Standing Committee on Justice and Human Rights

JUST • NUMBER 149 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, May 14, 2019

Chair

Mr. Anthony Housefather

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● (0845)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Good morning, everyone.

Welcome to the Standing Committee on Justice and Human Rights as we resume our study on the criminalization of non-disclosure of HIV status.

For our first panel this morning, we are joined by four witnesses. From Africans in Partnership Against AIDS, we have Ms. Fanta Ongoiba, Executive Director. She is joining us by video conference from Saskatoon. From the Alliance for South Asian AIDS Prevention, we have Mr. Haran Vijayanathan, Executive Director. As an individual, we have Mr. Eric Mykhalovskiy, Professor at York University. From the Ontario Aboriginal HIV/AIDS Strategy, we have Mr. Duane Morrisseau-Beck, President and Chair.

Welcome.

As everyone knows, you all have eight minutes to deliver your opening statements.

[*Translation*]

You can proceed in English or in French.

[*English*]

Ms. Ongoiba, since you're here by video conference, we're going to start with you. We don't want to lose you.

Ms. Ongoiba, the floor is yours.

[*Translation*]

Ms. Fanta Ongoiba (Executive Director, Africans in Partnership Against AIDS): All right.

Good morning everyone.

Thank you for inviting me to appear before the committee today.

I am extremely proud and delighted to address the committee today and to fight for HIV non-disclosure in support of all those affected. I will share with you how this issue impacts members of the African, Caribbean and black community in Canada, and Ontario, in particular.

Addressing this issue is a priority for us because it affects people from all walks of life, but especially marginalized populations. We have long been concerned about the criminal laws and the punishment they essentially inflict on people living with the virus. We think it is high time that the laws change for the better, so that those affected can lead a healthy and peaceful existence, like everyone else.

This is also about normalizing the face of HIV/AIDS to send the message that HIV/AIDS does not discriminate. It doesn't care about what colour a person's skin is, what they look like or whether they are rich or poor. HIV/AIDS crosses all boundaries. It would therefore be better if everyone were on the same page, working hand in hand to fight the scourge and surrounding negativity, while supporting prevention efforts. That would, at a very minimum, help those affected to lead happy lives, like everyone else, and to feel loved and accepted by all.

I know that we don't have much time for a presentation, but this is my plea regarding a disease that affects all strata of society. It's essential to rethink the law so that people can once again be seen as normal.

The most marginalized and vulnerable people affected are women. They, in particular, are vulnerable in the face of the disease. They are the ones who give life and are certainly not spared. What's more, women are the caretakers of children and men. Criminalization prevents people from revealing their status and being seen as normal. In the current climate, they are seen as abnormal.

We are all here for the same reason. I applaud you for holding a debate on this scale, bringing lawmakers and community workers together to foster mutual understanding in pursuit of the common good. In the African, Caribbean and black community, the effects of these laws are strongly felt, especially by women.

It's also important to look at the issue through the immigration lens. To some extent, people suffer prejudice. People leave war-torn countries for a better life here, in Canada. Not all of them bring the virus with them; some of them contract it here.

Therefore, no one can say that immigrants are bringing the disease to Canada. The justice system criminalizes people living with HIV/AIDS, mainly heterosexual African, Caribbean and black men. Their cases are highly publicized, with their photos being splashed everywhere. If they are sent to prison, they leave their families behind. Their reputations are ruined and they lose everything they had. The damage done by these laws leads to major isolation and even suicide. These cases come down to one person's word against the other's. The law makes no allowances for situations where a person claims that the other never disclosed their status even if they did. The person who makes the initial complaint will always win. Let's face it, it's the person who complains about the other.

● (0850)

The criminalization of HIV non-disclosure can be viewed in a number of lights. For instance, the current situation does more harm than good from a prevention standpoint. It drives people into hiding and discourages them from getting tested. It results in fewer people being diagnosed and receiving treatment. How can we treat someone when they don't even know they have HIV?

Furthermore, how can we achieve the UNAIDS 90-90-90 targets? That means diagnosing infected individuals, providing treatment to them and ensuring they sustain treatment. By criminalizing HIV non-disclosure, we rule out the possibility of achieving the 90-90-90 targets, in my view.

The statistics show that, in Canada, 86% of infected individuals are diagnosed, 91% receive treatment and 81% remain in treatment. That's a good thing. However, if you take the figures 86-91-81, it represents just 73%, which means we are still a good ways away from the 90-90-90 target. The situation is improving, though. The figures we have now are encouraging, especially when it comes to individuals who sustain treatment. That's a good thing in Canada.

Nevertheless, as far as the criminalization of HIV non-disclosure is concerned, I strongly believe we need to reconsider the laws. We need to relax Criminal Code measures that target people with HIV. I would suggest that we look to other countries for inspiration. Cuba, for instance, did not criminalize non-disclosure and has made significant strides with respect to HIV/AIDS infection rates.

Canada has the ability to consider other dimensions as well. We can look at ourselves in relation to other countries such as those in Africa, where the situation is endemic. Although that's not true for the entire continent, it is the case in a number of countries. Considerable progress has been achieved there. HIV non-disclosure is not criminalized, and every effort is made to help people living with the virus, while providing them with support.

By criminalizing HIV non-disclosure here, in Canada, we are preventing people from living their lives freely and disclosing their status, all of which does more harm than good.

I don't want to monopolize the committee's time. I'm not sure whether my eight minutes are up, but that's what I wanted to say. Criminal Code provisions targeting people living with HIV/AIDS need to be reviewed and relaxed so that we can all work hand in hand for the better.

Thank you.

● (0855)

The Chair: Thank you very much for your presentation.

We will now move on to the next witness.

[*English*]

Next we'll move to the Alliance for South Asian AIDS Prevention.

Mr. Haran Vijayanathan (Executive Director, Alliance for South Asian AIDS Prevention): Good morning, Honourable Chair and members of the committee. Thank you for the invitation to present today.

My name is Haran, and I am the Executive Director at the Alliance for South Asian AIDS Prevention, also known as ASAAP since our humble beginnings in 1989. Today our programs are inclusive of not just South Asian communities but also a very diverse Middle Eastern community. This year marks ASAAP's 30th year of service to a now broader demographic of racialized individuals living with, affected by and at risk of HIV and AIDS. That was really our primary purpose in forming ASAAP.

In our nascent year, tragedy struck when a South Asian couple died from AIDS-related complications. Their deaths were the direct result of not being able to access life-saving treatment, medical attention and care linked to a language barrier and a lack of ability to navigate our health care system.

In response to their loss, a group of South Asian LGBT activists founded ASAAP to ensure a crisis like this would never happen again. We have a very high rate of success, with 95% of our clients maintaining a suppressed viral load, which means that HIV cannot be passed on during sexual intercourse. Moreover, HIV is considered a manageable chronic health condition by the Public Health Agency of Canada, which is excellent news.

However, attitudes toward people living with HIV have not kept pace with the science. There is widespread stigma and accompanying discrimination against people living with HIV, and people living with HIV regularly face heightened legal issues because of their HIV positive status. Although 95% of ASAAP's clients have a suppressed viral load, every one of them has faced HIV discrimination, including loss of jobs, abandonment by family, eviction, denial of health or dental care, treatment as criminals even when no crime has been committed, physical assaults after disclosing their HIV status, denial of immigration status and being outed as HIV positive by family members and former partners.

Within the past two years, amidst the cheering for undetectable equals untransmittable, ASAAP's tight-knit group of long-term survivors have attended the community memorials of several of their beloved peers, half of whom have died by suicide or by refusing to take treatment and medical care. Imagine that. In the age of U=U, people are still dying of AIDS-related complications.

Criminalization of HIV is making things worse. In addition to blatant cases of individual injustice, the over-criminalization of HIV is hampering the HIV response in Canada. We know that people in South Asian and Middle Eastern communities are avoiding getting tested because they fear that, once diagnosed with HIV, they will face further repercussions in the form of stigma and discrimination, criminalization, incarceration, rejection and severe isolation.

Criminalization of HIV promotes and maintains the stigma. It reinforces fear and ignorance of HIV and those living with it. Clients of ASAAP have repeatedly stated that it was not HIV but the stigma that killed their peers too soon, long before the current life expectancy of people living with HIV.

Clearly, people living with HIV and AIDS in Canada are not living the improved quality of life they should be living as members of one of the richest countries in the world. This is despite the availability of highly effective HIV drugs that have minimized the long-term side effects. If Canada, as a signatory to the UNAIDS 90-90-90 goals, wishes to honour its commitment, there must be immediate Criminal Code reform in order to remove the offence from the realm of sexual assault law and have it focus on intentional and actual transmission.

As of 2016, 86% of Canadians were tested for HIV; 81% of Canadians were on treatment and 91% of Canadians achieved viral suppression. While we are all well on our way to achieving the 90-90-90 goals, with the elimination of criminalization of HIV—a significant root cause of stigma that hinders care, treatment, support and prevention—Canada would be well positioned to reach, if not surpass, the 90-90-90 goals.

The federal Attorney General's directive on limiting HIV non-disclosure prosecutions in the territories where federal prosecutors handle Criminal Code cases was a step in the right direction, but more is needed, including reforms to the Criminal Code to further limit the currently broad scope of HIV criminalization in Canada.

Using the MIPA principles, the meaningful engagement of people with AIDS, it is imperative that reform take place in consultation with meaningful engagement of those living with HIV along with leaders in the legal, scientific and AIDS services organizations endorsed by the broader HIV community. Those reforms should achieve two things. First, they should put an end to the use of sexual assault law as the means of criminalizing HIV non-disclosure; and second, limit any use of the law to cases of intentional, actual transmission of HIV to another person.

● (0900)

Intentional insightful deliberations will yield the community- and government-led initiative to address the criminalization of HIV and in what section of the Criminal Code this law would rest. As a government who has continued to demonstrate care for the well-being of all, I encourage you to now strive to be the first country to implement a nationwide educational policy against HIV stigma and discrimination.

You will be well informed and will monitor their health with regular testing, and due to the use of widespread educational campaigns, our youth as tomorrow's leaders will model a more positive outlook on HIV that could release the shame, secrecy, and fear people may have when they were first diagnosed.

I'm grateful to you for affording me the opportunity to speak on behalf of ASAAP and advocate for the people who continue to come back day after day to our office trusting us to represent them with dignity, care and grace.

I now pass on to you that same hope that in your deliberations about this issue you will acknowledge that the overuse of criminal law against people living with HIV has greatly impeded the progress we have made and will continue to strip those living with HIV of the very things that promote life, liberty, and health.

Thank you very much.

