Vanquishing the Victim:

The Criminalization of HIV non-disclosure and transmission in Canada

by

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Abstract

This thesis examines the legal complexities surrounding the criminalization of HIV non-disclosure and transmission in Canada, where, by law, an HIV-positive person (PHA) is required to disclose his or her HIV status before engaging in sexual activities where a potential risk of exposure to the virus exists. In analyzing how HIV/AIDS is treated under the Criminal Code, the thesis will focus on the HIV narrative over the past three decades; the rationale behind HIV criminalization; how media coverage of HIV has incited bouts of moral panic in society; the historical legal framework; the evolution of HIV non-disclosure laws; how past precedents have affected cases heard to date; and, importantly, the role of public health and the consideration of human rights in relation to HIV criminalization.

The criminalization of HIV non-disclosure and transmission is a complicated issue. Using the law as a HIV prevention tool is a blunt instrument that places the sole responsibility of disclosure on the PHA, and increases stigma and discrimination around people living with and affected by the virus. Although using criminal law to prosecute PHAs for non-disclosure may be necessary in situations where a person is blameworthy and the intent to harm another person can be proved, creating a policy framework would allow for clarity, protection of individual rights, public education and consistency in the application of the law.

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Acronyms

ACO	AIDS Committee of Ottawa
ASO	AIDS Service Organization
ART	Antiretroviral Therapy
AP	Associated Press
CARE Act	Ryan White Comprehensive AIDS Resource Emergency Act
CBSA	Canada Border Services Agency
CDC	The Centers for Disease Control and Prevention
CPS	Crown Prosecution Service
GPA	Global Program on AIDS
HALCO	HIV&AIDS Legal Clinic of Ontario
LTO	Long-Term Offender
MMWR	Morbidity and Mortality Weekly Report
NGO	Non-governmental Organization
OAPA1861	Offences Against the Person Act 1861
OCDC	Ottawa Carleton Detention Centre
OPS	Ottawa Police Services
PHAs	People living with HIV/AIDS

REPEAL	Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act
STI	Sexually transmitted infection
UNDHR	Universal Declaration of Human Rights
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDHR	United Nations Declaration on Human Rights
WHO	World Health Organization

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Introduction

October is called the “suicide” month for a reason. There is no shelter from the relentless, razor-like rays of the sun, which rapidly turn the lush green savannah into a dry, dusty wasteland. This is Zambia in the heat of the African summer, where the hope of rain is non-existent, a time when people huddle in the shadows for refuge.

Sarah Banda is a slight woman whose skin so closely traces the outlines of her bones that standing upright she resembles a walking skeleton. It is early morning when Sarah sits on the edge of the veranda looking up at the sky, praying she will make it through another day. Occasionally she breaks into a dry coughing fit, her body wracked by convulsions until the coughing stops. Her skin is pockmarked by the white rashes that erupt every three weeks; she does not understand what is happening, but she knows that each time the rash appears she becomes so tired that she cannot work. Instead of getting up each day to look after her two young *muzungu*¹ boys, she must remain either in a recumbent position or sitting still, as each little movement takes her breath away. On the days she is sick, her daughter Sophie looks after the young boys while Sarah watches silently. Everyone knows that if the boys fall and graze themselves, or if they hurt themselves and there is any bleeding, Sarah must not touch them—that is forbidden by the boys’ mother.

It is 1998, and Zambia is in the midst of the AIDS crisis. One in four adults is HIV-positive, and the number of AIDS-related funerals has reached an all-time high in the

¹ Bemba Slang for European.

capital city of Lusaka. No one says the words “HIV” or “AIDS” out loud; rather, it is referred to as the “slim” disease. The Zambian media says little about the disease, how it is contracted, and what can be done to prevent it from spreading. Newspaper articles skim over stories of people battling the “slim” disease and instead focus on the number of people dying.

The aid organizations that flock into Lusaka are responsible for implementing HIV-prevention initiatives. The non-governmental organizations are the ones that sponsor the big yellow billboards on Cairo Road promoting *Maximum* condoms—condoms that are given out free to anyone who will take them. The aid organizations also set up health clinics offering free HIV tests and counselling to couples and individuals brave enough to enter the whitewashed buildings. Once someone sets foot inside the door they know they will be stigmatized, and that rumours will circulate throughout the community that they have the “slim” disease.

Sarah was my two sons’ nanny. She had been with them since they were babies crawling on the red-painted concrete floors, their little knees covered in oily polish. Sarah was the person who would help them get out of bed in the morning and dressed for school. She was there when they came home from school, and she was the one who made them peanut butter sandwiches when they needed a snack. But then Sarah fell ill and all that changed. Sarah was HIV-positive, and although at times she could hardly function, she refused to go to the clinic for testing and counselling, even though she knew she could get better with Antiretroviral Therapy (ART) and would no longer have to suffer through three-week bouts of intense pain. Sarah was simply afraid. She was

afraid of being labelled as having the slim disease, because everyone would know, and no one would come near her or her family; they would be stigmatized and become outcasts. All Sarah wanted was for her own children to be safe, and to be looked after when she died, which she knew she would, since everyone knew that death followed the contraction of the slim disease.

Sarah died in 2002, when sub-Saharan Africa was the epicentre of the AIDS epidemic. She died in an age where, in the Global North, the threat of terrorism was greater than the threat of an infectious disease; where people living with HIV had access to Antiretroviral Therapy (ART), which helped them live longer and without the hovering threat of death. In Zambia, Sarah's life was marked by her ill-health and her fear of being stigmatized and ostracized by society because she was HIV-positive, and her death was another statistic in the growing number of mortalities due to AIDS-related illnesses. If Sarah had lived in Canada, she would have had access to ART, her quality of life and life expectancy would have improved, and her children would not have been abandoned as orphans, unable to fend for themselves. Yet living in Canada would still have meant that Sarah would have been stigmatized; she would still have been regarded as a potential criminal in the eyes of the law. I would never have thought that Sarah, or anyone I have known to be HIV-positive, would be labelled a criminal—until 2009, when I watched a young man dressed in a black and white prison uniform speak to a small crowd on Parliament Hill in Ottawa.

Standing on a makeshift podium, clutching a papier-mâché ball and chain, the man, whom I came to know as Michael Burtch, was protesting the criminalization of HIV

non-disclosure and transmission in Canada. Burtch's words resonated with me. He described how he had been called a murderer, a sex offender, a whore, a faggot, a public health nuisance and a criminal because, as an HIV-positive gay man, he advocated that sexual health is a shared responsibility, and he was outspoken about his sexual experiences—with and without condoms.

“There is nothing more threatening than someone who is HIV-positive, sexually active, confident in their sexuality, unapologetic, not portraying themselves as a victim— some people find that threatening,” said Burtch in a February 2015 interview, adding that many people do not understand how HIV is transmitted, and that they are scared of speaking about it because “people respond emotionally to a complicated issue.”

Burtch and his public protest introduced me to the lived realities of the criminalization of HIV non-disclosure and transmission in Canada. Once again, the narrative surrounding HIV/AIDS became part of my life, and the more I understood about the criminalization laws, the more I wanted to learn. Through Burtch, I have been introduced to many HIV-positive people who have helped me begin to comprehend what it must be like to live as a potential criminal under the law. Being HIV-positive means living a life marred by medical complications, legal impediments and social hurdles—a life where the discrimination and stigma surrounding HIV/ AIDS not only continues, but is intensified by HIV criminalization laws. Although HIV may no longer be a death sentence (if an individual has access to and complies with treatment), an HIV-positive person is still considered deviant, and this social marginalization is further

exacerbated by the ever-present threat of criminal charges because of laws that compel individuals to disclose their HIV-positive status. The criminalization of HIV non-disclosure and transmission is a complicated issue that is too often viewed within the simplified context of good versus evil. But in this scenario, people living with HIV and who are aware of their HIV-positive status are, by default, evil.

This thesis will examine the complexities of the criminalization of HIV non-disclosure and transmission in Canada, where a disease is regarded as a weapon, and an ill person as a perpetrator. Although the issue of HIV criminalization is well known and understood by many academics and researchers, HIV advocates and activists, medical and public health professionals, and criminal lawyers and federal prosecutors, the subject remains unfamiliar to many members of the public.

The evolution and complexity of the issues surrounding HIV non-disclosure obscure the nuances of what is right and wrong in law, and the notion of how the criminalization of non-disclosure protects ordinary citizens is lost in legal jargon. While this thesis will use academic papers and legal documents as its foundation, the larger unheard story of how HIV non-disclosure laws affect individuals will be told through interviews I have conducted with people living with HIV, activists who advocate for changes in the laws, academics who have researched the implications of the laws, lawyers who have argued HIV-related court cases, and with one individual who is facing the maximum sentence of life imprisonment for not disclosing his HIV-positive status to a sexual partner.

This thesis will examine how HIV/AIDS is treated under the Canadian criminal code by focusing on the historical legal framework and policy context around the criminalization of HIV non-disclosure and transmission in Canada. The thesis will also examine the rationale behind the criminalization laws, and in so doing will assess whether the original intent of the precedents set by common law has been changed, and whether the use of the HIV non-disclosure and transmission laws is on the increase. The thesis will further examine whether the criminalization of HIV non-disclosure and transmission undermines the social, political, and economic solidarity necessary to combat HIV, and thus violates individual human rights. In addition, the thesis will critically explore how the media has covered HIV/AIDS over the last three decades by investigating whether HIV criminalization cases are conveyed in a way that incites “moral panic” (Hall, Critcher, Jefferson, Clark, & Roberts, 1978) in society, and by illustrating how fear and panic play a role in defining news around HIV. Finally, the thesis will explore Canada’s position on HIV non-disclosure and transmission within the global context.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), there are currently 35 million people living with HIV in the world. The widespread use of the criminalization of HIV non-disclosure and transmission affects HIV-positive people living in countries where punitive laws are touted as an alternative HIV prevention method. Despite the growing evidence that punitive measures are not an effective HIV prevention method, governments around the world are adopting criminalization laws without acknowledging current medical and scientific advancements that minimize the

risk of HIV transmission. As a result, as Stephen Lewis articulated in a speech to mark the end of the XIX International AIDS Conference in 2012, “We are drowning in statutes, criminal law, legislation, public statements that demonize whole swaths of humankind.”

By examining the criminalization of HIV non-disclosure and transmission in Canada and its impact on HIV-positive people, this thesis will contribute to the understanding and analysis of the legal, human rights and public health literature on the global trend towards the criminalization of HIV non-disclosure and transmission; it will guide the reader through the complex maze of legal and public health arguments that form the framework of the HIV criminalization laws in Canada and the court rulings that mold the legal foundations of the laws; and it will familiarize the reader with the human rights concerns, public health fears, and the social barriers facing people living with HIV.

Chapter 1 will introduce the reader to Steven Boone, a gay man in his 30s, who was arrested for not disclosing his HIV-positive status. Boone, who was tried and found guilty of aggravated sexual assault, administering a noxious substance, and attempted murder, has been in the Ottawa-Carleton Detention Centre (OCDC) since 2010, and is currently awaiting sentencing. Boone was interviewed at the OCDC once a week, for 20 minutes, from March to May 2015. He shared stories about growing up, coming to terms with being gay, how he contracted HIV, his experiences during the trial, and his time in the OCDC. Through the interviews and an in-depth study of Boone’s case, the chapter introduces the reader to the implications surrounding Canada’s legal policy on HIV non-disclosure. As well, the chapter describes what it is like to live with a life-long disease, and how the legal requirement to disclose affects an HIV-positive person. It also

explores how public health authorities have become allies with the police in arresting people on non-disclosure allegations, and the fears expressed by HIV advocates concerning how the law is interfering with HIV prevention efforts.

Chapter 2 will take the reader back to the 1990s, when the AIDS epidemic was at its height in the Global North. It will show how fear of contracting HIV and misunderstanding about how HIV was transmitted cast the legal system into the role of protector against the disease. The chapter will illustrate the convoluted history of the criminalization of HIV non-disclosure and transmission in Canada by analyzing the initial legal justification of the laws and how they have evolved from the initial intent of protecting the public from an infectious disease into the current legal framework, where an individual's failure to disclose his or her HIV-positive status is regarded as a crime. The chapter will further highlight key HIV-related court cases from the 1990s to 2014, where the verdicts issued by the respective justices resemble the chaos of the court scene in Lewis Carroll's *Alice's Adventures in Wonderland*, and will examine how the Supreme Court of Canada's ruling in high profile HIV-related cases set the legal stage for the criminalization of HIV non-disclosure and transmission in Canada.

Chapter 3 will introduce the conflict between public health and the legal system. It will show how AIDS, at the height of the worldwide pandemic, was transformed from a public health concern into a human rights issue. The chapter will examine how human rights have evolved from the eighteenth century concept of the rights of man into the current framework, where individual rights include having access to HIV treatment prevention; it will describe the legal and human rights framework surrounding

treatment and prevention; and it will examine the issue of whether using punitive measures as an HIV prevention method forces public health and the law into opposite corners of the healthcare arena, where the rights of persons living with HIV are juggled between the two. How the HIV criminalization laws have encroached on efforts to eradicate the stigma and discrimination surrounding HIV will also be addressed.

Chapter 4 will critically explore and analyze how the media have covered HIV/AIDS since the disease was first discovered in the 1980s. It will demonstrate how media coverage of the disease echoed the prevailing mindset at the time, when HIV was associated with deviant sexual behaviour and intravenous drug users. The chapter will look at the social production of news by Western media within a cultural studies framework, where agenda-setting, gatekeeping and news framing of HIV/AIDS have instilled fear and moral panic in society. The chapter will demonstrate how Stuart Hall's (1978) concept of moral panic is reinventing itself by focusing on the local media coverage around the arrest and trial of Steven Boone, and how news stories about Boone echo the rhetoric of the 1980s. Also included are timelines of the HIV/AIDS narrative that mark milestones in the history of the disease and a chart highlighting key headlines used by the local media following the Boone case.

