I made as a young 18-year-old who ran away from a town of 2,500. I was an altar boy, raised on a farm.

When you give those people a voice, with regard to the sex they're having or the drugs they're doing, and you allow them to, they will tell you what the problem is, what barriers they face and what they need in order to fix things and to get medication.

I strongly suggest that we do legislative reform, because this is wrecking lives. It's one thing to have HIV, but it's another thing to be criminally charged, convicted, sentenced and now have to be on a sex registry for the rest of my life. I cannot travel for longer than seven days without having to notify the police, or it's a breach, which happened to me.

There's one thing I'd like to mention to you guys now. As I stand before you, I'm now homeless. I received an eviction notice on Easter Monday and had 12 hours to vacate my home as there was a person paid to be in my home to make sure I left. Once again—

● (1015)

The Chair: Mr. Clarke, we're at 10 minutes now for this presentation, and we have to go vote.

I'm going to suspend the meeting right now. Those of us who can come back will come back afterward to hear the rest of the testimony from the witnesses. We'll be back as soon as we can after the vote.

● (1015)

(Pause)

● (1055)

The Chair: I appreciate the witnesses' patience. I'm really sorry to have interrupted like that. We don't usually do that, but votes are beyond our control.

I've started the meeting as quickly as possible, because you never know what may happen. I want to make sure we at least get through your verbal testimony.

We're going to hear the Community-Based Research Centre first, then the Parkdale Queen West Community Health Centre next. Then we'll come back to Ms. Nicholson, who said she had four and a half minutes and she did not get a chance to do her part of the presentation.

We're going to start with Mr. Biggin. The floor is yours, sir.

Mr. Brook Biggin (Director, Program Development, Scale-Up, and Implementation, Community-Based Research Centre): Good morning on behalf of the Community-Based Research Centre. Thank you for taking up this important issue and inviting us to participate. To provide context for my remarks, in addition to my role at the CBRC, I'm also steering committee co-chair of the Alberta sexually transmitted and blood-borne infections strategy, as well as the founder of the EMHC, a grassroots health organization run by and for sexual and gender minority communities in Edmonton, Alberta.

In preparation for today's meeting, I had the privilege of reviewing the remarks made by my esteemed colleagues and I heard what was shared earlier. While I can think a little highly of myself sometimes, I'm not sure I can recount the background and the core facts of the matter much better than they have already. I'll save us all a little bit of time and move past that to what I think we can do about it.

Here, too, my colleagues have provided the committee with fairly consistent direction, namely that while we recognize the federal Attorney General's directive on limiting HIV non-disclosure prosecutions as a very important step in the right direction, we must also recognize the limits of its reach and impact.

Therefore, as echoed by multiple witnesses before the committee and nearly 200 organizations across this country that have all endorsed the community consensus statement to end unjust HIV criminalization, the only way we believe we can effectively address this issue at a national level is through the reform of the Criminal Code. While there remain some question as to exactly what that might look like, there's a very strong consensus shared by all the witnesses before you today that it must include the removal of HIV non-disclosure cases from the realm of sexual assault law.

If we have a general consensus on what we can do about this matter, the question then shifts to why it's important that we must act. I will provide the committee with two reasons.

First, as you've heard, a consensus has emerged, endorsed by the U.S. CDC and our own Minister of Health, that when someone living with HIV has and maintains an undetectable viral load, they cannot transmit the virus sexually to others. In other words, undetectable equals untransmittable, U equals U.

While that broad consensus is relatively new, the understanding that treatment as a form of HIV prevention is effective is not. In fact, in 2014, with this understanding, the UN set new global HIV targets known as “90-90-90”. In essence, these targets state that by 2020, 90% of those who are living with HIV will be diagnosed, 90% of those diagnosed will be on treatment and 90% of those on treatment will have a suppressed or undetectable viral load. If these ambitious goals were met, effectively that would result in 73% of all people living with HIV having a suppressed viral load, setting the stage to end the epidemic as we know it by the year 2030.

However, in the most recent publicly available data I could find, the Public Health Agency of Canada estimated that by the year 2016, only 86% of those living with HIV in Canada were diagnosed and only 81% of those diagnosed were on treatment, with the one bright spot being that 91% of those on treatment had achieved an undetectable viral load. This resulted in only 63% of people living with HIV being virally suppressed, a full 10% off our 2020 target.

While disconcerting, it's not without a bright light. We see that people living with HIV in Canada, when linked to effective HIV treatment, do a pretty good job of taking their medication as prescribed and achieving an undetectable viral load, benefiting their health, the health of the people they care about and the health of the greater public. Where we're falling behind, then, is in the health system and the two targets that it is most responsible for: namely, ensuring that people have access to safe and accessible screening options; and ensuring that those who are diagnosed are linked to care and treatment options that work for them. Therefore, one would think that, knowing this, we as a country would take a unified, coordinated approach to dealing with the situation. Well, one would think.