The Chair: Thank you very much.

Professor Mykhalovskiy.

Mr. Eric Mykhalovskiy (Professor, York University, As an Individual): Good morning, and thank you for the opportunity to appear before you today on this important issue.

In 2010, I was lead author on the first policy options report on HIV criminalization in Ontario, which addressed concerns that continue to be central to broader discussions about HIV criminalization in Canada today.

Our key arguments at that time were: first, that the criminal law disclosure obligation in Canada does not permit people living with HIV to determine with certainty when they are subject to criminal punishment for HIV non-disclosure; second, that the distribution of punishment for non-disclosure is uneven, with a heavy burden felt by marginalized and racialized populations; third, that the approach of the criminal justice system is insufficiently informed by up-to-date science on the risk of HIV transmission, resulting in unjust prosecutions; fourth, that the overuse of criminal law exacerbates stigma and damages HIV prevention care and support; and fifth, that sound, evidence-informed prosecutorial guidance is required to ameliorate these many problems.

Much has changed since those early days. There has been more research, advocacy and dialogue with provincial and federal authorities. There have been important legal developments, some troubling, such as the 2012 Supreme Court decision, others more promising, such as the federal directive, the 2017 Justice Canada report on non-disclosure of HIV, and the Ontario provincial policy announcement made in response to that report.

The most important change has surely occurred in the science of HIV transmission. As others who have appeared before me have made clear, a global scientific consensus has emerged that people living with HIV, who are virally suppressed, cannot transmit HIV. The extraordinary implications of that change have yet to fully register.

However, what seems clear is that moving forward, HIV non-disclosure will cease to be the matter of concern for state authorities that it has been in the past. The state, whether in the form of the criminal justice system or public health, will surely have more pressing matters to address than trying to govern the conduct of people living with HIV who cannot transmit the virus.

While there have been changes, much also remains the same. The concept of a realistic possibility of transmission continues the tradition of legal uncertainty about HIV non-disclosure. People living with HIV continue to be uncertain about their criminal law liability and courts have interpreted the concept in different ways, leading to differential judicial treatment across the country.

It is also the case that the legal concept of a realistic possibility of transmission more than ever lags behind the latest science on HIV transmission. The distribution of punishment for HIV non-disclosure continues to be skewed.

Over the years, research in Canada about the public health implications of HIV criminalization has accumulated. That suggests that HIV criminalization is a serious impediment to engagement with HV testing, care and support. Two Canadian studies have specifically examined the relationship between HIV criminalization and HIV testing, yielding findings suggesting that some people are unlikely to test because of fears about HIV criminalization.

Both used survey methods to study men who had sex with men. In one study, conducted in Toronto, 7% of participants stated that concerns about prosecutions made them less, or much less likely, to be tested for HIV. The authors then used a modelling approach to estimate that the reduction in testing could result in a potential 18.5% increase in HIV transmission.

In the other study, conducted in Ottawa, 17% of men who had sex with men stated that HIV criminalization affected their willingness to get tested. This group of participants was also more likely to have never previously had an HIV test and reported a higher number of sex partners in the two month period prior to the study, suggesting that those who are discouraged from testing, because of concerns about HIV criminalization, may be more likely to engage in HIV-related risks and therefore, be more likely to be unaware of their HIV-positive status.

Other HIV criminalization studies have looked at a range of topics, including the likelihood of disclosure, impacts on sexual risk taking, awareness of and perspectives on the law, experiences of stigma, impacts on HIV prevention counselling and clinical relationships, and the impact of HIV criminalization on the professional activities of public health workers and other providers.

These studies present findings that are relevant to the question of the impact of criminalization on access to and retention in care. A repeated finding is that some people living with HIV are afraid to speak openly about their sexual activities with public health and health care providers. These studies point to how criminalization can erode a sense of trust and confidence in the confidentiality of those relationships and can significantly hamper the ability to establish patient provider relationships in which people are able to talk about their sexual activities and their difficulties with disclosure.

● (0905)

Three reviews of this wide body of literature internationally emphasized that HIV criminalization provides no HIV prevention benefit and is associated with significant unintended impacts that interfere with public health efforts to prevent HIV transmission. An emerging perspective on the literature views HIV criminalization as a source of HIV stigma and therefore a structural impediment to the prevention, engagement, and care cascade, the single most important approach we have to responding to the HIV epidemic.

Taking this research into account the current situation might be described as a perverse form of injustice whereby the state's criminal law disclosure obligation punishes people on the basis of the amount of virus they have in their body but also interferes with their very ability to achieve the low levels of virus required.

How are we to respond? The federal directive is an important step but there are problems related to its geographical reach. Pursuing more lasting and widespread change through criminal law reform is a vital option. The federal government can continue to display leadership on the issue by outlining key principles that would guide the direction of that reform. One is that it first be based on a process of consultation involving legal experts, people living with HIV/AIDS service organizations, affected communities, medical and health care providers, and public health personnel. Second is that it detach HIV non-disclosure from the Criminal Code offence of sexual assault. Third is that it reserve the use of the criminal law for the most blameworthy of circumstances, namely, when a person intentionally and actually infects another person with HIV.

Finally, the question of collaboration between public health and criminal justice must be regarded as a complex and sensitive issue. Public health and criminal justice are different systems for governing human conduct with different formal powers, conventions of practice, cultures, and recent histories. Moving forward, public health should not be regarded simply as an alternative policing method and public health guidance must emphasize the significance of voluntary testing, counselling, and support for managing the epidemic. How, whether and what form any collaboration should take between public health and the criminal justice system including, for example, the matter of safeguards and guidance for flows of information about viral load, is something that requires careful consideration and widespread consultation.

Thank you.

The Chair: Thank you very much.

We will go to Mr. Morrisseau-Beck from the Ontario Aboriginal HIV/AIDS Strategy.

Mr. Duane Morrisseau-Beck (President and Chair, Ontario Aboriginal HIV/AIDS Strategy): Good morning.

I'd first like to acknowledge the unceded, unsurrendered territory of the Algonquin people.

My name is Duane Morrisseau-Beck, and I am the President of the Ontario Aboriginal HIV/AIDS Strategy. I am an indigenous person living with HIV, commonly referred to as an IPHA, for the past 27 years. I want to declare that, pertaining to this intrusive approach to law, I am not an expert or a lawyer.

As an IPHA, similar to others like me, I have been on the front lines fighting this disease and other Canadian colonial violations against indigenous people since 1995. I understand the impacts of the law, both professionally and personally.

According to the Canadian Coalition to Reform HIV Criminalization, HIV criminalization, as defined in the “End Unjust HIV Criminalization” community consensus statement, is the unjust application of criminal law to people living with HIV based solely on their HIV status. This includes the use of HIV-specific criminal statutes and general criminal laws to prosecute people living with HIV for unintentional HIV transmission, possible or perceived HIV exposure, and/or non-disclosure of known HIV-positive status. HIV criminalization is a growing, global phenomenon that undermines both human rights and public policy, thereby weakening the HIV response.

Professor William Flanagan from Queen's University told committee members on April 9:

> Criminalization erodes trust in voluntary approaches to HIV prevention and testing. It helps spread misinformation about the nature of HIV and its transmission. The overuse of criminal law compromises the ability of people living with HIV to engage in the care they need due to the fear that their HIV status and discussions with medical professionals may be used against them in criminal prosecutions.

Although we believe HIV criminalization impacts all genders among people living with HIV in the indigenous community, OAHAS would like to draw to the committee's attention the traumatic effects HIV criminalization has on HIV-positive women.

According to the 2017 national surveillance data, 31% of people with new HIV diagnoses were identified as aboriginal women. The 2016 national estimates were that 14,520 women with HIV and women aged 30 to 39 have the highest rates of HIV diagnoses. HIV estimates for women, since 2016, have increased from 23.4% up from 22.2%.

In Mr. Alexander McClelland's statement to the committee on April 9, he spoke about his doctoral research to examine experiences of people living with HIV across Canada who have been charged, prosecuted or threatened criminally in relation to alleged HIV non-disclosure. He discovered a wide range of experience and found that applying criminal law, specifically the law of sexual assault, causes greater harm, often exacerbating situations that are already marked by stigma, trauma, shame and discrimination.

It was also clearly stated to the committee on April 9, by Mr. Richard Elliott, the executive director of the Canadian HIV/AIDS Legal Network, that there is a “disproportionate impact of HIV criminalization on a number of different populations...among women who have been charged, indigenous women are disproportionately represented”. This is very alarming for OAHAS and the indigenous community.

The Public Health Agency of Canada estimates that between 5,100 and 8,000 women are living with HIV in Ontario. Indigenous women account for 4% of those newly diagnosed people. Transwomen are not described because there is no data collected on them, as noted in the 2015 briefing of the Ontario HIV Treatment Network.

Indigenous women are being diagnosed later, many at the AIDS stage. Aboriginal women are affected by HIV in ways that are unique to both their gender and cultural identities. Determinants rooted in the impacts of colonization have created entrenched poverty, social marginalization and unresolved trauma, which can increase their exposure to HIV/AIDS. For these reasons, aboriginal women’s position at the intersection of GBV and HIV/AIDS must be understood in the context of a colonized peoples.

We were optimistic to learn, in 2016, that Canada's former minister of justice and attorney general,Jody Wilson-Raybould, an indigenous woman, understood there was a problem with the over-criminalization of HIV non-disclosure and it further “stigmatizes those living with HIV or AIDS”.

In 2018 she issued a directive to the director of public prosecutions that applies only in Yukon, the Northwest Territories and Nunavut. Although the directive is viewed as a step in the right direction, this has caused some confusion in the indigenous HIV community in Ontario.

The historic relationship that indigenous people have with Canada is marred by human rights violations. These violations can be found in failed public policies like the Indian Act, residential schools and the policy of removing children which led to the sixties scoop. These failed public policies have caused overrepresentation of indigenous people in child welfare systems, jails, missing and murdered indigenous women and men, and in the high rates of chronic illness and infectious diseases observed among indigenous peoples.

● (0910)

As the only indigenous HIV organization in Ontario, OAHAS is implementing its five-year strategic plan, ending in 2024. One of our five goals is to provide information and supports to prevent the transmission of HIV and other STBBIs to indigenous people and indigenous communities. How are we to do this when criminalization undermines promotion and prevention work in the indigenous communities in Ontario? How will we meet UNAIDS' 90-90-90 targets or promote the U=U prevention campaign when we're dealing with an application of law that counters all our efforts as well as Canada's efforts? The outcomes of this overly broad application of criminal law are catastrophic and deter people from getting tested, accessing health care when tested positive or accessing antiretroviral treatment.