Chapter 5 will demonstrate Canada's position on HIV non-disclosure and transmission in the global context. It will first examine how the principles governing criminal theory have been used to justify the criminalization of HIV non-disclosure, exposure and transmission. The chapter will investigate the stance of the United Nations on the global increase in HIV criminalization laws and outline the different initiatives and

recommendations presented by the international organization and its affiliates. It will then highlight how some countries in the Global North—namely, England, Wales and the United States—have implemented different HIV criminalization laws.

Finally, Chapter 6 will analyze how Canada's current position on the criminalization of HIV transmission no longer serves the original intent to protect the public from an infectious disease. The chapter will summarize the complexities of the criminalization of HIV non-disclosure and transmission in Canada, where a disease is regarded as a weapon, and an ill person as a perpetrator. The chapter will examine how people accused of HIV non-disclosure have been charged and convicted for offences under the Criminal Code of Canada, and how the application of these laws perpetuate stigma and discrimination. The chapter will advocate for changes in the criminalization of HIV non-disclosure and transmission laws in Canada, summarizing recommendations from global organizations addressing HIV criminalization, and arguing that prosecutorial guidelines—which serve to protect persons living with AIDS, assist police services and Crown prosecutors in assessing potential cases, and provide the media with editorial guidelines—should be put in place to govern procedures around HIV criminalization. By examining Canada's non-disclosure laws and their impact on HIV-positive people, this thesis will contribute to a journalistic analysis of the legal, human rights and public health literature on the global trend towards the criminalization of HIV non-disclosure.

Chapter 1

A Voice from the Shadows: A Criminal under Canadian Law

The upcoming fifth anniversary of my arrest is weighing heavily upon me. It is a very emotional time for me knowing I have lost five years of my freedom that I will never get back.

—Steven Boone

It is a grey day in March. The snow has not yet melted, the sidewalks are icy and treacherous and the gusts of wind blowing across the Ottawa River whip right through me as I hurry to catch the bus to the Ottawa Carleton Detention Centre (OCDC). It is a slow journey as bus 94 ambles through the city streets, dropping off and picking up passengers making their way to the east side of Ottawa. The bus drives through busy intersections, along the Transitway and through a bustling terminal before turning onto Innes Road. In an instant, the feeling of being in the city fades as trees replace buildings, grass verges replace pavements, and the distance between bus stops is marked by minutes rather than seconds. The one visible building—a rambling red brick structure surrounded by a steel fence topped with barbed wire—is the detention centre where I will be meeting Steven Boone for the first time. As the bus doors close behind me, I make my way to the main gate where I am buzzed in by a guard and directed to the visitor's block. After checking into security, I lock away my bag, sit down on one of the benches and wait until a security guard calls out the visitor's list. I pass through another security check before I am shown to room 13, a small, square cell with heavy metal

doors, double-paned windows, two metal seats and a black telephone dangling from a cord. Boone, dressed in an orange prison jumpsuit, is sitting opposite me. He has a shaved head, a small tidy beard, and two black earrings that seem incongruous with his outfit. He looks younger than his 34 years, and even younger when he smiles, which is what he does when he picks up the phone to start talking.

Boone has been incarcerated in the OCDC since May 2010, when he was arrested for not disclosing his HIV-positive status to a sexual partner. After his arrest, a number of other young men stepped forward to press charges against him. At his trial in 2012, Boone was found guilty on three counts of attempted murder, three counts of aggravated sexual assault, and two counts of administering a noxious substance. The man sitting in front of me presents a contradiction to the labels “sexual predator” and “poz vampire”—an HIV-positive person with the goal of spreading the virus—given to him by the Ottawa Police Services (OPS), the Crown and the local media. He is soft spoken as he talks about life in prison, his bi-monthly visits from his step-grandfather, his problems filling out tax forms, and his delight at receiving his monthly magazines that run the gamut from *Popular Mechanics* to *Esquire* and *GQ*. It is March 18, 2015, and although Boone tries to be upbeat, he tells me that he has been segregated from the main prison population for the past 522 days. For over a year he was in solitary confinement, under the guise of protective custody, where he was locked in his cell for 23.5 hours a day. Recently he was moved into a segregated area where he now has access to a day room three times a day with two other inmates. Paul Champ, a human rights lawyer who went to court to get Boone moved out of solitary confinement, said in

a March 2015 interview that “he had one long-term boyfriend, and they [the OCDC officials] found out about it. That’s what prompted them to put Boone in segregation . . . there’s this idea that he’s going to convert heterosexuals.” While Boone remains in a protected area, he is not allowed to mingle with the main prison population. Boone’s experience in the detention centre is a harsh reminder of the potential consequences of being infected with HIV and not disclosing one’s status to sexual partners. Boone’s failure to disclose his HIV-positive status and his guilty verdict catapulted him into the tough reality of prison life. As an HIV-positive inmate, Boone is deemed a threat to the other inmates and, as such, will remain in segregation until his sentencing in October 2015, and most likely long afterwards.

This chapter will focus on Steven Boone and the cascading effect that failing to disclose his HIV-positive status has had on his life. While exploring the realities of living with a life-long disease categorized by the law as a moral affliction and by public health officials as a communicable disease, the chapter will examine how the HIV criminalization laws affect people living with the disease and will highlight how HIV advocates, human rights lawyers and academics interpret the laws. The chapter will also portray how public health authorities, the police service and the legal system work to uphold the criminalization of HIV non-disclosure and transmission in Canada.

The Legal Requirement to Disclose One’s HIV-positive Status

When Boone was arrested in May 2010, HIV-positive people living in Canada were legally required to disclose their HIV-positive status if there was a “significant risk

of serious bodily harm” due to the possible transmission of the virus. The Supreme Court of Canada established the “significant risk” test in 1996 with *R. v. Cuerrier*, which made disclosing one’s HIV-positive status a legal prerequisite for any Person Living with HIV (PHA) seeking to engage in sexual activity. By the time Boone went to trial in October 2012, the Supreme Court of Canada had ruled on another high profile HIV non-disclosure case. In *R. v. Mabior* (2012) the Court upheld the “significant risk” test determined by *Cuerrier*, while adding that the test applies only if there is a “realistic possibility” of HIV transmission (Adam, Elliott, Corriveau, & English, 2013). In the *Mabior* ruling, the Court determined that there is no duty to disclose if the PHA has a low viral load (if the amount of virus in the blood is below 1,500 copies per millilitre) *and* a condom is correctly used. The *Mabior* ruling made the non-disclosure laws more restrictive and even harsher for PHAs as the definition of “realistic possibility” remains vague, with the only certainty being that, with regards to heterosexual sex, an HIV-positive person does not have to disclose his or her status if a condom is used *and* the person has a low viral load. However, this reinterpretation does not hold for all forms of homosexual sex. Using either a condom or having a low viral load is not enough to exclude the possibility of criminal prosecution of HIV non-disclosure in cases involving vaginal and anal sex.

Richard Elliot, executive director of the Canadian HIV/AIDS Legal Network, an advocacy organization for the rights of people living with HIV, says there is a legitimate role for the law to play in circumstances surrounding HIV non-disclosure: “We must extend the criminal law to whatever extent we need in order to guarantee that someone

who does not disclose, whether or not he or she has HIV, is going to feel the full weight of society's objection to that" (interview, February 2015.) Elliot fears, however, that as the risk of HIV transmission is lowered (because of the use of antiretroviral therapy), "the [court's] justification for using the criminal law becomes lesser and lesser, and we start to approach the point where we are criminalizing people just for being HIV-positive as opposed to causing a significant risk of harm to people."

The criminalization of HIV non-disclosure and transmission is a complex issue, and the line between the moral responsibility and legal requirement to disclose one's HIV-positive status falls in a grey area. Eric Mykhalovskiy, an associate professor of sociology at York University, argues that disclosing is a moral obligation, but that when and where a person discloses his or her HIV-positive status depends on circumstances. The most common charge used in HIV non-disclosure cases is aggravated sexual assault, which carries a maximum of life imprisonment, a penalty that is not in line with the "crime" of non-disclosure. "The primary position [of HIV advocates, health researchers and human rights lawyers] has been that the current criminal law formulation and disclosure obligation is overly broad in the sense that the punishments associated with the failure to disclose are overly harsh," said Mykhalovskiy in a March 2015 interview. His argument was substantiated in Boone's case where, in addition to the sexually aggravated assault charges, Boone was also charged with attempted murder—a crushing penalty for someone who had been diagnosed with HIV only six months before he was arrested for not disclosing his HIV-positive status to his sexual partners.

The Law, Public Health and HIV

On April 30, 2010, the Ottawa Police Service (OPS) received a complaint from a sexual partner of Boone's claiming that Boone had not disclosed his HIV status before they had unprotected anal sex. After the investigating officer became aware of similar complaints against Boone filed in Kitchener, Ontario, she contacted Boone late on the night of May 4 to arrange a meeting at a local Tim Hortons at midnight. Boone, who did not have a car, arrived at the designated location with a friend and, as they did not see any police presence, ordered two Ice Capps before driving to the pick-up window where, Boone writes in a letter, "We were surrounded by a SWAT team with one officer pointing a Taser at me." At the time of his arrest—described by the police as a "high risk takedown"—Boone was charged with one count of aggravated sexual assault and with breaching probation (*R. v. Boone*, 2011). After his arrest, Boone was placed in a holding cell until his bail hearing the following morning, which was then postponed until May 10. While he remained in custody, Boone was further charged with nine counts of aggravated sexual assault, and two attempted murder charges were added later. Although the police followed protocol in arresting Boone and placing him in a holding cell, the aftermath of his arrest makes Boone's case unique. It calls into question an individual's right to privacy, the role that public health officials play in HIV non-disclosure cases, and the media's ethical duty to report on stories in a fair and balanced manner.

While Boone remained in the holding cell, the OPS released a media statement with a colour photograph of Boone to the Ontario Wire Services urging anyone who had

had sexual contact with Boone to seek medical attention and to contact the OPS. The statement included a comment from Acting Police Chief Gilles Larochelle justifying the release of Boone's photo as "an extraordinary measure" to ensure that all sexual partners were informed that medical follow-up was warranted, as well as a comment from Dr. Isra Levy, medical officer of health for Ottawa Public Health, offering people free and anonymous testing for sexually transmitted infections. The OPS also emailed the media release to the Gay, Lesbian, Bisexual and Transgender (GLBT) Police Liaison Committee's listserv with the subject line "sexual predator" (Juergensen, 2010).

The release of Boone's photo was followed by an outcry from HIV/AIDS advocates and the Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) communities, who claimed the media statement violated Boone's right to medical privacy, and that it further stigmatized members of the LGBTQ community and PHAs. There was fear that the "extraordinary measures" taken by the OPS would discourage people from seeking voluntary HIV testing from Ottawa Public Health, which was already known for its complicity in releasing the medical information of PHAs.

The current public health regulations require public health officials to contact all sexual partners of an individual who has tested positive for HIV, and all HIV testing laboratories and healthcare providers to inform public health authorities of all HIV-positive test results (HALCO & CATIE, 2013). Public health authorities also have the power to issue a PHA with a Section 22 order of Ontario's *Health Protection and Promotion Act* 1983 requiring the PHA to refrain from sexual activities if health professionals believe he or she is putting another person's health at risk. They may also

force a person to spend time in a hospital for treatment, and nurses and health care providers can be called to give evidence during an investigation or trial. Once a person has tested positive, he or she is “under the scrutiny of the state for potentially criminal liability. Public health [authorities] will use more coercive powers to try and get you to disclose more information [about your sexual history], including getting court orders, and ultimately contempt of court if you don’t comply with its limitations, “ said Elliot in our February 2015 interview. The only protection a person has from public health authorities' sharing his or her medical records is to opt for an anonymous HIV test (where the name is withheld and an access code is used to retrieve the results), but once he or she accesses health care, their HIV-positive status must be divulged.

Advocates fear that the role of public health officials in aiding and abetting the criminalization of HIV non-disclosure and transmission will undermine HIV prevention and public health protection efforts. Elliot is of the opinion that, if public health authorities acknowledged that the energy used in prosecuting PHAs could be channelled into making it easier for people to get HIV tests, it would create “a safe place and safe way to get connected to the care HIV-positive people need.” Despite their efforts, HIV advocates fear that the interplay between public health authorities and the law will continue to obfuscate guidelines around the criminalization of HIV non-disclosure. Public health authorities continue to take action against PHAs who are deemed to be a threat to the greater public.

Although Boone had not been handed a Section 22 order instructing him to refrain from sexual activities before he was incarcerated in the OCDC, the violation of his

medical privacy was publicly supported by Ottawa Public Health in their complicity with the OPS in the issuing of the Boone media statement. In just a few days, Boone's life was shattered—his errant sexual behaviour and past sexual history became tabloid news. He went from a man recently diagnosed with HIV to a criminal accused of sexually assaulting and attempting to murder multiple sexual partners using his semen. The Boone portrayed in the media was a far cry from the boy who was raised by his grandparents in the west end of Ottawa—a young child who longed to live at home with his mother and sisters, a boy who strived to do well at school, and a gay teenager who stayed in the closet because he feared rejection.

Steven Boone: Shattered Dreams

Boone's early life was marred by poverty, domestic violence, upheaval and uncertainty. As the eldest of seven children, Boone bore the brunt of being the first child of a teenage mother who struggled to survive on a low income, a woman who later went through a divorce only to find herself in a relationship with a schizophrenic second husband. Boone was born in 1981; as a one-year-old he went to live with his grandparents, where he stayed until he was three, when he returned to live with his parents and his newborn sister. Boone did not grow up in an idyllic neighbourhood where his journey from kindergarten to high school was carefree and seamless; instead, his life seemed destined to be tumultuous. His parents were transient, moving from house to house and between cities and provinces. By the time Boone reached Grade 5, he had attended three different schools, which Boone says made him feel that he was

always the newcomer. His mother divorced when Boone was ten; she remarried, but home life was fraught with tension, and at 13 Boone moved back to his grandparents' home to escape the violent outbursts of his new stepfather. He remained with his grandparents until he enrolled at Laurentian University.