In the previous session, William Flanagan shared a Canadian study, published in 2018, that demonstrated that the criminalization of non-disclosure decreased the likelihood of gay and bisexual men getting tested. I will remind the committee that this is a population that makes up about half of all new HIV infections each year. There goes your first “90”.

Other colleagues spoke to concerns HIV-positive patients had in sharing important information with health care providers about their treatment, out of fear that these intimate details could be used against them in criminal proceedings, inhibiting their ability to access treatment options that work for them. There goes your second “90”.

As the health system struggles to cross the finish line to end Canada’s HIV epidemic, why is the justice system cutting it off at the knees? You cannot, with the one hand, signal that U equals U, write #nohivstigma on one’s Twitter and hug the 90-90-90 targets, while with the other hand, uphold a scenario where the criminal law’s application is so disproportionate and extreme that you are adding HIV stigma at a faster rate than you can remove it. It is contradictory and it is self-defeating. No wonder people are confused.

Therefore, I ask this committee what is more just, committing to proven and widely endorsed public health strategies that can effectively end the HIV epidemic and decrease the vulnerability of all Canadians to HIV infection, or upholding a scenario where the law is applied so vaguely and unevenly that people living with HIV who are actually doing what they can to prevent transmission are unfairly and cruelly targeted as part of some crusade to which I can assign no benefit? I believe we do need to answer this question, because I do not believe it can be both.

In concluding, I’ll offer one final reason I believe we should act. In addition to my work in this field, I am a person who is living with HIV and have been for the past eight years. There has been a lot of talk before this committee of people living with HIV often being vulnerable or marginalized. Yes, HIV and the criminalization of non-disclosure do disproportionately impact those who are vulnerable, and it is our duty to ensure they are protected and can lead lives free of stigma, discrimination and unnecessary criminalization. However, more than vulnerability, the qualities that strike me most when thinking of people living with HIV are resilience, courage and innovation.

● (1100)

We are a people as diverse as one could imagine, united by a common thread that penetrated all of our lives and made us one, who in the face of what appeared to be certain death, mobilized and organized, participated in and led vital research, developed policy and pioneered best practice, all while many in power turned a blind eye to their needs. They did all of this and more so that we could live. And we do. Nearly 70,000 people in this country today will live and not die because of their sacrifice.

And as if that were not enough, the impacts of their efforts extend far beyond those living with HIV. Innovative models and crucial infrastructure pioneered and built by those living with HIV in this country have been successfully adopted and implemented by those working in the fields of sexual and gender minority rights, hepatitis C, the opioid response and more. Canadian society has been permanently and positively altered by the decades of contributions those living with HIV have made to this country.

With this in mind, as I sat to prepare these remarks and review the testimony from the previous session, hearing of the horrific experiences of those whose lives have been destroyed by the application of the law, I found myself to be gravely disappointed, angry even.

Of how little value are we, some of us sitting at this table, and our contributions to this country for such horrible things to knowingly continue to stand? Make no mistake. It is a deep disrespect to our collective legacy and contribution to this country to allow this vague, unevenly applied and unnecessarily cruel application of the law to continue unaddressed.

Fortunately for this committee, it does not need to be. Throughout this study, many of us, people living with HIV, community-based organizations, experts in law and public health, have offered our support in helping this committee to take something that's been wrong for so long and finally make it right.

For the benefit of those living with HIV in this country and everybody else, I do hope you will take us up on that offer.

Thank you.

● (1105)

The Chair: Thank you very much.

We will now go to the Parkdale Queen West Community Health Centre.

Ms. Gans, the floor is yours.

Ms. Maureen Gans (Senior Director, Client Services, Parkdale Queen West Community Health Centre): Thank you.

Good morning. My name is Maureen Gans. I am the Senior Director of Client Services at the Parkdale Queen West Community Health Centre. For those who may not be familiar with CHCs, we provide primary care services to clients, including clinical, mental health and health promotion services and activities. Our CHC operates within a harm reduction framework. One could actually argue that we are a harm reduction agency that offers primary health services. We receive funding from the provincial AIDS bureau to conduct point-of-care anonymous HIV testing. If an individual tests positive, we offer a confirmatory blood draw and referral to a specialist for treatment. AIDS bureau funding also supports our considerable outreach efforts.