No other medical condition has been criminalized in the way HIV continues to be. If you don't tell your sexual partner you have HIV, you can be charged with aggravated assault and be registered as a sex offender. For members of the indigenous community who deal with daily stigma, trauma, shame and discrimination, this furthers the mistrust they already have for government's laws, policies and its institutions. The application of this law as it pertains to indigenous HIV-positive women should be viewed as a form of structural gender-based violence. Unwarranted criminalization has a devastating effect not only on those accused and convicted. It also has a highly detrimental effect on the broader HIV prevention and care initiatives. The unjustified application of criminal law is traumatic to HIV/AIDS-positive women and the HIV-positive community.

As a UN member state, Canada has pledged to promote social and legal environments supportive of and safe for voluntary disclosure of HIV, further to the 2016 political declaration on ending AIDS. The UN Committee on the Elimination of Discrimination against Women, UNAIDS and the Global Commission on HIV and the Law have also specifically recommended to Canada that it limit the scope of criminal law to those cases of actual intentional transmission of HIV.

In 2018, the Journal of the International AIDS Society, during the international AIDS conference, which I attended, announced an expert consensus statement on the science of HIV in the context of criminal law. That statement was endorsed by the International AIDS Society, the International Association of Providers of AIDS Care and UNAIDS, which are three leading global HIV scientific organizations. We want to thank the Canadian Coalition to Reform HIV Criminalization, which, along with partner organizations, is leading the charge on this important human rights issue.

Given that the election is happening in October of this year, it is OAHAS' recommendation that you work quickly with federal, provincial and territorial attorneys general to take the necessary steps within your respective areas of jurisdiction, and in consultation with people living with HIV, HIV organizations, service providers, women's rights advocates and science experts, to limit the unjust use of the criminal law against people living with HIV. OAHAS further recommends that any reform also remove the law from the realm of sexual assault.

In the 2015 mandate letter to the Minister of Justice and Attorney General of Canada, the Prime Minister wrote the following:

> As Minister of Justice and Attorney General of Canada, your overarching goal will be to ensure our legislation meets the highest standards of equity, fairness and respect for the rule of law. I expect you to ensure that our initiatives respect the Constitution of Canada, court decisions, and are in keeping with our proudest legal traditions. You are expected to ensure that the rights of Canadians are protected, that our work demonstrates the greatest possible commitment to respecting the Charter of Rights and Freedoms, and that our government seeks to fulfill our policy goals with the least interference with the rights and privacy of Canadians as possible.

This statement generally articulates the true sentiments being expressed today. Canada's covenants to its citizens and people residing in Canada must be honoured. As section 35 rights holders of the Constitution Act, it is imperative that Canada end the unnecessary and intrusive attack on our communities and continue forging reconciliation, which will ensure the protection of IPHAs now and into the future.

Interference with the rights and privacy of Canadians should be a thing of the past. Please act in a manner that upholds our proudest legal traditions at the national and international levels.

Meegwetch.

● (0915)

The Chair: Thank you very much.

I would note, as we start our questions, that we seem to have lost Ms. Ongoiba for a moment. We'll be watching the screen to see when she comes back. Until then, please direct your questions to the other three members of the panel.

We'll start with Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Great. Thank you, Mr. Chair.

I'll direct my first question to you, Mr. Vijayanathan and Mr. Mykhalovskiy.

Both of you stated that in terms of criminal law reform, the predicate to be convicted of an offence of HIV non-disclosure would require two elements, namely, intention and actual transmission. How do you justify that, inasmuch as there could be an individual who engages in blameworthy conduct but doesn't actually transmit and gets off scot-free, and someone who actually transmits may spend time behind bars? How do you justify that?

● (0920)

Mr. Haran Vijayanathan: Just from working in the HIV sector for the last 19 years, I can say that a significant majority of our folks living with HIV don't want to transmit. In fact, when they find out their HIV diagnosis, they actually go backward. Very few individuals are intentional. I think in a court of law and through evidence gathering, you would be able to find out whether they were intentional or not.

I can tell you, again, through the individuals who come in, they are fearful of it and actually shy away. Relationships have ended as a result of their identifying it or it being found out that they were HIV-positive. They actually make the decision to say, “I'm not having sexual intercourse with you at all” for fear of transmitting the virus. When you are looking at a highly stigmatized issue of HIV and the practices of the majority, I think it would be very easy to prove intention in actual transmission in a court of law in Canada.

Mr. Eric Mykhalovskiy: I think the argument is not that criminal law should have no role in HIV non-disclosure but that it should be restricted to the most blameworthy of circumstances, which involve intentional and actual transmission. It needs to be guided by the best science we have available about the risks of transmission. If you look at what happened in terms of the pattern of cases that happened after Mabior, you would imagine that things would have gotten better, but the proportion of cases that involved no transmission increased. I think the direction needs to move in the other way.

Mr. Michael Cooper: Right, but I'm trying to understand situations where someone did not transmit but they engaged in very blameworthy conduct, whether it be a failure to comply with public health interventions, whether they took advantage of someone who was vulnerable deliberately, or whether they actively misrepresented their HIV status and they were not on antiretrovirals and it was not a situation where they were engaging in oral sex, three or four circumstances where the science is pretty clear that the likelihood of transmission is next to nil or very, very little. In both situations where there is a significant risk and the individual engages in blameworthy conduct but there isn't actual transmission, then how do you justify the fact that in those circumstances no criminal charges would be laid, but in another circumstance where an individual does the exactly same thing and there's actual transmission, they're up on a criminal charge? I'm just trying to understand the distinction.

Mr. Eric Mykhalovskiy: I can't answer that in a...since I'm not a lawyer; let's be clear about that. That's a question that is probably best answered by a legal scholar or legal counsel.

The position I would take is more as a sociologist in terms of looking at patterns and trends. When we do that, we see that the direction of prosecutions has proceeded in a way that is contrary to the guiding signs we have available about the risks of HIV transmission. In response to that, it is advisable to try to proceed in a direction that decreases the scope of use of criminal law and restricts it to circumstances that—

Mr. Michael Cooper: Sorry, but it's my time.

Where has the criminal law gone off the rails? Can you cite a few cases?

Mr. Eric Mykhalovskiy: In the HIV/AIDS Legal Network in Ontario, there have been 10 cases since Mabior where people faced criminal charges. Some were prosecuted when their viral load was undetectable and they had no risk of transmission.

Mr. Michael Cooper: Now, fortunately, we have the federal directive, which I support, by the way, which would clarify the law in that regard, so that's off the table now, right?

Ontario has it's own directive—

Mr. Eric Mykhalovskiy: No, it does not have its own directive. It has a policy statement that was made by the attorney general. The federal directive applies only to the territories. It doesn't apply to the jurisdictions.

● (0925)

Mr. Michael Cooper: You're quite right, but if we were to apply that directive, that would take that off the table.

Mr. Eric Mykhalovskiy: In answer to your question, there are a number of cases where people have been subject to criminal prosecutions and have been convicted when their viral load has been low and undetectable. My understanding from reading—

Mr. Michael Cooper: Let me just cite the case of Aziga, just so we're very clear. In that case, that individual had sex with 11 victims without telling any of them that he had HIV status. Two of the victims died in association with HIV infection. Another five were infected with the virus. The remaining four victims were placed at grave risk by exposure to the virus. That's what we're talking about.

The Chair: Thank you, Mr. Cooper.

Of course, in that case there was actual transmission, so they would be prosecuted.

Mr. Michael Cooper: They couldn't answer what the distinction was between actual and non-actual in the context of blameworthy conduct.

The Chair: I understand.

Perhaps other questions will now come up.

Ms. Khalid.

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

Thank you, witnesses, for coming in today and for your testimony.

To get clarification on some of the questions that have been asked, I'll start with you, Mr. Mykhalovskiy.

It's not a very common thing for somebody to be intentionally spreading this virus. Is that correct?

Mr. Eric Mykhalovskiy: Yes.

Ms. Iqra Khalid: Do we have any records of how many cases we are looking at in the span of a year or over the past number of years? How many cases have we seen where someone has intentionally spread HIV to unassuming victims?

Mr. Eric Mykhalovskiy: I don't think that's a question that can be answered because that's not the standard that has been used to convict people.

Ms. Iqra Khalid: Okay, but you did say that it is a very rare instance for people to be intentionally spreading a virus for the purpose of inflicting harm on other people.

Mr. Eric Mykhalovskiy: Certainly, and as my colleague has indicated, people living with HIV in general take great care to ensure the safety and health of their sex partners.

Ms. Iqra Khalid: Do you think, then, that these types of fears, that people are going out and spreading HIV on purpose, etc., have to do with a stigma associated with the illness, and, in fact, the demographic that is involved as well?

Mr. Eric Mykhalovskiy: The media reporting of criminal cases certainly contributes to this type of public perception. A few years ago, I had an opportunity to read all of the newspaper stories that we could accumulate about HIV non-disclosure criminal cases, from the very beginning to around 2016. It was about 1,600 newspaper articles. They are almost univocal in representing defendants as despicable people who are ruthless and have no regard for anyone. It's the type of representation that an earlier member of the committee represented.

Mr. Michael Cooper: By citing a specific case?

Mr. Eric Mykhalovskiy: In answer to the question, I would say that media does do that.

It is particularly the case that the media has focused on a small number of cases—actually four cases—involving African Caribbean black male defendants. I think about 60% of the coverage focuses only on those cases. It generates the type of profile of the person living with HIV who doesn't disclose as a type of racialized, oversexed, irresponsible and callous individual. That's the type of representation you do find in the media, so I do think it feeds that type of stereotype.

Ms. Iqra Khalid: Thank you very much.

Mr. Vijayanathan, in some of your recommendations you also talked about stigma and mentioned its impact on South Asian communities, or on communities of visible minorities in general. I will turn to the other two groups representing minorities as well, but can you explain a little bit about whether it's.... We talked about legal reform, but how we combat the stigma to really ensure that fewer and fewer people are transmitting the virus.

Can you talk about some of the impacts of minorities and racism, perhaps, on the communities that are impacted, and what measures can be taken to really reach the 90-90-90 goal, other than legal reform?

● (0930)

Mr. Haran Vijayanathan: As Eric mentioned, there is a stereotype in terms of who gets HIV, how they got HIV, and how they spread HIV. Those are, unfortunately, the historical accounts that have happened since the early epidemic, and they still maintain their way through. With the whole notion of criminalizing HIV as a virus, it continues to keep HIV as that dirty death sentence that is not going to change or that people aren't going to live active, healthy, long lives as people are now given the treatment and technologies that are available to individuals.