After completing high school in Ottawa, Boone was accepted into Laurentian University to study law and justice, but his university career was interrupted when he developed mononucleosis and had to be hospitalized for some time before returning to classes. Even after his illness and extended absence, Boone finished the year at Laurentian, but ultimately he dropped out. His intention was to return after a year off, but his plans were thwarted when he was unable to pay back his loan from the Ontario Student Assistance Program and was denied another loan. With no idea of what the future would bring, Boone took on a variety of jobs, including working as a security guard, at a call centre, and as a casual labourer for the Canada Border Services Agency. According to Boone, his personal life was low-key and involved mainly hanging out with friends and playing video games. Although Boone says he knew he was gay from an early age, he remained in the closet for most of his teen years and into his early 20s. At 22, Boone finally came out to his family and friends.

By Boone's own account, his dalliances with other men were not always of a romantic nature. As a young gay man, he had a number of sexual encounters with men he met in bars, nightclubs and online. Although he wanted a long-term boyfriend, he really had only one relationship, which he described as being emotionally and physically abusive. In 2009, Boone's life changed when he met an American man, Ned (not his real

name), online. Ned and Boone spent six months together in a long-distance relationship. Although Ned was HIV-positive, both men engaged in unprotected anal sex under the assumption that, since Ned was on antiretroviral therapy, they were safe. However, Boone surmises, there may have been factors surrounding Ned's drug compliance that affected his safety, in particular that Ned may not have been taking his medication regularly. Boone also wonders if Ned had left his medication in the car during the summer, which might have contributed to the drugs being less effective and to Ned's viral load being high. Ned and Boone broke up in October 2009 after Boone found out he was HIV-positive. In September, Boone had received notification from Ottawa Public Health informing him that he had had sexual relations with someone who had tested positive for syphilis. After receiving the letter, Boone followed the public health advice and was tested for syphilis as well as other sexually transmitted infections (STIs). He also sought out an anonymous HIV test, but was unable to receive the results as he had lost his access code. He followed this with a visit to Gay Zone, a clinic for gay men run by the AIDS Committee of Ottawa (ACO), where he had an HIV test under his own name. After testing positive for HIV in October 2009, Boone was referred to the Module G clinic at the Ottawa General Hospital for further testing in November 2009. Boone says that he was told he did not have to go on antiretroviral therapy immediately, and that he cannot recall being advised about the HIV non-disclosure laws.

After testing positive for HIV in October 2009, Boone continued to pick up men online and to have unprotected sex. Boone maintains that since his online profile stated his HIV-positive status, he assumed that his sexual partners were aware of this. He also

says he told his family and friends—including his roommate who later testified against Boone at trial—that he was HIV-positive. Trying to come to terms with being HIV-positive, Boone joined a youth group run by the ACO that helps young people living with the disease. Part of the focus of the youth group was to help people like Boone who had been newly diagnosed with HIV learn how to disclose their status to sexual partners. Despite this, Boone says that until he was arrested in May 2010, he did not fully understand what having a legal duty to disclose his status meant and, as he writes in a letter dated May 18, 2015, he struggled with “the fear, judgment and rejection that came with the idea of disclosing.”

Michael Burtch, an HIV-positive gay man and AIDS activist, was the ACO’s group leader at the time of Boone’s arrest. I interviewed Burtch in his Toronto home in March 2015. Burtch expressed his empathy for Boone as, he contends, learning how to disclose one’s HIV-positive status is extremely difficult: “I think it’s ironic that someone who has just tested HIV-positive is expected to have all the tools, the knowledge, and the ability to negotiate safer sex from there on. What ends up happening is there is a learning curve about trying to figure out what the best practice is in terms of disclosure.”

Being HIV-positive: Learning to Disclose

Burtch was first diagnosed with HIV more than a decade ago when he was 22 years old. He says he was sick for a month before he went to an Ottawa walk-in clinic to get an HIV test. This was prior to rapid HIV testing, where the results are available within 30 minutes, so Burtch had to wait for three weeks—one of which he spent in hospital—

before receiving his results. He surmises he contracted HIV after having unprotected anal sex with two partners, although both men denied they were HIV-positive. Burtch says he was shocked to find out that he was HIV-positive: “You’d think that at the age of 22 you’d have a complete understanding of HIV transmission. I still remember being a teenager and hearing a nurse on *MuchMusic* saying that if you’re going to have anal sex wear two condoms—which is not something you should ever do,” said Burtch.

Burtch says he was aware that having unprotected sex could lead to HIV transmission, but that he did not know if sexual acts like oral sex—particularly if one partner ejaculates and the other partner swallows the semen—were low or high risk. He recalls that, at the time, he found Ottawa Public Health to be a helpful resource: medical officials gave him counselling on HIV and safer sex and contacted Burtch’s sexual partners from the previous six months so they could get tested. Although his experiences with the public health system were mostly positive, Burtch says he would not advise anyone now to get an HIV test from a public health facility, or to seek HIV counselling because of the legal issues surrounding HIV transmission: “I know that public health co-operates with the police, and that anything you tell public health [officials] is recorded and can be subpoenaed. There’s always a chance you could be reported by public health, whether that looks like Section 22 or calling the police.”

In the ten years Burtch has been HIV-positive, he has never been subpoenaed or placed under arrest, but he says there were three instances where misunderstandings with his sexual partners about his status resulted in tensions. In each case, Burtch was either under the impression that the men had seen his HIV-positive profile online, or

that because he was open about his status, they understood he was HIV-positive. Burtch says he has tried to disclose in every way possible—before, during and after sex, over text, over the phone, in person—and that he moves from “being teary eyed to being defiant and empowered about it.” Burtch contends there is no one best way to disclose, but to figure it out on a case-by-case basis, and that after years of practice, disclosure is a lot easier for him:

I usually just disclose up front and would rather know right away whether or not the person is comfortable or not with my HIV status. You may think that, after a certain amount of time, you would have figured it out and that disclosing would become easier, but there are always misunderstandings that can arise. It’s a really difficult thing to do and it is scary for a lot of people, and there is no wiggle room around that.

Burtch states that since he found out he was HIV-positive, he has been rejected many times after disclosing: “There is nothing like seeing the passion in your partner’s eyes drain out and lose complete interest in you, and the way they are looking at you completely changing over the utterance of a couple of words. It’s amazing how stigmatizing and hurtful it is, to be being spoken down to and dehumanized.”

Some AIDS Service Organizations (ASOs), such as the HIV & AIDS Legal Clinic of Ontario (HALCO), have piloted and developed guidelines on HIV disclosure for gay men. The guidelines emphasize the need to make disclosure count: “Avoid words or hints. Do not assume he knows what words like ‘poz’ and ‘positive’ mean. It is best to tell him, ‘I have HIV,’ ‘I am positive,’ or ‘I am infected with HIV’” (HALCO & CATIE, 2013). The guide

also contains advice for making sure the HIV-negative partner understands what HIV infection or HIV-positive means, and how to “protect yourself against guys who might lie.” Also included are a number of ways to keep a record of one's HIV-positive disclosure, such as saving on-line conversations, emails and text messages where one's HIV-positive status has been acknowledged; having a third person witness the disclosure and write down the date, time and who was present; have a third person confirm with the HIV-negative person he has understood he has agreed to have sex with an HIV-positive person; make the person sign a document stating he recognizes he has agreed to have sex with an HIV-positive person; make a video of the disclosure and go to a counselling session with the perspective partner and disclose in front of the counsellor.

The guidelines, however, are theoretical and, as Burtch says, disclosure is a learning curve, which for some people leaves little room for mistakes, especially for people like Boone who was arrested a short time after testing positive. “I think back to my own first six months of being HIV-positive—I wasn't even quite clear as to the risk associated with oral sex, and I was engaging in oral sex, and trying to learn how to disclose and have those conversations, and to be knowledgeable about it and answer questions,” said Burtch.

Burtch was lucky. As an employed professional counsellor and activist, he learned to navigate between living the life of a sexually active young gay man and the nuances of living with HIV, a chronic illness stigmatized by fear and criminalized by the law. Boone was not so lucky. His online chats were frequently peppered with promiscuous and outrageous comments, leaving a lengthy trail of evidence to be used

against him in court. Boone's stated preference for having bareback sex and his lack of direct in-person disclosure of his HIV-positive status to several men led to his arrest in 2010, and to a trial by jury five years later.

On Trial for HIV Non-disclosure

During Boone's trial in October 2012, the Crown painted a dismal picture of him. He was portrayed as a predator who preyed on his victims, an immoral person who used sex, deceit and his semen to infect the young men with whom he had unprotected anal intercourse. The evidence against Boone was damaging: besides the several complainants who took the witness stand, the Crown had over 3,000 electronic messages and chat room discussions where Boone talked about past sexual encounters and his desire to infect someone with HIV:

He also speaks about lying about his HIV status in order to induce others to engage in unprotected sex so as to infect others with HIV. He makes reference to the fact that he is sexually aroused by the idea of infecting someone with HIV, and that he was refraining from using medication for HIV specifically because he believed he would be able to infect more individuals than if he was taking medication. (*R. v. Boone*, 2012)

The Crown highlighted Boone's participation in chat rooms where the discussions focused on "bug chasing" and "gift giving"—phenomena strongly associated with online sites where members talk about wanting to become infected with HIV or wanting to pass on the virus to sexual partners. Although the connotations associated with "bug

chasing” and “gift giving” may sound horrifying to people unfamiliar with the phenomena, research has shown that this is one way that individuals come to terms with their HIV status. Michael Graydon, in his paper titled “No Need to Wrap it Up: An Exploration of Gift-Giver and Bug-Chaser, Newsgroups, Gift Theory, and Exchanging HIV as a Gift,” writes:

Calling HIV a gift enables those offering it, and those accepting it, a way to control in a small way what it means to live in the age of AIDS. Rather than consider some gay men as having developed a fascination with abject forms of sex, I suggest they are experiencing an abject form of despair. A level of despair born out of an experience so isolating and nullifying that it is abject, taking them beyond the scope of the possible. (Graydon, 2003, p. 104)

Although Boone admits he participated in the forums, he writes: “I was quite mortified to hear them [chat logs and text messages] read out in court. I felt completely ashamed of the conversations that were used against me. When I was having these conversations, I never felt that they were based in reality. I was dealing with being newly diagnosed as positive . . . it was a very confusing and vulnerable time for me” (personal letter, May 18, 2015). Boone adds that he wanted to be part of a gang so he could be accepted and that he wrote what he thought people wanted to hear. Boone also states that he assumed the sexual partners he met online were aware of his HIV-positive status, but by his own account he admits that there were a “few times I did not disclose because the sexual acts were either mutual masturbation or just oral sex,” and that sometimes he used a condom, but not all of the time.

The Crown argued that Boone's failure to disclose his HIV-positive status endangered the lives of the complainant and that his failure to disclose amounted to fraud, which negated the complainants' consent to have unprotected sex. The prosecution claimed that it was Boone's intent to kill the complainants. In October 2012, Boone was charged and convicted of three counts of aggravated sexual assault, two counts of administering a noxious substance, and three counts of attempted murder. Three years later, Boone is waiting to be sentenced. After his sentence Boone will be moved from the OCDC to a federal penitentiary.

The charge of aggravated sexual assault is the most the common charge laid against PHAs in HIV non-disclosure cases, and it is, as Elliot says, "one of the most serious offences in the criminal code; prosecutions have been largely routed in that direction and that has meant heavy penalties have fallen." (interview, February 2015). However, the charges of administering a noxious substance and the additional attempted murder charges that were used against Boone have not been routinely used in HIV non-disclosure court cases.

Ian Carter, a criminal lawyer and Boone's defense counsel, says that the attempted murder charges are highly unusual: "In attempted murder you have to have a specific intent to kill someone. In some ways the intent required for attempted murder is higher than it is for murder, because you can be reckless and murder, but with attempted murder you have to actually intend to kill somebody" (interview, April 2015).

In Boone's trial, the Crown argued in favour of attempted murder on the premise that as HIV progresses, the disease eventually leads to AIDS and ultimately

death. In the closing arguments, the Crown contended that “death from HIV is not spontaneous. Those he [Boone] infected with HIV will die sooner and so will Mr. Boone” (notes taken at trial in October 2012 by the author). Carter says the Crown failed to take into account medical advancements such as antiretroviral therapy, which has helped turn HIV into a manageable chronic disease, and that HIV does not necessarily lead to death but often to a potentially shortened life span. Carter also says the attempted murder charges against Boone set a rare precedent, making it feasible to bring similar charges against PHAs in future HIV non-disclosure cases. Speaking from his personal point of view in an April 2015 interview, Carter says he believes there should be legal consequences for people not disclosing their HIV-positive status, but that it should be directed through the public health system: “The criminal law is about the most blunt instrument you can use to try and change human behaviour. This is a health issue where regulation should occur, but it has no place in criminal law.” Carter stresses that the consequences—going through criminal courts, being labeled as a sexual offender, and extended prison sentences—are too severe for PHAs. He also adds that in Boone’s case the Crown is seeking Long-Term Offender (LTO) status. The LTO designation targets sexual offenders who, in the eyes of the law, pose a substantial risk of re-offending. If an offender has been designated an LTO, he or she will remain on probation for up to ten years after release from prison (*Criminal Code of Canada*, RSC 1985, c C-46).

Whether or not the Crown is successful with the LTO application will be determined at Boone’s sentencing hearing in October 2015. After sentencing, Boone will be moved to a federal penitentiary to serve out his time. For five years Boone has

remained, without bail, in the OCDC, where the stigma of being HIV-positive and the institution's fear that he may have unprotected sex with other inmates has meant that most of this time has been spent in solitary confinement, or with access to extremely limited interaction with a small number of people. Each month Boone is allowed up to six visitors selected from the names on his visitors list. He is allowed a maximum of two 20-minute visits a week, where all communication takes place behind glass windows and over a phone. Due to staff shortages and random lockdowns, the visits are often cancelled without warning. In the five years Boone has been incarcerated in the OCDC, his only regular visitor has been his step-grandfather. His mother, who lives outside of Ottawa, has visited him only a few times.