This past fiscal year, we tested 485 individuals. Of those, nine tested positive. All have disclosed their status, all have access to a primary care provider and all are on antiretrovirals. For those who test negative, they often come back for regular testing. That provides us with an opportunity to develop trusting relationships with individuals, to counsel about pre-exposure prophylaxis, and to provide support and assistance if a test is positive.

ln your invitation, you asked speakers to consider the best ways or practices to address non-disclosure of HIV status. This assumes that non-disclosure, rather than the criminalization of non-disclosure, is the problem. There does not appear to be strong evidence to support non-disclosure as being an issue, given that many of the cases prosecuted to date have involved individuals with a low or negligible risk of transmitting HIV and, in the majority of cases, there was no actual transmission. So why criminalize?

Criminalization is often seen as a response that aims to protect women and provide justice in instances where women have been infected or potentially exposed to HIV by their male sexual partners. However, this can be detrimental. A 2007 study done in AIDS service organizations involving about 40 women living with HIV as well as front-line service providers identifies a range of concerns. There are the added challenges that some women, particularly those in vulnerable relationships, may face when insisting on condom use by their partners, meaning that they then must either disclose or face the possibility of criminal liability. There are the fears that disclosure could trigger the loss of relationships, not only emotional but also financial consequences, or consequences for immigration status if the woman is being sponsored by her husband. There are the fears of abuse and physical violence, as well as the use of criminal law as a weapon, especially in situations where relationships break down and the woman may be subjected to unfounded accusations or threats of criminal charges as a means of seeking revenge or exerting control.

lt is important to note that for any individual with HIV, but particularly those already marginalized and overrepresented in the criminal justice system, disclosure will not necessarily protect from allegations, threats, police investigations or criminal charges. The threat of making a complaint to police is a powerful weapon in the hands of a disgruntled ex-lover or abusive partner. Even if a case does not proceed, the threat or investigation can be extremely damaging.

For racialized communities and black/African communities in particular, what has been experienced in the application of criminalization of non-disclosure is the creation of a pathologizing, criminalizing and profiling of black men as dangerous sexual predators. Cases involving criminal charges against persons living with HIV garner considerable media attention. The profiled face of many media stories has been the face of black men. While black men may not have been charged in greater numbers than white men, studies reveal that public perception exists that black heterosexual men are the perpetrators and are overrepresented among those charged. When the accused in a criminal case was an immigrant, this fact was frequently reported, thus reinforcing the belief that HIV is a problem of outsiders, imported from the Caribbean and Africa by people wanting to take advantage of the Canadian system. Thus, the black communities have seen non-disclosure charges as serving to reinforce anti-immigrant sentiment.

Long before any resolution at trial, as was noted earlier, police media advisories may reveal publicly an accused's identity, including photograph and HIV status, as well as the criminal allegations and details about their personal and sexual life. Criminalization therefore increases stigma. No other infectious disease is viewed with as much fear and repugnance as HIV.

● (1110)

Infectious diseases exist with the capacity to create public health crises, and yet we do not criminalize parents, for example, who do not disclose their refusal to vaccinate their children against measles. Other STIs can result in significant psychological and health impacts, and while there is a requirement for individuals to inform their sexual partner of any STI, only non-disclosure of HIV is met with criminal action.

With many infectious diseases we have treatment for symptoms, but no cure for the disease itself, so why do we choose to exclusively criminalize the non-disclosure of HIV? What is the evidence to suggest that criminalization decreases the likelihood of infected individuals transmitting the disease? I would argue, as many before have, that criminalization can have the effect of preventing individuals from seeking testing. If you don't know your status, you can't be charged with knowingly transmitting.

So let's talk about testing and treatment. The advantage of anonymous testing within a harm reduction agency, especially testing delivered by community testers and not health care professionals, is that we see a significant number of individuals from marginalized communities who will not necessarily go elsewhere for testing: newcomers, including a significant number of racialized individuals; men having sex with men who also use drugs; uninsured individuals; sex workers and folks identifying as trans or non-binary.

I would note that for people who use drugs, the testing world has not always been inclusive or supportive. Perhaps ironically, testers often spend time trying to counsel individuals to stop taking drugs rather than counselling them in safer use.

Individuals who do not engage in treatment once diagnosed with HIV and do not disclose their status are assumed to be deliberately deceptive or even malicious, however there are a number of reasons that people may not receive treatment. There is the lack of access to pre-exposure or post-exposure prophylaxis; even in larger communities, access can be limited to specialized clinics. Regular, run-of-the-mill family physicians may not be familiar with treatment protocols. There is also the lack of access to treatment once diagnosed, a mistrust of the health care system, the lack of awareness of the degree to which an individual does have some right to privacy and the lack of understanding of treatment efficacy.