When you look at South Asian communities who test positive for HIV, for example, my staff take them to HIV & AIDS Legal Clinic Ontario or South Asian Legal Clinic of Ontario after they get diagnosed and before they even go to medical care, simply because they need legal advice in terms of how they disclose, when they disclose and to whom they disclose, and so that they're supported in that process knowing that I don't want my brown folks to face that racism that exists as well as being layered with HIV on top of that.

We have a significant issue. Again, because of the whole notion of criminalization and, again, based on the few stories that are reported in the media, a lot of people are fearful of getting tested for what that means to them in their lives in Canada. Many of our folks have lost jobs, and many folks have lost families and friends, so there's more of a deterrent to go get tested, and we're open about having conversations about a manageable chronic illness, as the Public Health Agency of Canada has stated. We should act in a responsible way of not criminalizing to aggravated sexual assault and look at what the accountability framework gives for an individual who has committed a crime.

Again, if we could really speak to the stigma and the discrimination and understand why people are doing what they're doing, then we're able to get them tested sooner. We're able to get them to access treatment sooner, maintain an undetectable viral sooner and allow them to be less of a strain on the medical system as well as the legal system and the complete health care system.

The Chair: Mr. Garrison.

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

I want to thank the witnesses for being here today. I know it was a concern of many committee members, since marginalized Canadians are quite often subject to prosecution, that we hear from those communities, so it's very important for you to be here today.

I want to start by asking a question that surrounds the context of barriers to testing. From my experience, people who are marginalized already face a lot of barriers to testing, and this becomes yet another barrier.

I'm going to start with Mr. Morrisseau-Beck.

When I was visiting some northern communities and talking about AIDS treatment, they were talking about things like the reluctance of people to go to health professionals in small communities because of the stigma and the “my auntie works there” factor. I just wondered whether you could comment on the access to testing and treatment barriers that already exist without the criminalization.

Mr. Duane Morrisseau-Beck: That's a very good question, and a very quick answer is that the Ontario Aboriginal HIV/AIDS Strategy is working on looking at various testing simply because, within our communities, we are already stigmatized and discriminated against, and access to health care within the northern communities is another level of barriers.

We are working with partners in the different jurisdictions where we provide services to look at how we can eliminate some of those barriers. Part of that is education to indigenous peoples, so that's sort of where we're at right now.

This has been going on for a very, very long time since the epidemic earlier on. I remember when I was tested positive, it was very difficult to access these different types of services and programs. In that context, we are just sort of starting that process of trying to look at what those barriers will be and trying to eliminate them.

Thanks.

Mr. Randall Garrison: Mr. Vijayanathan, would you like to comment on that same question for South Asian communities?

● (0935)

Mr. Haran Vijayanathan: As I said, the whole “auntie works there” phenomenon happens in South Asian and Middle Eastern communities as well, especially if they're new to the country or they're trying to figure out their ways.

Oftentimes a barrier to testing, especially for international folks and international students particularly, who are coming into this country spending double the tuition fees, is that they are not getting accurate, effective insurance coverage for testing and access to treatment, etc. Those are all barriers.

Again, when you add the criminal factor to it, committing a crime has far more of a wall to overcome than some of those other issues. We, as social service organizations, can work with individuals when they present themselves to overcome some of the other barriers and challenges based on the availability of services, but that criminal barrier really makes it a further jump, and again, it's our connection to HIV/AIDS legal clinics that help us with that.

Mr. Randall Garrison: Thanks very much. I think at this point in Parliament it's clear we're going to try to give some scope to reform.

I want to ask another question here because there are two aspects. There's the justice aspect and there's the public health aspect. Are there other aspects of the Criminal Code that criminalize behaviour, which also contributes to a fear of testing? I would include in those the criminalization of sex work and the criminalization of drug use.

I'll start with Mr. Vijayanathan.

Mr. Haran Vijayanathan: Those are things that we're constantly dealing with on a daily basis. A lot of folks who we work with have engaged in the sex trade in the past, or are active drug users, for various reasons. It's the whole criminalization aspect of it instead of looking at the individuals and the issues that they're facing and how we move them forward rather than criminalizing them for an activity. Oftentimes it's a lot of education. Again, we're doing well in that, but we're not dealing with the health issue there, where it is a health issue. We're actually dealing with a legal issue. To take people to a legal clinic before we access the health care sector is actually already further pushing them away from adhering to treatment even, or actively seeking more help in health.

Mr. Randall Garrison: Mr. Morrisseau-Beck, would you have any comment on the other aspects of the criminal law that might impact access to services or testing?

Mr. Duane Morrisseau-Beck: We work with marginalized populations, those who are homeless and those who are working in the sex trade. I think just engaging with them under the auspices of criminalization makes it quite hard for us to engage with that population if they're already involved in the justice and criminal processes. I would say that for us it's difficult to actually work with these individuals. Again, as I said in my statement around the trust factor, trying to build trust with those populations with criminalization on top, it's very difficult.

Mr. Randall Garrison: Thanks.

The Chair: You have 20 seconds left, if you want, Mr. Garrison.

Mr. Randall Garrison: I was just going to ask Ms. Ongoiba the same question about barriers to testing in the African Canadian and Carribean community.

[*Translation*]

Ms. Fanta Ongoiba: I'll answer in French.

The Chair: Yes, of course. You may answer in French.

Ms. Fanta Ongoiba: All right. Thank you.

I listened to the other witnesses talking about their objectives. As I said in my opening statement, the criminalization of HIV non-disclosure significantly impacts prevention success rates.

Before coming to Canada, members of the African community were tested for HIV/AIDS in their home countries. If they're infected, they can't even obtain a visa. Even students who are infected aren't allowed to come.

When people reach out to Africans in Partnership Against AIDS, which is a Toronto-based association, we give them information pertinent to the situation in Canada. In their home countries, signs informing the public about the reality of AIDS are very visible. People know about the disease and take precautions. They talk about it with one another. As soon as they set foot on Canadian soil, however, there is nothing telling them that AIDS exists here as well. Most of the time, then, the members of our community are infected here, in Canada. We do our best to remind them that AIDS is a reality everywhere, in Canada and Africa alike, and that they need to take precautions.

We've started working with the Centre francophone de Toronto to provide people with information at points of entry such as airports. Those arriving in Canada for the first time deal with immigration officials. The kits they are given upon arriving now include information pamphlets. They indicate who to contact and provide guidance on what to do.

We educate them on HIV/AIDS so that they don't become infected, but if they do, we tell them where they can turn to access the services and support they need.

● (0940)

The Chair: Thank you very much.

It is now Mr. Virani's turn. He will be sharing whatever time he has left with me.

[*English*]

Mr. Arif Virani (Parkdale—High Park, Lib.): Thank you.

For the benefit of the committee, in the context of some of the previous questions, I think we might want to look at the notions of attempt. Attempt is outlined in section 463 of the Criminal Code, and that might address some of the concerns raised by Mr. Cooper. Also, if we are in the realm of sexual assault, there are the provisions about when you vitiate consent through fraud. Therefore, there are provisions already within the Criminal Code that could possibly address what was being raised.

I want to start with Mr. Vijayanathan.

Haran, I've heard of your reputation through my wife, who served as the chair of your board. I've seen your work in action both here and in Toronto. You're obviously very modest, because you neglected to mention the leadership role you took with the Bruce McArthur investigation and the serial killings in the LGBTQ2 community in Toronto. That was a significant leadership role in terms of liaising with municipal leaders, particularly law enforcement.

I salute you for that, but I want to ask how that connects here, because what we've heard a bit today but also in previous testimony is that it's one thing to have directives and it's another thing for them to percolate onto the ground.

Can you comment on the work that needs to be done to ensure that the police officers, the law enforcement officials and the Crown prosecutors are understanding the science and using it to inform their decisions to lay charges and proceed with charges?

Mr. Haran Vijayanathan: Absolutely.

With a whole missing person's case, it's actually police officers, front-line officers, who don't understand how people come in to report something that's happening. Then when they go out there, they're using laws that they might not understand, that have changed, and so on. For example, right now, police officers are directed to connect with the Crown in Ontario before they lay a charge. That's actually really good news, but only a few officers know that.

There's work being done that's really good in addressing it. However, these overarching principles and laws that exist allow for misinterpretation and misrepresentation within communities. If only a few people have that knowledge, that knowledge gets misused, and by the time an individual goes through the system and comes out at the other end, it's again reported in media in certain ways and then there is an impact on a lot more people. They're not going to get tested or they're going to actually delay getting tested, delay getting access to treatment and delay getting support.

That's how it plays out in the real-life world. Again, our justice system is fair and just. That's what I'd like to believe. We have processes in place, but as I said in my statement, if we can't engage and support individuals working together as community individuals, legal representatives and government officials to sit down and really look at local situations and have conversations and hash out how this is actually going to happen, taking from policy to practice is actually quite challenging. However, it becomes easier when you do it all together.

Mr. Arif Virani: I have about two minutes left, and I want to ask both you and Mr. Morrisseau-Beck, we've heard from Ms. Ongoiba and others, about the disproportionate impact on the black Canadian community, but also on indigenous people, and you're adding South Asians and Middle Eastern LGBTQ to that pool.

If you remove the notion of a violent sexual offender from the charging provisions, what impact will that have on the people you are serving, both at ASAAP, and Mr. Morrisseau-Beck, the indigenous community that you serve at your agency?

Mr. Haran Vijayanathan: That actually has a huge impact, because it takes the severity of the law away. A lot of people are afraid of going to jail. A lot of people are afraid of interacting with the justice system from a criminal perspective.

If we can remove that fearmongering language, that would actually allow people to sit down and listen to what the laws are and be educated and treated well. Therefore, absolutely and certainly, and again, with the LGBT community and their history in this country and being illegal themselves, especially gay men, who were criminalized at one point, and the decriminalization, unfortunately some of those bawdy-house laws still exist within the justice system. However, because we decriminalized in 1969, we were able to educate and then allow people to advance their engagement.

● (0945)

Mr. Arif Virani: Mr. Morrisseau-Beck, did you want to add to that?

Mr. Duane Morrisseau-Beck: Yes. I want to concur with what my colleague said.

From an indigenous perspective, indigenous people have been suppressed and oppressed by the state of Canada, so when we're dealing with prevention and promotion and just working with indigenous communities, we have a really hard time advancing our work. By removing this and reforming it, we would be able to work with our communities a little more succinctly and hopefully begin to lower the rates of HIV in our communities.

Thanks.

Mr. Arif Virani: Thank you very much.

I'll turn it over to Mr. Housefather.

The Chair: Thank you very much.