The Aftermath of an HIV Non-disclosure Trial: Life in Segregation

In May 2013, Boone was moved out of the general inmate population into solitary confinement at the OCDC after prison authorities found a letter he had written to another inmate with whom he had had sexual relations while incarcerated. Boone was held in his cell for 23.5 hours per day, with access to a shower three times a week and occasionally time alone outside the cell. Paul Champ, who argued before the courts for Boone to be released from solitary confinement, says that in his opinion, the decision of the prison officials to confine Boone was a knee-jerk reaction to the HIV criminalization charges and the ongoing hysteria surrounding HIV:

It seemed to me that the HIV issue seemed to be a proxy for people to openly act on prejudices they had towards homosexual people generally. It was almost like

it gave them [OCDC] license to do it. I have learned more about the stereotypes associated with HIV in the criminal justice system, from the police officers, to the prosecutors, to the judge, to the prison officials. I just found it really enlightening and disturbing. (Interview, March 2015)

Despite Champ's taking the issue of Boone's solitary confinement to court, it was ruled that Boone's confinement was "lawful and necessary for the safety of other inmates . . . due to his history of unprotected sex with other inmates without disclosing his HIV status and because there was a "very high risk" that the appellant would "manipulate" cellmates into having sexual intercourse and thereby transmitting the HIV virus" (*Steven Boone v. Ministry of Community Safety and Correctional Services* 2014, p. 13). At the time of the court case, Boone had been on antiretroviral therapy since September 2010; as a result, his viral load was low and the likelihood of HIV transmission occurring was deemed as low risk. Champ appealed the lower court's ruling, but lost the case before the Ontario Court of Appeal. Boone remained in solitary confinement until Champ filed an application in September 2014 to the Supreme Court of Canada, which prompted the OCDC authorities to move Boone out of solitary and into segregation where he remains in a single cell, but in a cellblock with two other inmates. While in segregation, Boone is allowed out three times a day in a dayroom where he is able to use the phone, watch TV and chat with other inmates. As Champ says, "It's not as isolating as it was before, but it's still constricting."

Dealing with the Consequences of HIV Non-Disclosure

Steven Boone is no poster boy for people living with HIV. His failure to disclose his HIV-positive status to his sexual partners caused public health authorities to regard him as a public health threat and a criminal in the eyes of the law, while his association with the phenomena of “gift-giving” and “bug-chasing” made him morally objectionable to many people. Although Boone’s case is not a sympathetic one for his defence lawyer, his story highlights the potential severity of the law in HIV non-disclosure cases, and his trial and sentencing set new precedents in Canadian law. Boone's case shows how someone who has been newly diagnosed with HIV can tumble into a legal imbroglio with disastrous consequences. His story is an example of how an individual’s health, well-being and individual freedoms are cast aside in favour of protecting the public from a communicable disease, and how this emphasis on protection prolongs the misapprehension that legally requiring PHAs to disclose their HIV-positive status is an effective HIV prevention method. Boone is an example of a PHA who has paid a high price for crossing into a territory where the legal system, the public health system, and individual human rights have imploded into a quagmire of confusion.

In the five years Boone has been incarcerated— mostly alone, waiting for his trial and sentencing—he has become prone to depression and self-harm; he has been under suicide watch and undergone psychological evaluation, and has been locked in a cell for over 600 days without access to another human being or the outside. He has been stigmatized by the public, the media and the prison authorities, and, at 34 years of age, is facing the rest of his life as a prisoner, without the possibility of having a sexual relationship, because he was HIV-positive and failed to disclose his status to his sexual

partners—a transgression he will always regret. In a letter written on May 8, 2015, Boone refers to the past few years as “a difficult time, and I most definitely regret my actions, but I certainly never intended to hurt anyone. I wasn’t thinking clearly and often turned to drugs and alcohol to escape the reality of my situation.”

Boone’s situation is a debacle. He has made history by being the first person to be tried and convicted of attempted murder for not disclosing his HIV status, and his case has set the precedent for future non-disclosure cases. Boone’s arrest, incarceration and trial highlight the complexity of issues around the criminalization of HIV non-disclosure and transmission. This case shows how the personal and legal lines are blurred in the arena of public health, the law and human rights. It demonstrates how the police automatically assume that an accused is “high-risk,” and it highlights how media coverage skews towards hysteria, further stigmatizing PHAs. At face value, the criminalization of HIV non-disclosure appears to be a viable way to protect society from people who knowingly and willingly seek to infect others with HIV, but the overly broad use of the law assumes that all PHAs are potential criminals. As Carter says, “For the most part, these are people who have no criminal background. They are not criminals; they are caught up in this hysteria.”

The Legal and Policy Quagmire Surrounding HIV Non-disclosure in Canada

The criminalization of HIV non-disclosure is a complex subject. The legal requirements surrounding disclosure are often misconstrued and misunderstood; many people are unclear about HIV transmission, the potential risks associated with sexual

behaviour and activities, and the consequences of failing to disclose one's HIV-positive status. As it stands, there are no laws that specifically deal with HIV non-disclosure and transmission. Instead, legal precedents have been built upon existing laws in the *Criminal Code of Canada*, which have not kept pace with scientific advances around the risk of HIV transmission. Instead of taking these advances into account, the criminal law applied to HIV non-disclosure and transmission has become increasingly inflexible and the penalties harsh.

Today, when a PHA goes on trial for non-disclosure, the law is often unyielding, which is a direct consequence of using criminal solutions to complex issues. As Mykhalovskiy states, there is a long history of the inability of the criminal justice system “to respond in any effective way to complicated matters, or controversial matters related to sexual practice, whether we’re talking about sex work, or HIV, or behaviours outside of sex such as drug use and so forth” (interview, March 2015). Instead of protecting the public, the use of criminal law to prosecute PHAs stigmatizes the carriers and the disease by associating PHAs with criminality.

Associating a disease with a crime potentially erodes decades of national and international public health initiatives; instead of fighting stigma, it reinforces stereotypes and drives those most in need of HIV prevention efforts underground. The criminalization of HIV non-disclosure and transmission is part of a multifaceted framework involving lawyers, medical officers, members of the justice system, politicians, HIV advocates, and human rights activists struggling to find a fair way to intersect the law with public health concerns and human rights.

Caught up in this convoluted legal web are ordinary people, such as Steven Boone, who are struggling to find out how to manage an infectious chronic disease that, prior to the availability of effective medical treatment, would have killed them. In the midst of this challenge, Boone has inadvertently become a pawn in a game where there are no clear rules or guidelines. Boone's mistake was certainly that he engaged in unprotected sex, but also that he did not fully understand the consequences of not disclosing his HIV-positive status. His decision not to disclose and his errant sexual behaviour have made him morally repugnant to many people and a criminal in the eyes of the law. Boone is caught between a disease and the perception of the consequences of that disease. As Sontag (1990) has said, "AIDS has a dual metaphoric genealogy. As a micro-process, it is described as cancer is: an invasion. When the focus is transmission of the disease, an older metaphor, reminiscent of syphilis, is invoked: pollution" (p. 17).

Chapter 2

A Disease on Trial: HIV/AIDS Enters the Courtroom

For some minutes the whole court was in confusion, getting the Dormouse turned out, and, by the time they had settled down again, the cook had disappeared. "Never mind!" said the King, with an air of great relief. "Call the next witness." And he added in an undertone to the Queen, "really, my dear, you must cross-examine the next witness. It quite makes my forehead ache!"

—Lewis Carroll, *Alice's Adventures in Wonderland*

While *Alice's Adventures in Wonderland* is a tale that blends the absurd with the obscure, where the eccentricity of the courtroom scene is a metaphor for the real-life drama surrounding the criminalization of HIV non-disclosure and transmission in the Canadian courts. By all accounts, the King's court in Wonderland was a farce ruled by chaos: the crime revolved around tarts, jurors could not remember their names, the cook ran off the witness stand, while the rabbit was accused of stealing his own hat; and the main witness was a young girl who accidentally tumbled into a land ruled by bedlam. The courts should be, as Alice expected, a legal refuge where the objective truth should emerge, but, as she quickly realized, the search for truth is often lost in cases where negligible arguments supersede the core issues of innocence and guilt. Alice may have tumbled down the rabbit hole into a world without order, but it was an imaginary world, which we can abandon by simply turning the pages and closing the book. However, when HIV/AIDS entered the courtroom in the 1990s, People Living with HIV (PHAs) stumbled into a shifting reality, a maze of legal confusion in which a

communicable disease had metamorphosed into a punishable crime, where a PHA had become a purveyor of death, and where the human immunodeficiency virus was deemed a noxious, lethal substance.

The objective of Chapter 2 is to explain the evolution of HIV criminalization in Canada, from the initial intent of the law to protect the public from a communicable disease, to the current climate, where failing to disclose one's HIV-positive status is a crime. The legal justification for prosecuting PHAs did not begin with a theoretical big-bang moment, but evolved over three decades into the current legal framework, which is comprised of an amalgamation of various legal decisions. The chapter will outline how the initial justification of the law as an HIV prevention method ultimately developed into the criminalization of the disease. The inability of public health authorities to influence legal outcomes, the refusal of Parliament to enact HIV-specific laws, and the failure of the Supreme Court of Canada to clearly demarcate legal tests used to determine risk of transmission have all contributed to the current climate surrounding the criminalization of HIV non-disclosure and transmission in Canada.

Under the current legal umbrella, crimes such as aggravated assault and sexual assault as categorized in the *Criminal Code of Canada* have been adopted, manipulated and applied in HIV prosecution cases where a PHA has failed to disclose his or her HIV-positive status. This manipulation of the *Criminal Code*, and the concept that the law has a role to play in public health initiatives, begins with the idea that disease is the enemy:

Diseases are envisaged as an alien "other," as enemies are in modern war; and the move from the demonization of the illness to the attribution of fault to the

patient is an inevitable one, no matter if patients are thought of as victims.

Victims suggest innocence. And innocence, by the inexorable logic that governs all relational terms, suggests guilt. (Sontag, 1990, p. 99)

The Evolution of Canada's HIV Non-disclosure Laws

The climate of fear surrounding HIV/AIDS first arose in the early 1980s. As the number of HIV infections rose, fear of the disease increased greatly, particularly as the manner of its transmission was not well understood. The misconception that HIV affected only homosexuals and intravenous drug users persisted and perpetuated the myth that mainstream society was somehow exempt from contracting HIV: "The received wisdom from experts was that North American women could get HIV infection from heterosexual sex only after years of exposure to the semen of an infected man" (Callwood, 1995, p. 19). Information on how the virus was transmitted trickled out as scientists endeavoured to isolate the virus's path, and while public health authorities concentrated on prevention efforts, the disease remained shrouded under a veil of terror and dread. By the early 1990s, without any guidelines or legal framework, the law began to ease its way into the public health sphere for the second time in the twentieth century—this time under the guise of HIV prevention.

In 1919, a specific provision in the *Criminal Code* criminalizing the transmission of certain sexually transmitted infections such as syphilis and gonorrhoea was enacted. The provision made it an "offence punishable on summary conviction to communicate a venereal disease, knowingly or by culpable negligence, to another person" (Reeder,

1996, p. 412). In an ironic twist of timing, the 66-year-old law was rescinded in 1985 for two reasons: first, no one had been prosecuted for more than 50 years; and second, the transmission of a venereal disease was deemed a public health issue and not a legal one. Hence, when HIV/AIDS entered the courtroom in the 1990s, lawyers and judges within the Canadian judicial system found themselves in a legal quagmire. There were no specific laws regarding HIV transmission in the *Criminal Code* to guide the judicial system; therefore, no precedents had been set for the HIV-related cases that began to appear before the courts. Thus, each case rested on the individual judge's discretion.

Canada's first court case involving the prosecution of a PHA for non-disclosure and transmission was heard in the late 1980s, and by the mid 1990s the country had already earned the dubious distinction of being the only country in the world to imprison PHAs without any HIV-specific laws. As public fear about HIV/AIDS escalated, the Canadian courts began to see an influx of HIV cases, and the legal community turned to common law as a legitimate basis for prosecuting PHAs. This stratagem, however, resulted in inconsistent prosecutions as the lower courts, Courts of Appeal, and Supreme Courts used different rationales to criminalize HIV non-disclosure and transmission. Between 1989 and 2009, 104 people had been charged in HIV non-disclosure cases in Canada: PHAs had been arrested for having unprotected sexual intercourse, oral sex, and for zero risk activities such as spitting and biting; charges ranged from sexual assault to public nuisance; and sentences varied according to the discretion of the judges. Prosecuting PHAs for non-disclosure emerged as an area "so legally tenuous that Canadian judges continuously disregarded the few recent cases that

addressed the criminalization of the transfer of HIV, and instead developed their own legal analysis” (Reeder, 1996, p. 403). Most cases heard in the early 1990s flew below the radar of mainstream media and society, but the ones that entered the public sphere established the future direction of HIV non-disclosure prosecutions.

The first case on the criminalization of HIV non-disclosure to reach the Supreme Court of Canada was *R. v. Thornton*. In 1991, Thornton, an HIV-positive gay man, knowingly donated contaminated blood to the Canadian Red Cross. The case was significant in that the defendant knew that the Red Cross collected blood for patients needing transfusions, and that the organization would not accept blood donations from HIV-positive persons. Although HIV transmission did not occur as the contaminated blood was found before it was distributed to patients, Thornton was charged with being a public nuisance. The courts held that the defendant violated “section 176(a) of the *Criminal Code* (now section 180) because he ‘intentionally with[held] the information from the Canadian Red Cross Society’” (Reeder, 1996, p. 416). The Ontario Court of Appeal stated that the defendant’s conduct was unspeakable, and that it “[cried] out for a sentence that would act as a deterrent to others and which would express society’s repudiation of what he did” (Callwood, 1995, p. v).