What women, people who use drugs and racialized communities need is investment in the beneficial impact of HIV testing and other public health initiatives to modify behaviour that risks transmitting HIV. We need to make testing the centrepiece of our strategies and we need treatment to be available to anyone who needs it. We need investment in social and emotional supports for individuals living with HIV to eliminate the fear, isolation and discrimination that exists when people do disclose.

Thank you.

The Chair: Thank you very much.

We're going to go to Ms. Nicholson next, but Mr. Cooper just asked for the floor for one second.

Mr. Michael Cooper: Was there another witness? Let her speak, yes.

The Chair: Ms. Nicholson, please go ahead.

Mrs. Valerie Nicholson (Member, Canadian Coalition to Reform HIV Criminalization): Thank you.

I honour and acknowledge the ancestral traditional territories that I stand on today and all those across Turtle Island.

I am a storyteller, and I will present in my traditional ways.

Two of our many research papers are before you, bringing to light the living experience of HIV and criminalization. I did not ask to be HIV-positive, yet I stand before you, an indigenous warrior, advocating for all of us living with HIV. I have a dedication to the community to deliver with respect the voices from our research, which you are gifted. All names are pseudonyms to protect and keep safe the women who bravely shared their experiences and journeys living with HIV and the law.

I'm starting with a quote from Adele from B.C.:

> How do we know what the judge is thinking? What is his viewpoint on HIV, what is his viewpoint even maybe on women? Like we don't know. They're supposed to be impartial. But everybody has morals and values. And we don't know...or what their education level even is on medical terms.

Right now I want you to think of a loved one—a daughter, a sister, an aunt or a niece. Through no fault of her own, like me, she has HIV. She is sexually assaulted. She is fighting for her life. That is all that's on her mind, survival. She just wants to come out of this alive. She's not thinking, “Oh, I had better tell him I have HIV”. She is now charged with HIV non-disclosure, she's convicted and she serves time. She is now a registered sexual offender. She is released and faces community stigma and discrimination. Her face is on telephone poles, fences and even in store windows. “Do not have sex with this HIV-positive woman; she is a registered sexual offender”. She can't be around children, yet she's a life giver. She loses her children. She loses her newborn baby.

These are true stores, and with permission, I carry their stories, their tears and their fears.

Julie from B.C. bravely shared her story:

> I was raped by three [men]. They broke into my home and they held me prisoner for 24 hours and beat me and raped me. And if I had told him I was HIV positive, I would have been dead. I know it. So where does that fit in the picture?

How do we protect ourselves from this law? We've become fearful for our lives. Sex is no longer spontaneous or romantic. We are all sexual beings, yet we have to stop, as Lilian from B.C. role-played:

> Excuse me, we can't have sex yet. I've got to call a lawyer, my doctor, the judge, the policeman, a lab tech to prove that I have disclosed and have an undetectable viral load. So how many people have to be in the bedroom?

Why do I bring this up? It's because it happened to me. I was dating someone who wanted to be intimate and I told him I had to tell him something. I explained that I had HIV. He didn't have a clue what HIV was. I slowed him down and really explained it to him. I took the time to educate him. I asked him to wear a condom. We dated for about a year, and during this relationship I found he was sometimes taking the condom off without my knowledge or permission. I was not worried about me transmitting HIV; I was worried what he might have. I go for blood work every three months. I know my status, but I don't know his. I have no proof. Does he lie to me?

A year and a half after the relationship ended he called and wanted a visit. As a friend, I said yes. He said, “You gave me HIV”. My heart sank. I went into an emotional tailspin. My mind knew this was impossible. I am an educator; I know the science; I am undetectable. Yet I couldn't help that confusion. After asking him a few questions I found he was diagnosed only that month and had only just seroconverted. I explained that to him. His response was, “Let's have sex”. I told him no. He told me that, if I did not have sex with him, he would go to the police and tell them I gave him HIV and never disclosed to him. He was using his new knowledge against me, saying he knew he didn't give it to me but the police didn't. Where is my proof that I disclosed? I was strong enough to say, “Go ahead; there is the door; call the police; get out.”

I lived in fear for the next six months, waiting for that knock on the door. I jumped every time the phone rang. I was always looking around and was paralyzed every time I saw a police car. I am strong and educated in HIV. Imagine those who are not; they could still be in a controlling or violent relationship.

This concern is not surprising, given that in a court of law it could come down to a he-said-she-said argument, with the person living with HIV having to find ways to prove that they disclosed their HIV-positive status to that sexual partner.

Catherine from Saskatchewan said, “And they go to the police and get them charged, just out to be spiteful and mean”.