I want to come back to the crux of what we're actually looking at, which is whether or not we're promoting reforms to the criminal law.

My question is for Professor Mykhalovskiy.

In response to Mr. Cooper, you said earlier it was a legal question. I think it's more an ethical question, and that's why I want to come back to it. The criminal law is built on ethics. For me, there are two particular issues. One is, what is the standard we use to actually charge someone? Is it whether or not there's an actual infection? Then there's the question of whether there is intention. I think you are both saying that it should be both intention and actual infection.

Let me look at another scenario, an ethical scenario, for a sociologist. You have someone who has a viral load that is high, who is not on antivirals and who knows that they're infected. They engage in sexual behaviour that could transmit the disease—either vaginal or anal sex—with another individual. They're in a relationship in which they're peers, so nobody is coercing one another—and the other person says, "Are you infected with HIV? I want to make sure that you're not before I engage in sexual behaviour with you." The person lies and says, "I am not infected," in which case the person decides not to use a condom or to go ahead with something they wouldn't go ahead with, and the virus is then passed from one to the other.

There's actual infection and there is reckless behaviour. The person didn't intend to transmit the virus, but they engaged in reckless behaviour that led to the transmission of the virus. Can you explain to me why that person should not be prosecuted?

Mr. Eric Mykhalovskiy: I think whether a pattern of reckless behaviour is interpreted as intention is a legal question. What the appropriate use of the criminal law would be in that circumstance is a question that should be discussed. I don't think the argument is that there's no role for the criminal law in circumstances in which there is significant reckless, or whatever the—

The Chair: That's exactly what I'm trying to establish, Professor: that as opposed to "intentional", which everybody is using, the standard may well be "reckless".

Mr. Eric Mykhalovskiy: I can't answer that question because I don't know what the legal repercussions are of using the definition of "recklessness" in the law. You had lawyers here all week.

The Chair: We've been asking it.

Mr. Eric Mykhalovskiy: Well, then, I'm not sure that I can add much to it. When you get into that, you're asking me a question about.... I don't know what the definition of "recklessness" in law is, and what it opens the door to in terms of how it could be used in an expansive way. What we've seen in the past is that prosecutors will use whatever charge they can to secure a conviction. I think the approach is to try to encourage a parsimonious use of the criminal law in ways that are sensible, and the specifics of that constitute a question of deliberation.

The Chair: I understand. I just wanted to explain that.

Thank you very much. I appreciate all of the help we've had.

[*Translation*]

Thank you very much.

I hope it wasn't too much trouble to join us from Saskatoon.

[*English*]

Again, I really appreciate all your testimony. It was all very helpful.

We'll take a short break and move to the next panel.

I'd ask the members of the next panel to please come forward.

● (0945)

(Pause)

● (0955)

The Chair: I will resume the meeting. We are now joined by our second panel of the day.

From the Black Coalition for AIDS Prevention, Mr. Shannon Ryan, the Executive Director, is joining us from Toronto. Welcome, Mr. Ryan.

From the British Columbia Centre for Excellence in HIV/AIDS, Ms. Kate Salters is joining us by video conference from Vancouver. Welcome, Ms. Salters.

From Ottawa we have from Egale Canada Human Rights Trust, Ms. Jennifer Klinck, who is the Chair of the Legal Issues Committee. Welcome.

Ms. Jennifer Klinck (Chair, Legal Issues Committee, Egale Canada Human Rights Trust): Thank you.

The Chair: Basically, we start with the people who are on video conference first because we don't want to lose them. We're going to start with Mr. Ryan.

Mr. Ryan, the floor is yours.

Mr. Shannon Ryan (Executive Director, Black Coalition for AIDS Prevention): Great.

Good morning, everyone. I'd like to thank members of the committee for the opportunity to speak to all of you today.

My name is Shannon Thomas Ryan and I'm the Executive Director of the Black Coalition for AIDS Prevention, otherwise known as Black CAP. Black CAP is a non-profit organization with a mandate to address HIV in Toronto's African, Caribbean and black communities. We've delivered services for 30 years, and are the largest black-specific, HIV-focused organization in Canada. We work with more than 300 black people living with HIV every year.

I've led this organization for almost 13 years, and over this time I've witnessed the detrimental and significant impact that the criminalization of HIV non-disclosure has upon Canadians living with HIV and, more specifically, black Canadians living with HIV.

You've heard from a number of highly qualified witnesses about the issue, and I won't offer my thoughts on the science or the law. Other witnesses have accurately and adequately addressed advances in treatment, the science of viral transmission, the unjust nature of the law in this area and emerging thinking about appropriate responses to non-disclosure.

Black CAP strongly endorses these positions. We also endorse the brief on ending HIV criminalization in Canada recently submitted to you by the Canadian HIV/AIDS Legal Network. It reflects the thinking of our sector and sensitively considers the realities of people living with HIV in Canada.

Today I'd like to speak about the unique and specific impact that the criminalization of non-disclosure has on black people in Canada. As you may know, black people in Canada carry a significant burden of the HIV epidemic. According to the Public Health Agency of Canada, black people account for almost 22% of all HIV cases in our country, while comprising about 3.5% of the population. Black people in Canada also have highly disproportionate incident rates, about 6.4 times higher than people of other ethnicities living in Canada.

We also know that between 2012 and 2016 about a half of those charged with these crimes were black men. It's also important to highlight the media portrayal of black people in Canada charged in these cases. According to a 2016 report, black communities are differently portrayed in media narratives than others. The report cites that African, Caribbean and black men living with HIV are highly represented among racialized defendants, and while black men account for about 20% of people who have faced criminal charges related to HIV non-disclosure in Canada, they're the focus of about 62% of newspaper articles dealing with such cases. The report also indicates that there are more than 2.5 times the number of newspaper articles featuring black than white defendants. This is highly problematic.

We also know of many black defendants unjustly charged with sexual assault crimes who have been deported to their country of origin because of these charges, whether founded or not.

This tells us something very important about how black Canadians living with HIV are impacted by non-disclosure law. These realities support our assertion that black people in Canada carry a significant and disproportionate burden of the HIV epidemic and charges for non-disclosure.

I'd like to cite the recent ACCHO “Criminals and Victims?” report. Importantly, the report highlights the impact of racialization or the process by which non-white groups are designated as different and singled out for unequal treatment on the basis of their race, ethnicity, language, religion or culture. There's no doubt that the criminalization of HIV non-disclosure is a highly racialized issue when we consider the experiences of black people in Canada living with HIV. This racialization is created by sustained, institutional anti-black racism in Canada. In order to understand how the criminalization of HIV non-disclosure is a racialized issue and to develop appropriate interventions and responses, we must recognize the historical legacy of racism and injustice within which the contemporary criminalization of HIV exposure sits. Deep-seated and institutional anti-black racism has long been a feature of black people's interactions with police, courts and prisons, and for centuries in our country racist beliefs and practices have permeated our criminal justice system.

Today, the relationship between police and a broader criminal justice system and black people in Canada is more troubling than ever. We all know this. Racialized communities experience over-policing, and the practice of racial profiling is very well documented. Racialized people tend to be under-represented among lawyers, judges and juries, leading many accused people to feel that justice will not be done because the system does not understand or represent them.

Lawyers and judges are also criticized for relying on stereotypical attitudes and views of racial minorities and for failing to recognize or being unprepared to deal with issues of race and racism. As a result, although the Canadian justice system strives to provide an impartial adjudicative process that dispenses justice, regardless of race, it does not often deliver on its promise of equality, and often contributes to the marginalization of people of colour within Canada.

● (1000)

Moreover, the law has a difficult time taking into consideration the obstacles and limitations black people face within Canadian society. The criminal process is an adversarial one. Complex events, subject to multiple interpretations, are reduced to simple statements of fact. There is a perpetrator and a victim. One person is responsible; another is claiming redress. It is very difficult to fit into this tradition a nuanced and contextualized understanding of HIV disclosure, and sex and intimate interpersonal encounters, mediated with gender roles.

We would also like to reiterate that the criminalization of HIV non-disclosure in any form is at odds with public health objectives that our organization works to uphold. As it is, HIV is highly stigmatized in black Canadian communities. Black CAP struggles with discussions about the basics of HIV prevention and treatment, the importance of HIV testing and the value of disclosure. However, the legitimate fear of prosecution of black people in Canada living with HIV strongly deters people from testing, treatment and disclosure.

HIV criminalization can also deter access to HIV care and treatment by undermining Black CAP's work with people living with HIV. Prospective clients have simply chosen not to engage with health care professionals due to this environment and this makes our work much more challenging.

We strongly believe that public health approaches, especially approaches that include collaboration between front-line and community-based organizations and public health teams, are a much more appropriate response to non-disclosure. We've seen the best outcomes when Black CAP staff, who share similar identities with black HIV-positive folks, have collaborated with public health staff to provide supports, facilitate disclosure, manage viral load and reduce the likelihood of transmission to a negative partner. This is one of the ways to effectively and meaningfully address the drivers of non-disclosure. However, we do recognize that other drivers that limit one's ability to attain an undetectable viral load, such as immigration status, housing, health care and health treatment access, also exist.

You also asked witnesses to speak to the best way to improve co-operation between the criminal justice system and public health authorities. We strongly believe that there is a significant and pressing need for a frank examination of the realities of pervasive and deeply rooted anti-black racism in Canada, within these institutions. We seek your leadership in this area.

We also believe that Criminal Code reform is urgently required, in consultation with the HIV community, in order to remove the offence from the realm of sexual assault law. We are highly concerned that Canada has the unfortunate distinction of being the world leader in the persecution and prosecution of people living with HIV, and we call on the federal government to use any means at its disposal to repair the damage it has done to those living with HIV. This includes adhering to the directives from the legal networks providing briefs to this committee, calling for the creation of evidence-based prosecutorial guidelines, the reform of the Criminal Code, and resources, such as training.

We also ask that such training include a focus on anti-racism and its specific and unique impact on black and indigenous communities in Canada. This should also be done in collaboration with organizations such as the Canadian HIV/Aids Legal Network, HALCO, Black CAP and others, researchers and academics and most importantly, people living with HIV.

Finally, I would really like to recognize the advocacy efforts of leaders such as Richard Elliot from the Canadian HIV/Aids Legal Network, Ryan Peck from HALCO, Jonathan Shime and others who have represented the HIV sector in communities so ably. Their advocacy efforts have resulted in meaningful debate on this issue. Most importantly, we need to recognize black people living with HIV, who have been unjustly charged with these crimes, publicly shamed, had their lives turned upside down and spent time in prison. They have suffered the unfair impact of unjust laws. We call on you for action in this area.