In 1993, the Supreme Court of Canada upheld the Court of Appeal’s findings. The majority ruled that the presence of HIV in someone’s blood probably indicated the person was infected with AIDS. The charge of public nuisance was substantiated by the premise that Thornton was aware of the threat posed to the public when he knowingly donated blood contaminated with HIV. In this instance the court referred to common

law, which, under Canada's legal system, is not based on statutes adopted through legislation but on precedents set by previous court decisions. Using common law, the court recognized a person's fundamental duty to refrain from conduct that could potentially harm another person. In *Thornton*, the defendant was found to have a "legal duty to refrain from giving blood because it was reasonably foreseeable that the donation could cause harm to another person" (Reeder, 1996, p.416).

While the *Thornton* decision rested on protecting the public at large, other HIV cases centred on protecting individuals who had unknowingly engaged in sexual interactions with HIV-positive people. As the number of HIV-related cases increased, the motivating force for bringing HIV/AIDS into the courtroom departed from its original intent of protecting the public at large to prosecuting HIV-positive people for sexual promiscuity. HIV cases became part of a legal cycle that attempted to legitimize the criminalization of HIV non-disclosure and transmission under the guise of HIV prevention. The biggest trial to come under public scrutiny was *R. v. Ssenyonga*.

Bringing Sex onto the Witness Stand

Charles Ssenyonga's sexual practices, including his penchant for having unprotected sex, came under legal scrutiny after he failed to disclose his HIV-positive status to three women, all of whom contracted HIV. Although there had been other HIV non-disclosure hearings, Ssenyonga's case, since he pleaded not guilty, became the first HIV non-disclosure case to go to full trial. According to June Callwood (1995), whose book *Trial Without End* centres around Ssenyonga, the case "was unique in that it

brought together all the explosive elements of AIDS in the 90s: the spread of HIV to heterosexual women, the emergence of technology to match the genetic makeup of viruses, and the manifest failure of public health authorities and the law to control sexual behaviour” (p. vii).

Ssenyonga was a Ugandan refugee who came to Canada in 1983. By 1987 he was involved with a young woman who, after seeing him succumb to frequent bouts of colds and flu, urged him to see a medical doctor. Despite concerns that Ssenyonga might be HIV-positive, he was not tested for the disease, but was told by his physician to either abstain from having sex, or to only have sex with a condom. Ssenyonga, however, despite being aware that he might be HIV-positive and knowing the possible consequences of having unprotected sex, failed to follow his doctor’s advice and continued to have sexual relations with two women, both of whom became infected with HIV. In 1989, after infecting two sexual partners, Ssenyonga tested positive for HIV, and subsequent to the test infected a third woman with HIV. Ssenyonga finally came to the Middlesex-London Health Unit’s attention after the doctor of two of the HIV-positive women wrote to the health authority demanding that something be done to protect more women from becoming infected. The demand threw Public Health Ontario in a quandary as to how to deal with Ssenyonga.

In the 1990s, the Canadian public health framework for preventing the spread of communicable diseases encompassed three levels. In the lowest risk category were diseases such as chicken pox and measles. Doctors, nurses, and schools were asked to report these cases so that patterns could be tracked. The second-tier illnesses included

HIV and Hepatitis B; in order to restrain spread of these diseases, medical officers had the power to issue a restraining order against the infected person. The third tier priorities were virulent diseases such as TB, syphilis and gonorrhea. Within this category, public health authorities held the legal power to force the infected person to receive treatment, and could order the individual to stay for up to four months in hospital or jail.

In order to restrain Ssenyonga from having unprotected sex, public health officials turned to Section 22 of the Ontario *Health Protection and Promotion Act* of 1983 that referred to communicable diseases. Section 22 states that a medical officer may

require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease . . . where [the officer] is of the opinion, upon reasonable and probable grounds, (a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health; (b) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and (c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease. (*Health Protection and Promotion Act*, 1983, SO 1983, C10, p. 12)

With few options other than using Section 22, Richard Schabas, the chief of Ontario's public health department, stated at the time that "public health is flying blind

so far as to know what to do in these circumstances. Some people don't think public health should try and deal with it at all. They think it is a matter that should be handed over to the criminal courts" (Callwood, 1995, p. 80).

In October 1990, Ssenyonga was issued with an order under Section 22 forbidding him "to engage in sexual acts that involve any penile penetrations into the mouth or anus, or into the mouth, anus or vagina of another person" (Callwood, 1995, p. 74). However, Ssenyonga disregarded the Section 22 order, and in 1991 lawyers acting on behalf of Public Health Ontario applied for a further judicial order under Section 101 of the *Ontario Health and Promotion Act*, which allowed health officials to call any person who contravened an order to appear before a judge. The major advantage of using Section 101 was that medical confidentiality was no longer a mandate, and therefore Ssenyonga's name could be made public. However, the application of Section 101 to Ssenyonga meant that criminal charges had to be laid against him, and the challenge for the lawyers was to find something in the *Criminal Code* that could be constructed to fit this particular case, an exercise that "demands recall of precedents and obscure rulings, ability to anticipate what an opposing lawyer will do and what the judge will think" (Callwood 1995, p. 96).

In late 1991, for the first time in history, a person's sexual relations became the focus in a Canadian courtroom. *R. v. Ssenyonga* signalled the increasingly blurred line between public health and the law. As Schabas said, "In this case we are pushing the boundaries of criminal law. We were taking conduct that's not traditionally been seen as part of the criminal law and saying that this is criminal" (Callwood, 1995, p. 156). In his

preliminary hearing, Ssenyonga was charged with criminal negligence, aggravated sexual assault, common nuisance, and administering a noxious substance. The Crown prosecutor argued that even though the women consented to have sex with Ssenyonga, the consent was vitiated by fraud, reasoning that a woman cannot consent to having harm inflicted upon her. In most sexual assault cases, the term “vitate” is used to determine that the complainant's consent to engage in sex has been nullified because of false information given by the defendant. In this aspect, the Crown argued a person could not consent to sex if AIDS—therefore death—could be the outcome. The courts in this case followed common law that addresses vitiating sexual consent when dealing with venereal disease. “In *Ssenyonga*, the Crown pointed out that the traditional rule in England regarding venereal diseases is that if deception causes a misunderstanding as to the nature of the act itself, there is no legally recognized consent because the act was beyond the scope of that to which the partner consented” (Reeder, 1996, p. 415). In his ruling, the preliminary trial judge dismissed the common nuisance charge and that of administering a noxious substance, as Ssenyonga had not endangered the public at large. However, the judge ruled that there was adequate evidence for Ssenyonga to be convicted on aggravated sexual assault charges.

In April 1993, Ssenyonga's trial opened. After hearing from both the Crown and Ssenyonga's defence lawyer, Justice Dougald McDermid acquitted Ssenyonga of the aggravated sexual assault charges. The justice wrote that, in his opinion, “the law of assault is too blunt an instrument to be used to excise AIDS from the body politic. If no other section of the *Criminal Code* catches the conduct complained of, which remains to

be seen, then it is a matter for Parliament to address through legislation” (Callwood 1995, p. 306). The justice ruled that consent was not vitiated by exposure to HIV, and that the sexual assault section in the *Criminal Code* was not designed to deal with cases of “ordinary” sexual relations. The trial continued to July 1993, but before Justice McDermid could rule on the charges of criminal negligence, Ssenyonga fell ill and died of AIDS-related infections in the hospital. Although the trial never came to a close because of Ssenyonga’s death, the case set a precedent for determining that “the defendant should have known that harm to sexual partners could result from unprotected sex, and that such recklessness is synonymous with intention” (Reeder, 1996, p. 414).

R. v. Ssenyonga established the legal parameters for future prosecutions by criminalizing intentional and risky conduct of PHAs who do not disclose their HIV-positive status. A person, therefore, who is unaware of his or her HIV-positive status and who has unprotected sexual relations is, by default, innocent. The Ssenyonga case highlighted that the court’s intention was not focused on HIV prevention, but on the “punishment of the guilty-minded” (Reeder, 1996, p. 414). The trial also marked the beginning of a series of conflicting court rulings that resembled the moves in a beleaguered chess game, with each legal manoeuvre overturning previous motions. The legal confusion surrounding HIV prosecutions came to the forefront when, after *Ssenyonga* fizzled in a quagmire of AIDS non-law, a court case in Newfoundland highlighted the questionable objectivity of judges’ decisions in cases involving HIV non-disclosure and transmission.

Pawns on a Legal Chessboard

Raymond Mercer was an HIV-positive man in his late 20s. Like Ssenyonga, Mercer had been warned by public health nurses to refrain from having unprotected sex. He ignored all orders, and continued to have sexual relations without disclosing his HIV status. Mercer infected several women, including a sixteen-year-old who became pregnant only to later abort the fetus for fear of mother-to-child HIV transmission. Two of the women infected by Mercer subsequently died from AIDS-related infections. In July 1992, Mercer was charged with criminal negligence causing bodily harm. In finding Mercer guilty, the lower court established criminal negligence rather than aggravated sexual assault, as used in *Ssenyonga*, as the appropriate crime because it punishes risky conduct rather than the actual transfer of the virus. Aggravated sexual assault requires proof that the defendant's actions endangered the life of his or her sexual partner, whereas criminal negligence requires a higher level of culpability as it necessitates proof that the defendant intended to cause harm. Section 221 of the *Criminal Code* states: "Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offense and liable to imprisonment for a term not exceeding ten years" (*Criminal Code of Canada*, RSC 1985, c C-46, p. 267). Mercer pleaded guilty to the charges, and was sentenced to two years and three months by the presiding trial judge. The Crown, however, appealed the sentence and in 1993, the Newfoundland Court of Appeal—in a surprise legal manoeuvre—increased Mercer's sentence to 11 years and three months. Chief Justice Marshall wrote for the majority: " Mr. Mercer's conduct for

these two young women must be viewed as catastrophic and dreadful.” The justice added that people who fail to heed medical advice to protect others from infection represent a grave danger to society and they cannot be allowed to circulate freely in it for fear that they will continue to knowingly infect other unwitting partners with impunity. . . . The consequences are too grave for society not to take every means at its disposal to curb such conduct and the court has the duty to protect the public accordingly. (Callwood, 1995, p. 360)

Although *R. v. Mercer* highlighted the judicial extremes in the legal landscape, the case was just one of an increasing number of HIV prosecution cases to come before the courts. As the 90s progressed, each court decision established a different precedent. Instead of following prosecutorial guidelines— as they were, in fact, non-existent—the courts continued to mold common and criminal law into a flimsy legal framework that was guided—or misguided—by the notion that the law’s role was to protect the public from health threats. Lower courts continued to oversee HIV non-disclosure and transmission cases until 1998, when the Supreme Court of Canada ruled on the historic *R. v. Cuerrier* case (Figure 1).

A Legal Crossroad in the Criminalization of HIV Non-disclosure and Transmission in Canada

In 1992, Henry Cuerrier, a PHA living in British Columbia, was charged with two counts of aggravated sexual assault for having unprotected sex with two women without disclosing his HIV status. Cuerrier was charged under Section 265 of the *Criminal Code*, which states: “A person commits an assault when . . . without the

consent of another person, he applies force intentionally to that other person, directly or indirectly”; and under Section 268: “Everyone commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant” (*Criminal Code of Canada*, RSC 1985,c C-46, p. 312).

Figure 1. Criminalization of HIV non-disclosure in Canada in the 1990s

Like Ssenyonga and Mercer, Cuerrier was instructed by a public health nurse to disclose his HIV status to prospective sexual partners, and to refrain from engaging in penetrative sex without a condom. Although both women consented to having sexual relations with Cuerrier, at the trial they both stated that if they had known Cuerrier was HIV-positive they would not have engaged in sexual intercourse with him. The Crown argued that even if the women consented to sexual intercourse with Cuerrier, the consent was vitiated, as they were unaware of Cuerrier's HIV-positive status. Yet the presiding judge acquitted Cuerrier of all charges on the basis that his HIV status was irrelevant to the issue of consent. The Crown appealed the judge's ruling, and the case went before the British Columbia Court of Appeal, where the justices unanimously dismissed the appeal, noting that the charge of aggravated assault was an unusual legal tool to use. Judge Prowse, writing for the majority, stated that "the purview of Cuerrier's actions cannot be considered assault," and he further recommended that Parliament take steps to create a new *Criminal Code* offence specific to HIV non-disclosure (Dej and Kilty, 2012, p. 60). With the Appeal court's dismissal of the case, the Crown appealed to the Supreme Court of Canada.

In 1998, the highest court in Canada overturned the Appeal Court's decision. Seven Supreme Court justices ruled on *Cuerrier*, and while they issued three separate sets of reasons, each with a different legal approach, they were unanimous in declaring "the non-disclosure of HIV-positive status could nullify a partner's consent to sex, thereby rendering the physical contact an assault as a matter of law" (Adam, Elliott,

Husbands, Murray, and Maxwell, 2009, p. 145). In the case of HIV non-disclosure and possible transmission, the Supreme Court ruled that the charge of aggravated sexual assault was permissible under the law. The Supreme Court also confirmed that criminal law could, and would, be used to deter PHAs from placing the lives of other people at risk, and to protect the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities (*R. c. Cuerrier*, [1998] 2 RCS).

The Supreme Court's ruling on *Cuerrier* set the precedent for future HIV non-disclosure and transmission cases by establishing legal parameters for determining whether fraud, which vitiates consent, has occurred in a given situation. First, the accused must be aware of his or her HIV-positive status and how the virus can be transmitted. Second, the accused must either fail to disclose or deceive the other person as to his or her HIV-positive status, so that the other person believes they have consented to engage in sexual relations with an HIV-negative person. Third, the most ambiguous criterion put forth by the Supreme Court was that the accused's dishonesty must result in a "significant risk of serious bodily harm" to another person. Fourth, the accused must be found guilty of having "caused the other person to consent," meaning the Crown has to prove the complainant would not have consented to have sexual relations if he or she had been aware of the accused's HIV status (Dej and Kilty, 2012). The Supreme Court's decision established that the disclosure of one's HIV-positive status is an essential prerequisite for any PHA seeking to engage in any sexual activities with another person. The Court also made clear that, in the absence of any significant risk, there was no duty to disclose, and that the "careful use of condoms might be found

to so reduce the risk of harm that it could no longer be considered significant so that there might not be either harm or risk of harm” (Adam et al., 2009, p. 145).