Zainab from Ontario asked, “Do I need to make him sign a document and lock it up and have it witnessed by the neighbour?"

Trudy from Saskatchewan wanted to know, “How can you be prosecuted if it's not transmitted?”

Rita from Ontario asked, “What about the ones that are out there that are not even educated, can't read, and they're sick and they don't even know?”

Marisa from Saskatchewan asked, “Do I have to tell someone I had sex with ten years ago?” “What happens if the condom breaks...?”

We are all living in fear of this Canadian law, and we are not sexual offenders.

● (1115)

Thank you.

The Chair: Thank you very much to all the members of the panel.

Mr. Cooper, you wanted to speak very briefly?

Mr. Michael Cooper: I just want to put on the record, first of all, that I thank all the witnesses for their very helpful testimony. It's unfortunate we don't have time to ask questions.

I think it was said by one or more of the witnesses today, and if not today it's been said by others, that HIV has been uniquely singled out in aggravated sexual assault provisions of the Criminal Code. I just want to cite that in the Jones case from New Brunswick, an individual was charged pursuant to aggravated sexual assault for transmitting hepatitis C or alleged to have potentially transmitted hepatitis C, but was acquitted on the basis of the Cuerrier test.

As well in the 2012 Boone decision, an individual was charged under aggravated sexual assault for transmitting syphilis but those charges were not pursued. So there are other cases out there.

● (1120)

The Chair: Thank you.

I appreciate your clarification. I'll read from the Department of Justice so we all have the facts: “HIV is treated in an exceptional way by the criminal justice system compared to other transmissible diseases”.

I think that's what everybody is trying to say. For example, with regard to hepatitis B, hepatitis C and the human papillomavirus, “Prosecutions for non-disclosure of HIV appear disproportionate and discriminatory given their relatively high number in comparison to prosecutions for non-disclosure of other transmissible diseases”.

We'll just make sure we have all that on the record.

We are about to have another vote. Does anybody have a very short exchange? Otherwise if it's okay with the witnesses we will send you our questions by email and ask you to respond.

I think Mr. Virani or Mr. Boissonnault also wanted to have a brief comment.

Mr. Arif Virani (Parkdale—High Park, Lib.): Thank you to all of you for your time and your courage and being so forthright. It's very helpful for the study that we're doing. In terms of the Parkdale Community Health Centre, I know you, Maureen, and the work you're doing.

Can you just talk to us a bit about that anonymity component? You said it helps empower people to come forward who might not otherwise come forward to get the testing. Can you then draw the link between those who test positive to getting the treatment they need because that's an important piece? That's where we're trying to close that loop. You said there was some success on your part. What accounts for the success for the people who are testing positive getting the treatment?

Ms. Maureen Gans: I think it's a couple of things. Because we operate within a harm reduction framework, there's no value judgment. People are positive or they're negative. They use drugs or they don't. They have sex for money or they don't. It just is.

When they come for testing, first of all, it starts with the outreach we do. We have a lot of harm reduction coordinators going into the community of Toronto offices, sometimes in very formal ways, and testing. But we also have people going out to people who live on the streets, under the bridges, in shelters.

They talk to people about testing. They encourage them to come in. They let them know that it's anonymous, not nominal but anonymous. Often people will come in and have a chat before. They won't even be tested the first time. They'll start to understand what we're about. They get comfortable with the idea. They eventually come back.

They're tested. Sometimes they've tested negative the first time. They come back on a regular basis. They eventually test positive. Sometimes at the first visit they test positive. The folks who do the testing are exceptionally good at counselling. You have to be certified to do this testing and part of it is because of the counselling component. Again, getting them into treatment for us is easy because we have a pathway to the physicians who offer treatments. As far as I know, we have never had anyone test positive who has said no to treatment.

The one exception might be somebody who is uninsured. I don't believe we've tested anyone uninsured for whom we couldn't find treatment. About 20% of our clients do not have OHIP. They are probably the most vulnerable in terms of treatment. A group of community health centres in downtown Toronto are looking at starting a shared clinic to treat those folks, to test and to treat folks who don't have health insurance.

The Chair: Thank you.

We can't get into a question period.

Again, on behalf of everyone, I want to thank all of the witnesses.

I want to apologize for the fact that you've been put through a voting procedure; that is not normal. We really appreciate it. We will send you, if that's okay, questions in writing to answer by email.

I thank you again for being here.

Mr. Chad Clarke: I would just like to say one last thing.

I want to take the word “stigma” and turn it into an acronym: Stop To Investigate Getting More Aligned.

The Chair: Thank you very much.

The meeting is adjourned.