Thank you, again, for the opportunity to share my thoughts on this issue. We appreciate the opportunity.

● (1005)

The Chair: Thank you very much, Mr. Ryan.

We seem to have some trouble with the connection to Ms. Salters, so we will ask Ms. Klinck to go next, and then we'll come back to Ms. Salters.

Ms. Klinck.

Ms. Jennifer Klinck: Thank you.

On behalf of Egale Canada, I would like to thank the chair and the members of the committee for the opportunity to speak today on this fundamental issue of human rights and public health.

In 2017, Egale's Just Society Committee published a report reviewing Canada's criminal justice system and identifying provisions of the Criminal Code that have a discriminatory effect on LGBTQ2SI Canadians and that are therefore in need of reform.

That report identified Canada's criminalization of HIV non-disclosure as a key area for change. Consistent with the report's recommendations, Egale fully endorses the community consensus statement of the Canadian Coalition to Reform HIV Criminalization.

In particular, Egale's position emphasizes that, first, any use of the criminal law should be limited to actual and intentional transmission of HIV. Second, in keeping with the "Expert consensus statement on the science of HIV in the context of criminal law", in no circumstances should the criminal law be used against people living with HIV who use a condom, practise oral sex, or have condomless sex with a low or undetectable viral load for not disclosing their status to a sexual partner. Third, the offence of sexual assault must not be applied to HIV non-disclosure in the context of sex between otherwise consenting adults, as it constitutes a stigmatizing misuse of this offence. Reforms must ensure that they do not further stigmatize people living with HIV or undermine protections against sexual violence.

Egale's position is informed by the reality that the criminalization of HIV non-disclosure discriminates. It disproportionately affects already marginalized populations and contributes to their marginalization.

To begin, the criminalization of HIV non-disclosure cannot be separated from the discriminatory stigma that attaches to HIV. It is important to recall the historical context. Homophobia marked the response to HIV from the outset, when the first cases of the illness were reported in 1981. At first, it was labelled "gay-related immune deficiency" or GRID.

Further, criminalization of HIV non-disclosure continues to have a disproportionately harmful impact on marginalized people, including members of the LGBTQ2SI community. Troublingly, some of these inequalities have only become worse since the Supreme Court of Canada's decision in R. v. Mabior.

As set out in "HIV Criminalization in Canada: Key Trends and Patterns", which was included in the materials submitted to the committee by the Canadian HIV/AIDS Legal Network, black men are overrepresented in the prosecution of HIV non-disclosure, especially since the Supreme Court of Canada's decision in Mabior. They are also significantly overrepresented in media coverage, contributing to intersectional stigma and prejudice.

Nearly half of the women charged with this offence are indigenous.

Criminalization of HIV non-disclosure also continues to cause particular harm to gay men, bisexual men and other men who have sex with men. According to the Public Health Agency of Canada's 2017 surveillance report on HIV in Canada, the "gay, bisexual and other men who have sex with men" exposure category continued to represent almost half of all reported HIV cases in adults at 46.4%. As such, the threat of criminal prosecution disproportionately affects the lives of gay men, bisexual men and other men who have sex with men.

As noted by the key trends and patterns document, men who slept with men represented 25% of all men charged from 1989 to 2016, and post-Mabior, the numbers increased significantly to 38%.

Finally, to date, consideration of the impact of criminalization of HIV non-disclosure on members of the trans community in Canada has been woefully inadequate. However, there are strong indications that such criminalization harms transwomen in particular.

The Public Health Agency of Canada's 2012 population-specific HIV/AIDS status report on women noted that it found no Canada-specific data on HIV prevalence among transwomen, but that a meta-analysis estimated a particularly high HIV prevalence rate of 27.7% among transwomen in North America.

Further, the academic research on the experiences of transwomen who have sex with men has found that their experiences of violence, transphobia and stigma, depressive symptoms, substance use, unstable housing and extreme poverty contribute to HIV-related sexual risk behaviour. These factors often cluster together.

● (1010)

Egale echoes concerns about the failure of HIV policies to take into account the lived experiences and perspectives of the trans community that have been raised by community activists Nora Butler Burke, Professor Zack Marshall and Professor Viviane Namaste, the research chair in HIV/AIDS and sexual health at Concordia University.

In short, people who are already marginalized face a disproportionate risk of contracting HIV. Risk factors for HIV are often interrelated circumstances of marginalization. For example, members of the LGBTQ2SI community include injection drug users and sex workers. Criminalization of these already marginalized communities only adds to their social exclusion, fuelling stigma and frustrating public health initiatives.

The LGBTQ2SI community knows all too well the harm of being criminalized based on existing grounds of social exclusion. As such, the criminalization of non-disclosure of HIV status is an issue of critical concern to the LGBTQ2SI population.

Egale is encouraged by the directive to the federal prosecution service and recognizes that it is a step in the right direction. However, more needs to be done. In terms of its content, the federal directive does not fully reflect the principles in the community consensus statement. For example, it calls for prosecutorial judgment regarding the types of activities triggering criminal liability and the use of sexual assault offences.

Further, because it is drafted as guidance to prosecutors, it does not set clear standards for what constitutes criminal conduct.

Most significantly, the federal directive, which applies only in three territories, does little to meaningfully curb prosecutions. Although the federal directive is a positive step forward, legislative action is required to ensure clear and uniform application of the criminal law across the country; to constrain the application of the criminal law to cases of actual and intentional transmission of HIV; and to build upon and make durable the federal directive's positive step forward.

Finally, while it is Egale's position that amendments to the Criminal Code are necessary, it is also essential that these be carefully considered and developed in consultation with people living with HIV, medical experts, legal experts and community stakeholders. The much needed amendments must be crafted to avoid perpetuating stigma toward people living with HIV and continuing to thwart public health initiatives.

In terms of immediate action, while a legislative solution is developed, Egale calls upon the federal government to actively encourage the provinces to adopt similar directives or directives more consistent with the community consensus statement.

Thank you.

The Chair: Thank you very much.

We still have not recovered the video connection to Ms. Salters or an audio. My suggestion is we proceed to questions and if we recover Ms. Salters, we'll give her eight minutes.

Mr. Cooper.

Mr. Michael Cooper: Thank you, Mr. Chair, and thank you to the witnesses.

I'll direct my first question to Mr. Ryan.

You stated that the criminalization of HIV non-disclosure discourages testing. What evidence do you have to back that up?

● (1015)

Mr. Shannon Ryan: From my perspective, and I'm sure there's academic evidence out there that could speak to this, it is largely anecdotal. We do hear from folks every day about the articles and stories they see in their local papers. We have many conversations with our community members about their understanding of non-disclosure law. The media portrayal and its challenging framing of often black men who are living with HIV really limits people's level of engagement with testing, treatment and disclosure. We often hear this from our clients in our organization.

I believe folks like Eric Mykhalovskiy may have spoken to some of the evidence in this area already, but unfortunately, my perspective on this is largely anecdotal.

Mr. Michael Cooper: Ms. Klinck, you stated that in terms of criminal law reform, similar to some other witnesses, the law should be reflect intent and actual transmission.

I'm still trying to understand those situations where someone who isn't on antiretrovirals, who is at a significant risk—let's put it that way—of transmitting HIV, doesn't disclose it, actively misrepresents, transmission doesn't occur, and no charges are laid, but someone who engages in exactly the same blameworthy contact is charged. Why should one person not be charged and another charged on the basis of transmission alone notwithstanding the very same blameworthy conduct?

Ms. Jennifer Klinck: I think the starting point in answering that question is to really ask ourselves why this isn't being considered as a public health issue first and foremost. Egale's position, which is entirely consistent with that of the community consensus statement, is based on the opinions of medical and legal experts and members of the community as to what will best comport with achieving the optimal health outcomes and with the general perspective that the use of the criminal law should be most exceptional in this circumstance, if at all.

Mr. Michael Cooper: So, you don't really have a problem where there is an active misrepresentation and a significant risk of transmission. That's okay?

Ms. Jennifer Klinck: I'm not sure that would be the position Egale would advance, but there's a distinction to be drawn between what should be the subject of criminal law and the types of criminal sanctions that should be imposed based on conduct that might be viewed as morally questionable. For that reason, we're relying on the extensive thought that's gone into the community consensus statement and the input from medical experts as to what is likely to lead to the best outcomes.

I do think that, when we take some extreme examples, there may be situations where what is intentional and what is reckless may coincide from the perspective of legal interpretation. There may also be room for further discussion on some of these marginal cases, but our view is that we support the community consensus statement on how to best approach the criminal dimension of HIV non-disclosure.

Mr. Michael Cooper: Mr. Ryan, do you have anything to say in response to that?

Mr. Shannon Ryan: We strongly endorse the consensus statement as well.

Speaking as a community person here, I'll say that misrepresentation is a funny thing in the context of sexual relationships. It can happen on many levels in many ways. We've all, perhaps, done it in our lives and in our relationships at some point. To frame HIV specifically and uniquely around this issue is perhaps a challenging thing to do; it's problematic.

Again, I want to say that we support the content of the consensus statement as well. We really need to consider the use of criminal law in, perhaps, only the most extreme cases when every other public health approach has been exhausted. Again, from our perspective at the organizational level, our best approach, our greatest success in getting folks to disclose, is to work closely with them in collaboration with public health teams and public health units before it advances to the level of criminality.

Mr. Michael Cooper: Thank you.

The Chair: Thank you very much.

I've been advised that Ms. Salters is now on the phone.

Ms. Salters, can you hear me?

I guess I was not correct about that.

We will move to Mr. Boissonnault.

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

Thank you to the witnesses who presented today.

I'll turn quickly to Egale and Ms. Klinck.

We heard from Dr. Tyndall from the BC Centre for Disease Control last week that it is entirely within the purview of the public health statutes across the country...that when somebody's engaging in reckless behaviour, there are all kinds of statutes that the public health authorities can use, from basically saying, “no more contact with people”, all the way to quarantine, and that applies to TB, to Ebola. Shouldn't we be using the public health authorities in the kind of case that Mr. Cooper raised?

● (1020)

Ms. Jennifer Klinck: That's a really good point. Public health regulations and statutes already create a framework for managing issues that are truly matters of public health, and they also provide opportunities for enforcement and some involvement of the state in telling people what to do. There is a real question as to why HIV non-disclosure receives this peculiar treatment as the subject of criminalization.

Mr. Randy Boissonnault: You and I would agree, and I would go further and say “discriminatory”.

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Mr. Ryan, would you agree with my assertion that the public health authority has all kinds of authorities and parameters to contain somebody who's doing what Mr. Cooper said earlier?