The Supreme Court’s decision, however, did not clarify what constitutes a “significant risk,” and thus failed to clearly define the legal parameters for the lower courts to establish whether, in a particular case, risk may or may not be significant. Rather than providing closure and certainty, the absence of clear guidelines propelled the judicial system into a state of “confusion and uncertainty, both within and beyond the legal system, about criminal liability for HIV non-disclosure” (Mykhalovskiy and Betteridge, 2012, p. 34). Since *Cuerrier*, the lower courts have continued to issue conflicting decisions in cases where PHAs have been charged with criminal offences ranging from aggravated sexual assault and administering a noxious substance to murder and attempted murder. A PHA's viral load (the amount of the virus in the blood) affects the level of risk associated with his or her sexual acts. Cases have been brought before the court for low-risk behaviour such as spitting and oral sex as well as for riskier behaviour involving vaginal and anal sex, with or without a condom. The failure of the Supreme Court to specify the legal definition of what constitutes a “significant risk” has forced the lower courts to hear each HIV prosecution case on an ad hoc basis, resulting in a random miscellany of decisions, charges and convictions, further contributing to judicial and nation-wide confusion.

Tumultuous Legal Interpretations

In 2001, James Edwards picked up a man at a local gay bar in Halifax, Nova Scotia. The two men left the bar, returning to Edwards's house where they performed consensual oral sex on each other, followed by anal sex where Edwards was the penetrator. Edwards was afterwards accused of stealing the man's ring and was summoned to police headquarters. Preceding his polygraph test, Edwards admitted that he was HIV-positive to the operator. The operator, in turn, relayed this information to Edwards's sexual partner, who stated he was unaware of Edwards's HIV-positive status and that all sexual activity had been unprotected. Edwards was subsequently arrested and prosecuted for non-disclosure of his HIV status. At his initial trial, Edwards was charged with aggravated assault and sexual assault. He admitted to unprotected oral sex, but stated the two men had practised safe anal sex. Edwards was acquitted of all charges for having unprotected oral sex, and it was ruled that the Crown had failed to establish that the anal sex was not consensual or that unprotected sex had occurred.

The Crown appealed the lower court's ruling and the case made its way to the Supreme Court of Nova Scotia, where Justice Goodfellow wrote the decision. The justice stated that the case was about whether or not the Crown had established "reasonable doubt that "unprotected" anal intercourse took place between these two men" (*R. v. Edwards*, 2001, NSSC80, p.10). In his decision, the justice wrote that the Crown had failed to establish beyond a reasonable doubt that the men had engaged in unprotected anal sex, that the sex was not consensual, and that the conduct endangered the life of the complainant. The justice maintained that it was not for the

trial judge to “expand what constitutes a criminal act,” and he found Edwards not guilty on both charges. While *Edwards* highlighted the inconsistencies in what is deemed low-risk versus high-risk behaviour, the next high profile case, *R. v. Williams*, focused on the nuances of aggravated sexual assault charges in HIV non-disclosure cases.

Five years after the *Cuerrier* decision, the Supreme Court of Canada heard the case of *R. v. Williams*. In June 1991, Nushawn Williams began an 18-month relationship with a woman, who later became the complainant in the case against him. The two engaged in unprotected sex on numerous occasions before Williams learned in November of the same year that he was HIV-positive. Although medical doctors and public health nurses counselled Williams on HIV transmission and safe sex practices, he failed to inform his partner of his HIV-positive status, and he continued to have unprotected sex with her for the duration of their relationship, which continued for another year. Two years after the relationship ended, the complainant learned that she was HIV-positive. During the trial, the court acknowledged that although the complainant tested negative for HIV in November 1991, there was a risk that she may have been in the “window period” (the length of time after infection before the virus becomes detectable) before Williams was tested for HIV. At trial, Williams was charged with, and convicted of, aggravated sexual assault and common nuisance. The case was appealed, and the Court of Appeal of Newfoundland and Labrador upheld the conviction for common nuisance, but downgraded the aggravated sexual assault to attempted aggravated assault on the grounds that the complainant could have been HIV-positive before Williams learned of his HIV status.

The Crown appealed the Appeal Court's decision and the case went before the Supreme Court of Canada. The question before the High Court centred on determining whether a PHA who has unprotected sexual intercourse without disclosing his HIV-positive status to a partner, where there is any possibility that the partner has already been infected with HIV, can be convicted of aggravated assault or attempted aggravated assault. The Supreme Court ruled that Williams could only be charged with attempted aggravated assault, as there was a possibility that the complainant had already been infected with HIV through unprotected sex with Williams before he learned of his HIV-positive diagnosis. "As a result, the prosecution could not prove beyond a reasonable doubt that Williams endangered the complainant's life and decided that, absent the aggravating factor of endangerment, he could not be convicted of aggravated assault" (Canadian HIV/AIDS Legal Network, 2009, P. 4). Although *Edwards* and *Williams* underline the inconsistencies in court decisions, the cases are just two examples of a series of court cases that contributed to the evolution of HIV prosecutions in the Canadian courts.

By 2011, more than 130 people living with HIV had faced criminal charges relating to HIV non-disclosure. The gravity of the charges has increased incrementally over time. People are often charged with aggravated sexual assault, which carries the maximum penalty of life imprisonment and registration as a sex offender; individuals have also been charged with murder and attempted murder.

In 2011, Johnson Aziga was charged with 11 counts of aggravated sexual assault for having unprotected sex with 11 women, seven of whom contracted the HIV virus.

After two of the HIV-positive women died, the charges were changed to first-degree murder, thus making Aziga the first person in an HIV non-disclosure case to be charged and convicted of first-degree murder. The premise behind Aziga's murder charges was that he knowingly attempted to transmit the virus to these women "with the intention of using the virus as a murder weapon" (Dej and Kilty, 2012, p. 63). Since Aziga's conviction, other PHAs have also been charged with murder and attempted murder. The inconsistencies in how the different courts have interpreted the HIV non-disclosure laws, laid charges, and imposed penalties have thrown judges, lawyers, activists and public health officials into a legal quagmire and given rise to a lengthy debate over the broad use of HIV criminalization laws. This debate was given a temporary reprieve in 2012, when the Supreme Court of Canada released its decision on two HIV non-disclosure cases, *R. v. D.C* and, most notably, *R. v. Mabior*.

Expanding the Scope of Criminal Culpability

In January 2004, Clato Lual Mabior tested positive for HIV. Public health nurses advised Mabior about safe sex practices, the proper use of condoms, and his legal obligation to disclose his HIV-positive status to potential sexual partners. Mabior failed to heed this advice, and continued to have sexual encounters with various women both before and after he was placed on Antiretroviral Therapy (ART) in April 2004. Regular ART has proven to lower the viral load of a PHA. The approximate viral load of an untreated PHA ranges from 10,000 copies to a few million copies per millilitre. "Copies per millilitre" refers to the amount of HIV in a person's bodily fluid. With ART, the viral

load can drop to less than 1,500 copies per millilitre, when the PHA is considered to have a low viral load. At times the viral load of a person on ART can be even lower, less than 50 copies per millilitre, which is considered undetectable. A high viral load indicates the virus is still reproducing and thus the risk of transmission is higher, while a low viral load indicates the amount of HIV in the blood is either low or undetectable and the risk of transmission is minimal. Mabior engaged in unprotected sex without disclosure with both a high and a low viral load.

In 2008, Mabior was brought to trial in Manitoba on nine charges of aggravated sexual assault, sexual touching, and forcible confinement. Mabior was found guilty on six counts of aggravated sexual assault for failing to disclose his HIV-positive status to six women. Although the charges were identical, the circumstances under which Mabior was charged varied. In some sexual encounters he used a condom, but had a detectable viral load; in others he had unprotected sex, but with a low viral load; and in still others, the condom broke or was removed before ejaculation. Most of Mabior's sexual encounters occurred after he was on ART, and none of the women had contracted HIV by the time of the trial. At his month-long court hearing in Winnipeg, the Crown argued that first, none of the complainants would have consented to having sex with Mabior if they had known about his HIV-positive status; second, that there was no scientific evidence that a significant risk of harm did not exist with a low viral load; and third, that the improper use of condoms reduced their effectiveness.

In her ruling, Justice Joan McKelvey agreed with the Crown's argument that "any chance of HIV transmission endangered the life of these complainants and no tolerance

of such a risk was appropriate” (*R. v. Mabior*, 2008 MBQB 201, p. 37). The Justice reasoned that Mabior “preyed upon these vulnerable women,” and that “the accused’s conduct was deplorable and despicable in all of the circumstances and must be condemned in the strongest possible terms. Those that are infected with HIV cannot inappropriately and indiscriminately engage in sexual relationships for their own pleasure without regard to the consequences to others” (*R. v. Mabior*, 2008 MBQB 201, p. 64). Mabior was convicted on six of the charges but acquitted of three others on the grounds that “where the accused’s viral loads were undetectable and a condom was used . . . the risk of transmission [fell] below the legal standard of ‘significant’” (*R. v. Mabior*, 2012 SCC47, p. 591). After Mabior was sentenced to 14 years imprisonment, his lawyers appealed the decision on the grounds that the justice had erred in judgment, and the case went before the Manitoba Court of Appeal.

The Court of Appeal expanded on the lower court’s decision by reasoning that using condoms or having low viral loads could nullify significant risk. The court agreed with the Crown and Justice McKelvey that Mabior knowingly applied “force” to the complainants in circumstances of a sexual nature, and that although the accused knew he was HIV-positive, he did not disclose his status to any of the complainants, who would not have consented to sexual intercourse had they been informed. However, the court also ruled that Justice McKelvey incorrectly interpreted and applied the *Cuerrier* decision on “significant risk” and erred in her understanding of the relevant evidence at trial, specifically that the trial judge mistakenly ruled that only a combination of both undetectable viral load and the use of a condom would be required to escape criminal

liability (*R. v. Mabior*, 2012 SCC47). The Court of Appeal struck down four of the six previous charges. The Crown appealed and the case proceeded to the Supreme Court of Canada.

In February 2012, the Supreme Court heard two cases concerning HIV non-disclosure, including *R. v. Mabior*. The second case, *R. v. D.C.*, concerned an HIV-positive woman who had vaginal intercourse without disclosing her status. At the time, she had an undetectable viral load. At trial, D.C. was convicted of aggravated assault and sexual assault on the grounds that no condom was used during sexual intercourse. The Quebec Court of Appeal, however, set aside the conviction on the grounds that the accused's viral load at the time of sexual intercourse was low enough to exclude any "significant risk of bodily harm."

In *D.C.* and *Mabior*, the Supreme Court was asked to decide on the circumstances in which a PHA can be convicted of aggravated sexual assault, and to determine how a low viral load and condom use could impact criminal liability in an HIV non-disclosure case. In addressing the issue of HIV disclosure in any sexual encounter, regardless of the risk, the Supreme Court dismissed the legal obligation to disclose in all sexual relationships, stating that such a requirement "arguably casts the net of criminal culpability too widely" and that it would unfairly stigmatize people living with the disease (*R. v. Mabior*, 2012 SCC47, p. 610). However, the Court upheld the legal test of "significant risk of bodily harm" as determined in *Cuerrier*, while adding that this only applies if there is a "realistic possibility" of HIV transmission (Adam, Elliott, Corriveau, and English, 2013). The Supreme Court ruled that if the HIV-positive partner had a low

viral load (1,500 copies per millilitre or less) and used a condom correctly, there would be no “realistic possibility” of HIV transmission, and therefore no duty to disclose.

Conversely, if a condom is not used and the viral load is not low, the Supreme Court determined there is a legal obligation for PHAs to disclose their HIV-positive status.

The *Mabior* case was an opportunity for the Supreme Court to give clear guidelines on the legal test of what constitutes the risk of transmission in HIV non-disclosure. However, instead of narrowing the definition, thus allowing the lower and appeal courts a legal yardstick to measure “realistic possibility,” the *Mabior* decision expanded the definition of “significant risk” to mean “any risk at all.” A PHA is obliged to disclose his or her HIV status when engaging in vaginal or anal sex without a condom, even if his or her viral load is low; and also if engaging in vaginal or anal sex with a condom, if the viral load is higher than the low viral count threshold determined by the Supreme Court. Instead of legal clarity, *Mabior* sent the legal community back into a tangled web of legal unpredictability, where the only certainty is the continuing prosecution of PHAs for offences appropriated from the criminal code. Isabelle Grant, a professor of law at the University of Toronto, argues that the underlying problem with *Mabior* begins with condoning the charge of aggravated sexual assault in HIV non-disclosure cases. Grant argues the charge is the most severe of all sexual assaults, where the accused is charged of wounding, maiming, disfiguring or endangering the life of the complainant. Aggravated sexual assault carries a potential life sentence, which is warranted by “the harmful consequences that ensue from the sexual assault, along with a heightened level of moral culpability” (Grant, 2013, p. 478). Grant also argues that the

Court's decision treats all HIV prosecution cases where there is deemed to be a realistic possibility of transmission as aggravated sexual assault, even if no transmission has taken place. The criminal emphasis, therefore, rests on disclosure, or the lack thereof. Under this premise, the only requirement to prove assault is to show that one partner was aware of his or her positive status and did not disclose; having a low viral load or using a condom is not considered enough to preclude significant risk. This expands the scope of criminal liability beyond *Cuerrier*, and does not take into account that

[lower courts] have held that the use of a condom alone precludes criminal liability, a position that promotes responsible behaviour and is most consistent with public health efforts. Some courts have also commented that an undetectable viral load may preclude criminal liability. *Mabior* requires both condom use and a low viral load before criminal liability can be avoided. (Grant 2013, 483)

The *Mabior* ruling muddied the waters for future HIV non-disclosure cases by its stringent interpretation of the legal requirements for disclosure. By expanding the risk threshold, the court's decision opened the door for more prosecutions and harsher charges for HIV non-disclosure. The first prominent case to come to trial after *Mabior* was *R. v. Boone*, a case that represents the most damning interpretation of the *Mabior* precedent: in the Boone case, the accused was charged and convicted of administering a noxious substance, aggravated sexual assault, and attempted murder.