Mr. Shannon Ryan: It absolutely does. There's no doubt about that.

Mr. Randy Boissonnault: Thank you.

I have six minutes, so I'm going to go to rapid-fire questions between the two of you.

Mr. Ryan, how many people does your organization see on a daily basis, roughly?

Mr. Shannon Ryan: People living with HIV?

Mr. Randy Boissonnault: How many people?

Mr. Shannon Ryan: Probably 20 to 30.

Mr. Randy Boissonnault: You see 20 to 30. So, you would see 100 to 150 in a week.

Mr. Shannon Ryan: Yes.

Mr. Randy Boissonnault: What percentage of those people would say that the criminalization of HIV status prevents them from getting tested—a rough percentage?

Mr. Shannon Ryan: It's probably 100% for those who are aware of the criminal—

Mr. Randy Boissonnault: So, 100 to 150 visits times 50 weeks, would it be 5,000 people who are not getting tested right now because of the criminalized status of HIV, in your opinion?

Mr. Shannon Ryan: Yes, it absolutely deters people from testing.

Mr. Randy Boissonnault: Thank you very much.

I have a question for both of you. I want to bounce back and forth.

Ms. Klinck, first of all, do you agree that criminalization of non-disclosure of HIV status prevents people from being tested?

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Mr. Ryan you've already said so, correct?

Mr. Shannon Ryan: Yes.

Mr. Randy Boissonnault: Ms. Klinck, do you believe that, if the over-criminalization of HIV status were taken out of the Criminal Code, more people would seek their status, more people would be tested?

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Mr. Ryan.

Mr. Shannon Ryan: Absolutely, and I'd add to that. It would increase rates of testing, but it would also increase access to treatments.

Mr. Randy Boissonnault: That was my next question.

Do you think that if more people knew their testing and their HIV-positive status, more people would get treated in Canada?

Mr. Shannon Ryan: Yes, absolutely.

Mr. Randy Boissonnault: Ms. Klinck, do you think that's the case?

Ms. Jennifer Klinck: Yes, criminalization and stigma do not help access to treatment.

Mr. Randy Boissonnault: Let's be very clear for the record. If more people knew their HIV status, would more people get treatment in this country?

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Would that help us get beyond 90-90-90 to 100-100-100, Mr. Ryan?

Mr. Shannon Ryan: Ideally, yes, if there are a number of important components in place, including universal access to treatment and a number of other things.

Mr. Randy Boissonnault: Thank you.

Ms. Klinck.

Ms. Jennifer Klinck: Would it help?

Mr. Randy Boissonnault: Would it help us to get to higher numbers?

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Yes. I'm not saying it's a panacea. Great.

Let me ask this question. Do you think that non-disclosure of HIV status should no longer be considered a sexual assault in the Criminal Code?

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Mr. Ryan.

Mr. Shannon Ryan: Absolutely.

Mr. Randy Boissonnault: It should no longer be.... Thank you.

I'm going to test four thoughts with you.

Based on the science we have now, at this point in time, would you agree that nobody should be prosecuted if the following conditions apply: that they had an undetectable viral load; that a condom was used; that the infected partner is on PrEP or a similar preventive medicine; and finally, that the type of sexual act, like oral sex, is one where there is a negligible risk of transmission? Would those be conditions under which people should not be prosecuted?

Mr. Ryan.

Mr. Shannon Ryan: Yes.

Mr. Randy Boissonnault: Ms. Klinck.

Ms. Jennifer Klinck: Yes.

Mr. Randy Boissonnault: Let me ask you this question. If we could say that lying about status were considered a reckless act, and that was combined with actual transmission, could that kind of scenario be where the criminal law could step in?

Ms. Klinck.

Ms. Jennifer Klinck: I'm not prepared to take a position on that without—

Mr. Randy Boissonnault: It's okay.

Ms. Jennifer Klinck: —further engagement with the community, because I know that the consensus is around intent.

Mr. Randy Boissonnault: Yes.

This is where—and I'm going to get to you, Mr. Ryan—intent is a challenging area in the law, right? We get into issues of morality when we start to use things of intent.

What we're trying to do is isolate the difference between reckless behaviour, which we have provisions for.... Mr. Virani mentioned vitiating consent through fraud.

Intent gets us into issues of, "Oh, you bad person. You have HIV +. You lied. You intended to transmit." There are a whole lot of value judgements in there that are very tough to prove in law, so what we need to do on our side is understand the definitions around reckless behaviour.

I'll tell you my personal opinion. I think reckless behaviour plus transmission should be the standard. It's a high standard, and it would be a high standard to prove.

Mr. Ryan, do you have any thoughts on those two combinations?

● (1025)

Mr. Shannon Ryan: I'd say two things. Reckless behaviour that's demonstrated to be repeated and intentional after all other public health approaches have been exhausted seems like an appropriate approach.

Mr. Randy Boissonnault: Ah, thank you.

Mr. Shannon Ryan: I would also say that I've worked with hundreds of black people who are living with HIV over my career at Black CAP, and one of the biggest concerns of the folks who I've worked with is transmission to a negative partner. Folks living with HIV are often framed as reckless and determined to negatively impact public health. I would say that is absolutely the farthest thing from the truth. People stress about the possibility of transmitting to a negative partner and are highly concerned about the health of their partners, as well.

Mr. Randy Boissonnault: Thank you. I have to pause you there; I have 15 seconds.

Ms. Klinck, would a federal-provincial-territorial meeting of the justice ministers to talk about the directive being applied in more provinces help, in your opinion?

Ms. Jennifer Klinck: Yes, absolutely.

The Chair: Thank you very much.

We're going to try one more time to see if Ms. Salters is now available by phone.

Ms. Salters, can you hear me?

Okay, we'd been told that she was there, but I guess not.

We're moving to Mr. Garrison.

Mr. Garrison.

Mr. Randall Garrison: Thank you very much, Mr. Chair. After Mr. Boissonnault's rapid-fire questions, I think we all need to take a deep breath.

I do want to say that I know the justice committee has to look at extreme cases, but I don't think this is the point in our deliberations where we should be looking at the extreme cases. What we're trying to do, I believe at this point, is give some shape to what the reform is going to look like and how the reform might proceed. I think that there is an inadvertent danger in focusing on those marginal cases, that we actually contribute to the stigmatization and marginalization again.

As I've said before, I'm a gay man of a certain age, and I've lived all my life with gay men who are trying to do evil in society, and it is particularly true, I think, in the black community as well.

Towards the end of your presentation, Ms. Klinck—

Ms. Kate Salters (Research Scientist, British Columbia Centre for Excellence in HIV/AIDS): Can you hear me?

The Chair: Ms. Salters, Mr. Garrison is in the middle of a question round right now. We're going to come back to you in about five minutes, if we're able to hear you properly.

Mr. Garrison.

Mr. Randall Garrison: Thanks very much.

Ms. Klinck, toward the end of your presentation, I believe you talked about the criminalization of sex work and the criminalization of possession of drugs for personal use.

Can you come back to that and maybe spend a bit more time on the connection you see between that and the criminalization of non-disclosure?

Ms. Jennifer Klinck: The important point here is that social determinants of health are often interrelated. One of the points we have tried to draw attention to is the failure to take into account the experiences of particularly transwomen in work on HIV. We also want to point out that for members of the LGBTQ2SI community who may also be sex workers, or who may also be injection drug users, the criminalization of that behaviour as well tends to contribute to their social exclusion, marginalization and difficulty accessing health care.

Mr. Randall Garrison: Mr. Ryan, would you like to comment on that same issue of the relationship between criminalization of sex work and injection drug use? I know you work on prevention of HIV AIDS, so can we hear from you on that topic?

Mr. Shannon Ryan: I really concur with the other witness on this issue. I don't know that I could say too much more than that.

Mr. Randall Garrison: Sorry, did you say that you do concur?

Mr. Shannon Ryan: Yes.

Mr. Randall Garrison: Okay.

Again, toward the end of Mr. Boissonnault's question, he talked about a federal-provincial meeting and asked for just a very rapid answer to that.

Ms. Klinck, with the limited nature of the current directive, we now are in a situation where people may be treated quite differently depending on where they live in the country. Can you comment on that and how a federal-provincial meeting might address that?

Ms. Jennifer Klinck: Yes. It's absolutely a concern that the directive as it now stands only applies in the three territories. In fact, that may create the risk that people misunderstand the degree to which they are at a threat of criminalization.

Increasing co-operation with the provinces to extend the application of the directive, which is imperfect for sure and needs to go further, but as an immediate measure, trying to have that actually apply in a more coherent fashion across the country is an important immediate step.

● (1030)

Mr. Randall Garrison: What would you envision as an outcome of that meeting? Could it be something such as a statement or a directive in all the provinces that said, until there's reform, prosecutions should focus only on intent in transmission? Is that what we're seeing as an outcome?

Ms. Jennifer Klinck: Similar directives could be adopted in the provinces to allow for much better coherence with the federal directive, or they could be mirroring or they could go further.

Mr. Randall Garrison: Mr. Ryan, do you think the federal directive has had any impact in your community? Are people aware of the directive in the territories, or are they not aware of this and still believe that, in fact, they will be prosecuted?

Mr. Shannon Ryan: I think there's a strong belief among many of the folks we work with. We try to educate folks as much as possible about the often-changing nature of the law in this area. We try to work with them to deepen their understanding, but folks are walking around with so many assumptions about what the law says and what the law does not say. There's a fair amount of confusion, and these regional differences absolutely contribute to that at this point.

It is an arcane subject and issue for many folks. It really is. Folks are dealing with the complexities of treatment, and in many cases of our clients, the complexities in settlement in Canada. This is another complexity within which people must engage. There is a lot of confusion and the need for a lot of clarity.

Mr. Randall Garrison: Would you say that certainly in the racialized communities in Toronto, better access to things such as point-of-care testing, and perhaps self-testing, would help with particularly men who have sex with men getting to know their status?

Mr. Shannon Ryan: Yes, absolutely. We do know there are a good number of folks who are HIV-positive and are not diagnosed. Increased access to testing absolutely supports our work in this area.

We want to really get people engaged in something called the cascade. We want to get people diagnosed. We want to get them in treatment. We want to have them sustained in treatment. We want them to achieve an undetectable viral load. This reduces the overall burden of HIV in all communities, including within the gay male community.

Mr. Randall Garrison: Thank you.

The Chair: Thank you very much, Mr. Garrison.

Ms. Salters, can you hear me now?

Ms. Kate Salters: I can.

The Chair: Perfect.

Before we get to our last round of questions, we're going to give you the opportunity now to do your presentation to the committee.

The floor is yours, Ms. Salters.

Ms. Kate Salters: Thank you. I hope you can hear me. Please let me know, or interrupt me, if you cannot.

Good morning, everyone.

My name is Kate Salters. I'm a Ph.D. trained infectious disease epidemiologist working as a research scientist at the B.C. Centre for Excellence in HIV/AIDS and a faculty member at Simon Fraser University within the faculty of health sciences.

Thank you very much for inviting me to speak with you, despite the technical difficulty.

I would like to first acknowledge the land and territories on which we gather today. It is critical to reflect on the role of colonialism in the disproportionate burden of HIV among indigenous populations nationwide.

During my brief time with you, I hope I'm able to impress on you the overwhelming evidence that challenges the criminalization of non-disclosure of one's HIV status. I will demonstrate how the law poses direct and significant barriers to our prevention efforts and provides barriers to clinical care for those living with HIV.

I'm here on behalf of and speaking on behalf of many other scientists, community members and clinicians with whom I have consulted who have witnessed the impact these laws have on our communities and the way they threaten our public health efforts.

Quite frankly, the law does not reflect reality or science. There is overwhelming scientific evidence demonstrating that when a person living with HIV is on treatment, antiretroviral therapy, not only does their health and longevity improve, but HIV replication is halted. Antiretroviral therapy drives HIV to undetectable levels in biological fluids, including blood, semen and cervical-vaginal fluid. Having an undetectable viral load is the goal of antiretroviral therapy and means that HIV cannot be transmitted to a sexual partner. I know you've heard this before, but it's very important to reinforce. This double benefit of antiretroviral therapy is known as “treatment as prevention”, or TasP, a made-in-Canada strategy formally endorsed by the World Health Organization, the UN and the Government of Canada since 2015.

My organization originally postulated the TasP strategy in 2006. Implemented in B.C., it has subsequently led to the largest decline in new HIV cases in this country. This phenomenon is not new. In 2014, 70 Canadian scientists signed a joint statement affirming the negligible possibility of sexual HIV transmission by a person living with HIV who is receiving antiretroviral therapy or uses a condom. This was five years ago. There have been at least 12 non-disclosure cases since then.

That was as of 2017, as reported by the Canadian HIV/AIDS Legal Network. Since then, major international studies have definitively confirmed that consistent and sustained antiretroviral therapy stops the onward transmission of HIV. Most recently, the partner study assessed HIV transmission amongst zero-discordant gay couples, meaning one partner was living with HIV on treatment and the other was HIV-negative.

Scientists measured more than 77,000 episodes of sex in which a condom was not used. How many transmission events were observed between study participants? There were none—zero cases. To add, previous partner studies have shown no cases of HIV transmission between zero-discordant gay and straight couples after observing over 58,000 acts of condomless sex. In other words, undetectable means HIV is untransmittable, or U=U.

The Honourable Ginette Petitpas Taylor acknowledged the science behind the U=U message to end stigma and in 2018 became the first minister of health to officially endorse the campaign, demonstrating Canadian leadership on science-informed health policy.

In stark contrast to these efforts, the current Criminal Code perpetuates HIV-related stigma, leading to significant delays or total lack of testing. As a result, individuals living with HIV will not initiate treatment in a timely manner that eliminates the risk of onward HIV transmission. The virus rapidly replicates during acute or early infection. Eliminating delays to diagnosis and connecting people to care are the steps needed to eliminate the HIV epidemic in Canada.

Women are especially at risk of delays in access and care. This is linked to many factors, including HIV-related stigma, poverty and poor understanding of the needs of women living with HIV.

A study conducted by our organization found that of nearly 1,000 participants, significantly more men than women living with HIV, 65% versus 45%, reported fulfilling the current legal requirement to have both a low viral load and condom use with a new sexual partner. This was despite the fact that nearly 100% of the participants reported doing either one or the other. This means that despite taking the established steps needed to guarantee the elimination of transmission risks, more than half of the female participants in our study could have been at risk of being charged with aggravated sexual assault.

● (1035)

The current law fails to address how women, particularly cis women and transwomen, may not be able to safely negotiate condom use with their sexual partners. These real, gendered risks are not reflected in the current interpretation of the law. Research conducted by me and colleagues found that over 80% of women living with HIV in B.C. have reported experiences of violence in their lives. Similar studies have been published, across the national cohort of over 1,400 women living with HIV, showing very similar statistics. More recently, we have shown that over 60% of women living with HIV have experienced sexual or physical intimate partner violence, suggesting huge inequities in sexual relationships. Women have reported being threatened, assaulted, abandoned and outed as being HIV-positive after disclosing their HIV status to sexual partners. Women living with HIV may, then, instead choose to take actions within their control in order to eliminate the risk of HIV transmission onward by maintaining an undetectable viral load, or using condoms.

It is naive and inappropriate to assume that women living with HIV should be legally required to ensure that their male sexual counterparts use condoms. Under the current interpretation of the law, a woman with undetectable HIV who is unable to convince her male sexual partner to use a condom may be charged with aggravated sexual assault. She would then be classified as a violent sexual offender despite having no intention of transmission and there being no risk of HIV transmission. Nevertheless our research shows women living with HIV are doing everything in their power, through adherence to antiretroviral therapy and sustained virologic suppression, to eliminate the risk of onward HIV transmission.

Relying on an undetectable viral load is an empowering and effective way for women living with HIV to reduce the risk to themselves and others. Aggravated sexual assault is among the most serious offences within the Criminal Code and should be applied when the perpetrator wounds, maims, disfigures or endangers the life of the complainant. This law has been used by disgruntled former partners as a form of violent retribution against people living with HIV. This law stigmatizes people living with HIV. This law prevents people from getting tested and treated. It is imperative that we stop erroneously using this law to criminalize the sexual behaviour of people living with HIV.

Thank you for your time.

● (1040)

The Chair: Thank you very much. I'm really glad we finally were able to get that connection working.

We have one more question, which is from Mr. McKinnon.

Mr. McKinnon, the floor is yours.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair, and thank you, witnesses, for being here.

Thank you, Ms. Salters, for hanging in with us to give your testimony. Unfortunately, at this point most of my questions are directed elsewhere.

I'm going to start with a question that Mr. Boissonnault has asked me to ask Mr. Ryan.

You thought the lightning-fire questions were over. They're not.

In accumulating statistics, Mr. Ryan, about the number of contacts you have per day, how many days a week are you open?

Mr. Shannon Ryan: Five days a week.

Mr. Ron McKinnon: Thank you.

I'd like to carry on with Ms. Klinck.

You indicated the federal directive doesn't go far enough. Certainly it only applies to the territories. But assuming a similar thing would be applied elsewhere in the provinces, you said that it's imperfect and needs to go further.

How should it be changed?

Ms. Jennifer Klinck: The primary difficulties with the directive are that it still requires prosecutorial judgment regarding the types of activities that will trigger criminal liability, so there is room for prosecutions based on conduct, such as sex with a condom, depending on the vague sense of other risk factors that aren't defined in the directive. That leaves the directive unclear and it is inconsistent with the community consensus statement that says where a condom has been used, there shouldn't be criminal liability.

It also still contemplates the use of sexual assault offences, again based on the exercise of prosecutorial judgment, based on factors that aren't clear. Given that the community consensus is against sexual assault offences being used for simple HIV non-disclosure, those are certain defects with the directive as it currently stands. Of course, the basic point that a directive is less clear than amendments to the Criminal Code, because it's just guidance for prosecutors, is a more long-term concern. If we could have the directive or a better version of the directive applied on the national scale that would be an improvement. But, ultimately, legislative reform is the only way to ensure clarity and consistency in the application to the criminal law.

Mr. Ron McKinnon: I guess I'm focusing on the HIV directive at this point, because at this point in Parliament, there is no chance of changing the law. Improving the HIV directive is something that could be done sooner, and it could be propagated by the other attorneys general across the country.

Thank you for that answer. I'll switch to Ms. Salters.

I know this is not your field of expertise, but are you aware of whether or not there is an HIV directive, or similar approach, issued by the attorney general in British Columbia?

Ms. Kate Salters: Yes, there is a directive in this province.

Mr. Ron McKinnon: Is it similar to the federal one? Do you think it's an appropriate directive?

Ms. Kate Salters: It's a step, but it doesn't go far enough.

As the other speakers have mentioned, it needs to be applied consistently. It's a step, but what we've called for is that public health does not warrant criminal sanctions for sexual behaviour.

Mr. Ron McKinnon: Are there any circumstances in which the criminal law should apply? I agree with everyone who has testified, basically, that sexual assault provisions should not apply in any case. I'm wondering if, in any case, criminal negligence causing bodily harm might not be more appropriate. In what circumstances might that be?

Ms. Klinck.

Ms. Jennifer Klinck: The point was previously made by Mr. Boissonnault that public health legislation already provides for a device to respond. Egale has serious concerns about the criminalization of HIV non-disclosure in general and particularly outside the context of actual and intentional transmissions.

● (1045)

Mr. Ron McKinnon: Are you saying that in no circumstances should the criminal law be applied?

Ms. Jennifer Klinck: Criminalization should be seriously questioned, and the only circumstance in which it should be even contemplated is actual and intentional transmission.

Mr. Ron McKinnon: Mr. Ryan, would you agree?

Mr. Shannon Ryan: Yes, I think so. The intentional transmission, as I said earlier, after every other public health approach has been exhausted. We've been most successful in addressing challenges with disclosure when we've collaborated with public health units as an organization, and been able to have real conversations, really through a cultural lens, with folks who are struggling with disclosure. Intentional transmission is incredibly rare, in my experience. It's not something we see much of, at all. Only in the rarest of cases do I believe this happens.

Mr. Ron McKinnon: Ms. Salters, would you agree?

Ms. Kate Salters: I do. There are rules at the disposal of health officials to identify and control the very rare instances where there is intentional transmission. I would agree that, in my work as an epidemiologist working to get past the 90-90-90, using laws which criminalize non-disclosure are a direct and very significant barrier to our efforts to diagnose, treat and support the health and livelihood of people living with HIV. It would be in direct contrast to our public health effort.

Mr. Ron McKinnon: Thank you.

The Chair: Thank you very much, Mr. McKinnon.

I want to thank this panel of witnesses. You've all been very helpful. Ms. Klinck, we'll see you again on Thursday, in your regular performance before the committee.

We are going to have our own in-committee meeting to have discussions, shortly. I'll suspend for about three minutes, and I'll ask everyone else to clear the room.

Thank you very much, and thanks again to the panel.

[*Proceedings continue in camera*]

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