Steven Boone was arrested in May 2010 for not disclosing his HIV-positive status to eight sexual partners. Although he was initially acquitted of attempted murder

charges at the preliminary hearing in 2011, the acquittal was overturned on the grounds that the judge erred by “wrongly weighing competing inferences” and was selective in accepting evidence (*R. v. Boone*, 2011). The Crown argued that the judge erred in favour of the defence by ruling that “while death is a possible consequence of contracting HIV, it is not an inevitable consequence, nor even a probable consequence.” The Crown stated that Boone had deceived his sexual partners and got “high” while engaging in high-risk behaviour—behaviour that could result in the transmission of HIV, which would inevitably lead to death. By dismissing the attempted murder charges, the judge “added an element of immediacy to the offence of attempted murder and in the process, usurped the role of trier of fact and failed to consider all evidence” (*R. v. Boone* 2011, p. 2). The Crown surmised that the trial judge had dismissed evidence that HIV reduces life expectancy and if left untreated could kill a person. With most of the charges reinstated, Boone’s trial commenced in October 2012.

At trial, Boone was convicted of three counts of attempted murder, three counts of aggravated sexual assault, and two counts of administering a noxious substance—his semen. Boone was accused of having unprotected sex between December 2009 and April 2010 with eight young gay men, one of whom contracted HIV. The Crown argued that Boone failed to disclose his HIV-positive status, that he lied about his status to his sexual partners, and that he deliberately tried to infect people with the HIV virus. The Crown commented that the men would not have had unprotected sex with Boone if he had disclosed his HIV-positive status. Boone was found guilty on all charges save one—a charge of attempted murder. At the time of writing, Boone remains incarcerated in the

Ottawa-Carleton Detention Centre awaiting sentencing for his Ottawa convictions.

Boone's case, the most blatant example of the over-expansion of HIV non-disclosure cases and punishments since the early 1990s, may have marked a milestone in the evolution of HIV prosecutions in Canada (Figure 2).

The Criminalization of HIV non-disclosure and Transmission in 2015

Since 1989 approximately 155 PHAs have been prosecuted for HIV non-disclosure and transmission. Prosecutions have occurred in all provinces except New Brunswick, the Northwest Territories, Yukon and Nunavut. Ontario leads the provinces in number of prosecutions with over 60 (B.C. Centre for Excellence in HIV/AIDS, 2015).

As there are no HIV-specific laws in Canada, the courts have utilized a broad range of charges from the *Criminal Code of Canada*, including the following: administering a noxious substance, common nuisance, assault, sexual assault, assault causing bodily harm, aggravated sexual assault, attempted aggravated sexual assault, sexual assault causing bodily harm, attempted murder, and first-degree murder. The most common criminal charge in most HIV non-disclosure cases is aggravated sexual assault, which carries a maximum sentence of life imprisonment without eligibility for parole for 25 years. In addition, all convicted PHAs are registered on the National Sex Offender Registry.

Figure 2. Key HIV non-disclosure Cases in Canada in the 2000s

2003**R. v. Williams**

Unprotected sex with one woman who tested HIV-positive after relationship ended

2010**R. v. Aziga**

Unprotected sex with several women
Two die from AIDS related complications

2012**R.v. Mabior**

Unprotected sex with women before and after taking ARTS

Charges

Aggravated sexual assault
Common Nuisance

Lower courts dismiss common nuisance.
Downgraded aggravated sexual assault to sexual assault

Supreme Court of Canada overturns ruling to attempted sexual assault.

Implications

Sets precedent for prosecutors to use attempted aggravated sexual assault

Charges

Aggravated sexual assault, upgraded to first-degree murder

Guilty and sentenced to life imprisonment

Implications

Set precedent for the first person to be charged and convicted of first-degree murder

Charges

Aggravated sexual assault

Supreme Court of Canada: duty to disclose one's HIV-positive status where there is a realistic possibility of transmission

No duty to disclose if condom is used and PHA has low viral load

Implications

Broadens definition set by Cuerrier. Fails to define "significant risk"

2012**R.v. Boone**

Unprotected sex with several men

Charges

Aggravated sexual assault
Administering a noxious substance
Attempted murder

Guilty, awaiting sentencing in 2015

Implications

Sets precedent for attempted murder

The lack of specific laws regarding the criminalization of HIV non-disclosure and transmission, and the failure of the Supreme Court of Canada to clearly define what constitutes a “significant risk” have contributed to the inconsistent interpretation and application of laws relating to the criminalization of HIV non-disclosure and transmission in Canada. The criminalization of HIV non-disclosure and transmission is a complex issue, and the lack of clear guidelines around the law has led to cases where PHAs have been charged with not disclosing their HIV-positive status even when scientific and medical evidence indicated that their sexual activities did not pose a significant risk of transmission. The misconceptions surrounding HIV transmission and the criminalization of HIV non-disclosure also extend to the general public; for example, people think that PHAs who have been charged, convicted and incarcerated have transmitted HIV to other people, but this is not necessarily the case.

Although some prosecutions are warranted, the mayhem surrounding criminalization may result in ever-increasing expansion of the use of criminal law against PHAs. The law has floundered over the past three decades. While criminalizing HIV non-disclosure and transmission as an HIV prevention method has fallen by the wayside, fear has continued to drive forward the criminalization of HIV; public health has become a proxy for the criminal justice approach, as officials are required to inform clients that the failure to disclose may lead to their arrest; while the Supreme Court of Canada, instead of taking into account ongoing advances in medical science in controlling the disease, has broadened the criteria for PHAs' legal requirement to disclose their HIV-

positive status. After three decades, HIV is no longer a death sentence, but PHAs are still seen as potential criminals in the eyes of Canadian law.

Chapter 2 demonstrates how the criminalization of HIV non-disclosure and transmission in Canada evolved from the original intent to protect the public from an infectious disease into the current legal climate where PHAs are prosecuted for failing to disclose their HIV-positive status. The chapter outlined how public health authorities helped endorse the criminalization of HIV non-disclosure and transmission. It highlighted the lack of legislation, and the Supreme Court of Canada's failure to clarify the legal tests used to determine risk of HIV transmission. All of these developments have contributed to the current legal environment surrounding the criminalization of HIV non-disclosure and transmission in Canada.

In Chapter 3, I will outline how the HIV criminalization laws have inadvertently pushed public health's role in HIV prevention efforts and the judicial system into opposite corners. The chapter will describe how AIDS, as a public health issue, developed into a human rights concern, and how the HIV non-disclosure laws violate an individual's rights and freedoms.

Chapter Three

Challenging the Historical Human Rights Framework

The town of Oran had no place for the ill. Human rights were not respected; those who fell ill were quarantined, jailed and treated as vermin until the plague ceased to claim any more lives. The town, which had been tranquil until the deaths started mounting, was thrown into a state of shock, and while panic reigned, bureaucrats fussed over policies, medical officials argued over treatment and community members fought to leave the plagued city.

It was as if the Earth on which our houses stood were being purged of its secreted humours; thrusting up to the surface the abscesses and pus-clots that had been forming in its entrails. You must picture the consternation of our little town, hitherto so tranquil, and now, out of the blue, shaken to its core, like a quite healthy man who all of a sudden feels his temperature shoot up and the blood seeping like wildfire in his veins. (Camus, 1947, p. 8)

The town of “Oran” is an amalgam of many real towns around the world where the residents found themselves facing the AIDS epidemic. Like Oran, these towns had no place for the ill. Oran’s reaction to the plague foreshadows the sentiment of communities living in cities in the Global North in the 1980s, when the first AIDS cases emerged. Fear of contracting the deadly virus cast a dark shadow over communities,

and People Living with HIV/AIDS (PHAs) were seen as menaces to society and treated as outcasts.

By the time the human immunodeficiency virus was isolated in 1983, AIDS was associated with the deviant lifestyle of gay men and was deemed a disease of “others.” However, as the disease crossed over into the heterosexual community, clinicians began to fear they were witnessing the onslaught of an epidemic that, like the plague and leprosy outbreaks of the past, did not discriminate among its victims. They were not wrong; in three decades, AIDS has claimed more than 30 million lives, it has become one of the world’s greatest public health disasters, and despite decades of intense research, a vaccination or cure has remained elusive.

AIDS is the modern plague. It came out of nowhere and, as it traversed across borders, it devastated communities, leaving behind dead bodies, ill people and a fear that the disease could never be controlled. AIDS is a disease that has confounded the medical community, but it is also a disease that has brought human rights and public health onto the same stage. AIDS changed the way public health researchers and policymakers looked at modern diseases: “It led them to consider the relationship between disease and broad social factors in greater depth and in new ways, with human rights as a central guidepost” (Klein, 2009, p. 264).

The criminalization of HIV transmission discriminates against PHAs. HIV non-disclosure laws mark the ill as criminals and turn victims into pariahs. These laws also strip away the social, political, and economic solidarity necessary to combat HIV, and by doing so violate individual human rights, which have been evolving since the 1800s.

In Chapter 3, I argue that using punitive measures as an HIV prevention method forces public health and the law into opposite corners of the health care arena, where the rights of PHAs are juggled between the two. The chapter will give an historical overview of human rights, ending with the formalization of human rights in the United Nations Declaration of Human Rights (UNDHR). The chapter will show how AIDS fits into the human rights framework, how the non-disclosure laws are at odds with public health efforts, and how the laws are eroding human rights.

The Unfolding of Global Human Rights

The political discourse of human rights has its roots in the intellectual reasoning and the social, economic and political rhetoric stemming from the French Revolution and the Enlightenment period. The late 18th century was “the period in which divine right was challenged by secular, or natural, interpretations of rights. With the progress of the Reformation, natural law, rather than divine law, became for the first time in history, the source of justification for the rights of individuals as well as nations” (Ishay, 1996, p. 499). The 1700s were a time for new beginnings, where universal and natural rights were no longer reliant on the approval of hereditary governments. Jean-Jacque Rousseau’s *Declaration of the Rights of Man and Citizen*, written in 1789, stated that all men, as citizens of the world, were born and remained free with equal rights. The treatise, which advocated for political and economic freedom from the French aristocracy and an archaic form of monarchist government, was an inspirational work and a sounding block for other philosophers. The 18th century was a time when the

discussion of the rights of man found its way into sentimental tropes and philosophical musings, but it was Thomas Paine's rebuttal in *Rights of Man* (published in 1791) of Edmund Burke's *Reflections on the Revolution in France* (1790) that laid the groundwork for a serious discourse on human rights.

In *Rights of Man*, Paine applauded the French revolution and opposed Burke's philosophy that put tradition and chivalry before democracy and a new order. Paine questioned the system of hereditary government that assumed power on the basis of an antiquated tradition. He saw history as tyrannical and, by shifting the temporal element of the past, which Burke used to justify the present, Paine put the rights of the living ahead of those of the dead: "I am contending for the rights of the living, and against their being willed away, and controlled and contracted for, by the manuscript assumed authority of the dead" (74). Paine advocated for a modern society where welfare redistribution, including old age pensions, were part of its democratic values. By demanding individual rights, Paine paved the way for a simple and fundamental human rights principle: "Whatever is my right as a man, is also the right of another; and it becomes my duty to guarantee as well as to possess" (Paine, 2011, p. 147).

The debate between Burke and Paine in the late 18th century was the starting point for the debate on the definition of human rights, and to whom they should be extended. The end of the century saw momentum towards freedom from the political shackles of monarchical governments, as well as a corresponding move to break away from the social and cultural acceptance of slavery. However, despite the narrative of the rights of man and the call for universal rights, the 1800s failed to deliver on promises of

universal human rights, as “human rights guidelines were eclipsed by the rise of nationalist resentments and the politics of national interest” (Ishay, 1996, p. 498).

Although the waves of rebellion that marked the century would serve to delay serious political consideration of human rights, discussions continued among various players:

[T]he major trend of human rights ideas entertained by the socialists of the mid-eighteenth century was . . . still imbued by romantic and communitarian influences. Anarchists, among others, rejected the idea of entrusting the state with the task of implementing human rights principles: The state was a vehicle for capitalist interests and domination. (Ishay, 1996, p. 500)

Thus the quest for human rights never wavered entirely. At the end of the 19th century, with the Industrial Revolution and the rise of the labour movement, there was renewed vigour in the calls for the global abolition of slavery, the emancipation of women, the establishment of safety measures in factories, and the right to health care and education as universal entitlements. The 20th century saw further revolutions and wars, which again revitalized the struggle to define human rights. In 1948, after World War II, human rights were finally codified in the Universal Declaration of Human Rights (UNDHR). Although the declaration “relies upon abstract norms, set forth without reference to longer history, culture, or local tradition and without reference to any stipulated ontological or metaphysical ground” (Wagner, 2005, p. 200), the UNDHR changed how human rights were perceived and led to the codification of human rights as universal, inalienable and indivisible. Although the UNDHR outlined a broad characterization of human rights, the question of what precisely defined a human right

remained unclear: “The abundance of its meanings may not be reduced to a false totality such as ‘basic human rights’ inasmuch as all human rights are basic to those who are deprived, disadvantaged, and dispossessed” (Baxi, 1998, p. 28).

To this day, the UNDHR constitutes a flimsy framework for human rights, which “implicitly accords centrality to the market, as the forum within which rights-bearing individuals undertake exchanges according to individualized preferences” (Wagner, 2005, p. 207). Individual rights in the 20th century were not universal or guaranteed; the basic right to health care, for instance, has long remained salient in the human rights debate. With the onset of the AIDS epidemic in the 1980s, public health became an integral piece of the human rights discourse, and the disease became the site of a contemporary human rights struggle in response to the extreme measures— the banning of PHAs from entering the United States, the isolation of infected children from schools, and the introduction of compulsory HIV testing for people from at-risk communities—proposed by governments to help stem the rising tide of AIDS-related infections. These proposals unduly affected marginalized groups, who made up a disproportionate number of PHAs.

The initial reaction to the HIV epidemic by policymakers bore a striking similarity to the narrative in Camus’s *The Plague*: “Compulsory declaration of all cases of fever and their isolation were to be strictly enforced. The residences of sick people were to be shut up and disinfected; persons living in the same house were to go into quarantine; burials were to be supervised by the local authorities in a manner which will be described later on” (1947, p. 32). Although proposals to quarantine PHAs never came to

fruition, HIV is a communicable disease and precautions had to be taken to protect the greater community as well as individuals affected by the virus. The debate over HIV/AIDS extended well beyond the confines of the human rights framework determined by the UNHCR; it became part of a moral debate that rested on human dignity where “human rights are not just a doctrine formulated in documents, they rest on a disposition towards other people, a set of convictions about what people are like and how they know right and wrong in the secular world” (Hunt, 2007, p. 27). How to destigmatize HIV and its association with deviant behaviour also became part of the human rights discourse, especially near the end of the 1980s, when every country in the world had reported cases of HIV. The rising number of infections clearly indicated that the world was facing a global epidemic, and that a more equitable and universal approach was needed to curb the spread of HIV infection.

AIDS as Part of the Human Rights Discourse

The AIDS epidemic fundamentally altered the way public health researchers and policymakers regarded the disease; it made them understand that HIV was not isolated, but a disease closely linked to various social factors and human rights. Although HIV may have baffled scientists and rattled politicians, the disease brought activists, advocates and public health officials into the same arena, where efforts to control the epidemic and to bring HIV into the human rights discourse began in earnest in 1981.

On April 28, 1981, the Centers for Disease Control and Prevention (CDC) published its Morbidity and Mortality Weekly Report (MMWR), stating that five gay men

had contracted a rare form of lung disease. The report marked the beginning of the AIDS epidemic in North America and its association with deviancy and the homosexual lifestyle. As the disease spread across North America, the term “gay disease” was coined, and it was only when the number of AIDS-related deaths in heterosexual communities began to spiral upwards that the threat of the disease was taken seriously. By the end of the decade, HIV had developed into a global health crisis that was clouded by a climate of fear and denial. In South Africa, for example, governments continued to deny the existence of HIV, despite growing evidence that sub-Saharan Africa had the highest number of AIDS-related deaths in the world and was on course to becoming the epicentre of the disease. In the Global North, HIV was a reality that could not be ignored, and fear of contracting the disease reached panic levels.

Discrimination against PHAs was rampant. Hemophiliacs like Ryan White, a teenager who contracted HIV through a blood transfusion, were banned from attending school, nurses refused to attend to dying patients for fear of contracting the virus, and doctors were evicted from buildings for treating AIDS patients (Shilts, 1987). Regulations implemented by public health officials and policymakers to stem the rising tide of HIV infections not only echoed the widespread panic surrounding HIV, but also were restrictive, and they disproportionately affected at-risk groups such as homosexual men, intravenous drug users, sex workers, Haitians, and immigrants or visitors from Africa. These regulations violated many individual and privacy rights: for example, newly diagnosed HIV-positive persons were asked to identify their sexual partners, health information was disclosed to third parties, and the names of PHAs were included in a

public health registrar—a requirement that still exists if the HIV test is not anonymous. Other infringements included curtailing the sexual freedom of gay men through the forced closures of bathhouses, banning gay men from donating blood, and imposing mandatory HIV tests for people from developing countries travelling to North America. Such a heavy-handed response to the AIDS crisis was disappointing to AIDS advocates and human rights activists; as a result, “civil and political rights were seen to respond to intrusive public health infringements on individual liberty and to serve as a bond among HIV-positive activists” (Meier & Onzivu, 2014, p. 181). AIDS activists and human rights advocates joined forces with non-governmental organizations (NGOs) to pressure governments to prioritize the rights of PHAs and to end discriminatory policies against people affected by the disease.

In the late 1980s, Dr. Jonathan Mann again put AIDS onto the human rights map when he established the Global Program on AIDS (GPA) under the umbrella of the World Health Organization (WHO). The GPA “conceptualized civil and political rights claims in opposition to restrictive public health measures, examining human rights violations as a key driver in the spread of the disease, and operationalizing human rights in WHO programming through strategies to combat HIV discrimination, promote health equity, and encourage individual responsibility” (Meier & Onzivu, 2014, p. 181). Mann regarded HIV as a health problem, where the social, cultural and political reaction to HIV/AIDS was as central to the global AIDS challenges as the disease itself. He worked under the premise that discriminatory and punitive measures against PHAs would “drive the infected underground, making it much more difficult for health agencies to track the

epidemic or treat people with the disease” (Fee & Parry, 2008, p. 60). Under Mann’s guidance, the GPA set up a human rights office, which developed and approved a Global AIDS Strategy in 1987. The strategy focused on non-discrimination against PHAs and equitable access to health care and treatment. Its objectives were to prevent new HIV infections, to reduce the personal and social impact of HIV infections, and to mobilize and unify national and international efforts against AIDS (World Health Organization, 1992). The strategy, which was updated in 1992, emphasized the need to give adequate and equitable health care to PHAs, expand availability and access to ART, create a supportive social environment for AIDS prevention programs by removing any legal or policy barriers, and focus on communicating the public health rationale for overcoming stigma and discrimination against PHAs and survivors affected by the disease.

Throughout the 1990s, the GPA continued to emphasize that AIDS has socio-economic ramifications, and that the effects of discrimination interfere with the “supportive environment needed for prevention programs and hampers the enlisting of HIV-infected persons as allies in prevention” (World Health Organization, 1992, p. 11). Through this rights-based framework, the WHO shifted the global AIDS policy away from a biomedical framing of international health to an individual rights-based strategy. The new approach went beyond the traditional program-based strategies that focused on education, health and social services, and on establishing a holistic supportive environment for PHAs. New prevention and treatment programs operated according to the understanding that “belonging to a discriminated against, marginalized, or stigmatized group reduces personal capacity to learn and respond. The practical

implication is that interventions are needed to reduce the societal risk of discrimination, in order to strengthen the personal capacity of people who are most vulnerable to HIV/AIDS” (Mann, Tarantola, & O'Malley, 1994, p. 50).

This new public health framework became the mainstay of the global effort against AIDS. In the new millennium, non-governmental and international health organizations continued global prevention and treatment efforts with a focus on lowering the cost of ART, so that even the poorest of the poor had access to treatment, and to developing comprehensive care strategies for people affected by HIV/AIDS. In 2001, the United Nations renewed its commitment to fighting AIDS, pledging to “enact, strengthen or enforce, as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS” (UNAIDS, 2011, p. 4).

However, as the 2000s unfolded and despite global efforts to lower HIV transmission rates, HIV/AIDS remained a global epidemic, and policymakers in the Global North once more turned to restrictive measures in an effort to curb the spread of the disease. More governments began to enact legislation that made it a criminal offence to transmit the HIV virus. These HIV non-disclosure laws made it the legal duty of PHAs to disclose their HIV-positive status to sexual partners.

Dismantling the Human Rights Framework

The increasing global adoption of HIV non-disclosure laws has cast a dark shadow over the modern public health framework promoted by the WHO. The HIV criminalization laws fail to put the rights of the ill at the forefront of public health, and indeed may even increase the risk of transmission among stigmatized groups by driving them away from health services. The criminalization of HIV non-disclosure and transmission erodes the existing bridge between health and human rights, which for the last two decades has put individual rights at the centre of public health approaches to HIV/AIDS (Klein, 2009). The dismantling of the modern public health framework, which Mann argued offered a more “coherent, comprehensive, and practical framework for analysis and action on the societal root causes of vulnerability than any other framework inherited from traditional public health or biomedical science” (J. Mann, 1996, p. 204) throws the future of HIV/AIDS as a human rights issue into uncertain territory.

In effect, the application of HIV criminalization laws takes away the rights of PHAs by casting them into a legal quagmire and potentially labelling them as criminals. Using punitive measures to prevent the transmission of a communicable disease can serve to perpetuate the stigma surrounding the disease—“stigma that governments have an interest in fighting for both human rights and public-health-related reasons” (Klein, 2009, p. 255)—and negate the efforts of programs dependent on stigma reduction. The concern of public health officials is that the criminalization of HIV transmission may drive at-risk populations, such as gay men, sex workers, intravenous drug users, immigrants, ethnic minorities, and Africans underground and cut them off

from public health services. People may refrain from getting tested or treated for fear of subjecting themselves to criminal prosecution for knowingly exposing others to HIV or transmitting HIV. Fear of being reported to the police may make it harder for sex workers to negotiate safe sex conditions and for intravenous drug users to access harm reduction programs. Many human rights activists fear the laws may be cast too wide and that they will unjustly punish those who do not deserve punishment:

[T]he constant challenge facing the human rights movement is ensuring that the state does not act outside the constraints of the law, including abusing its power to enact criminal laws that: violate principles of individual privacy or non-interference; undermine freedom of expression and assembly; are enforced in discriminatory ways; have the effect of criminalizing a person's status as opposed to an act; are imprecise or overly broad; and/or enable the state to use the law in an arbitrary or capricious manner. (Brown, Hanefeld, & Welsh, 2009, p. 120)

Although there is potential for the legal environment—laws, enforcement and the justice system—to better the lives of PHAs by protecting equal access to health care and by mitigating discrimination, the punitive laws and the “discriminatory and brutal policing and denial of access to justice for people with and at risk of acquiring HIV are fuelling the epidemic” (Global Commission on HIV and the Law, 2012, p. 7). As the legal environment cannot keep pace with medical and scientific advances in prevention, transmission and treatment, judicial decisions remain arbitrary in nature. The HIV criminalization laws put the legal system at odds with public health efforts; they cast

policymakers into one corner of the field and health officials into the other, while the rights of PHAs are juggled between the two.

The current trend among governments to criminalize HIV transmission erodes the rights of the ill; however, these laws continue to be implemented despite the concern of international health and human rights organizations, including the United Nations. In 2012, the Joint United Nations Programme on AIDS (UNAIDS) urged governments to use criminalization laws only in cases of intentional transmission when an HIV-positive person knowingly, purposefully, and successfully transmits the virus to a sexual partner. In 2013, UNAIDS reiterated its stance in an updated policy document that highlighted the extensive use of HIV criminalization laws, and again raised serious concerns over human rights violations and public health implications as a result of these laws. The Global Commission on HIV/AIDS also states that the criminalization of HIV transmission discourages the development of HIV prevention programs, and it recommends that governments would be better off expanding HIV prevention programs to encourage counseling and voluntary testing, and to directly address stigma and discrimination around HIV. This, however, is not the direction in which governments seem to be heading. The widespread use of HIV criminalization laws only serves to erode the progress made by health experts, AIDS activists and human rights advocates to bring HIV into a public health framework centred around a human rights discourse.

An Ongoing Debate

The debate over human rights and who is entitled to receive them has had a tumultuous history. After the French Revolution in the mid-1800s, British philosophers put pen to paper to present arguments urging society to move beyond archaic monarchies that put tradition before progress, chivalric values before public opinion, and self-determination before collective rights. As the centuries unfolded, the human rights discourse evolved and expanded to include the abolition of slavery, rights for the proletariat, women's emancipation and universal access to education and healthcare. After numerous rebellions, uprisings and two world wars, the quest for the definition of human rights culminated in 1948 with the historical development and adoption of the UNDHR. Under the UNDHR, collective rights as well as individual rights were codified under international law.

In modern societies, legislation is put into place to protect collective well-being. Individuals are obliged to live within the boundaries of the law, which is enacted for the greater good, and is enforced to protect the society. If the latter is true, then how does the criminalization of HIV transmission fit with the concept of protecting communities? It is undeniable that society needs laws to protect people from the wrongdoings of others, but can the criminalization of HIV transmission protect society when it punishes the vulnerable, undermines public health efforts by encouraging risky behaviour, and marginalizes a community that needs medical help and access to social services?

The government's use of the power of the law ignores the reality that AIDS is a complex disease intertwined with many socio-cultural issues. Using an iron fist to

grapple with the spread of HIV can only serve to incite fear around the disease and negatively affect the most vulnerable of PHAs—sex workers, men who have sex with men, intravenous drug users, immigrants, and ethnic minorities. Fear of being prosecuted for an illness isolates PHAs and may discourage them from getting tested, participating in prevention or treatment programs, or disclosing their status to sexual partners. In short, criminalization of HIV essentially quashes public health initiatives and divides “populations into the sick and the healthy, or the guilty and the innocent, . . . denies the complex social nature of sexual communities and fractures the shared sense of moral responsibility that is crucial to fighting the epidemic” (Global Commission on HIV and the Law, 2012, p. 20).

Although monumental efforts have been made to fight the rising number of HIV infections over the past three decades, AIDS is an ongoing epidemic that continues to claim the lives of millions each year. Criminalization laws loosely tie a noose around PHAs, forcing them into vulnerable positions reminiscent of the 1980s, when the rights of the ill were ignored while the healthy and unaffected looked the other way. Each HIV non-disclosure case is a building block that is steadily constructing a brick wall, which has the potential to increasingly isolate the ill from the healthy and to marginalize certain groups of people. Once again the world has been enclosed inside the walls of Oran, where the memories of plagues gone by remain only in the mind of the ageless narrator:

Figures floated across his memory, and he recalled that some thirty or so great plagues known to history accounted for nearly a hundred million deaths. But

what are a hundred million deaths? When one has served in a war, one hardly knows what a dead man is, after a while. And since a dead man has no substance unless one has actually seen him dead, a hundred million corpses broadcast through history are no more than a puff of smoke in the imagination. (Camus, 1947, p. 19)

Chapter 3 analyzes how the criminalization of HIV non-disclosure and transmission has distorted the relationship between public health HIV prevention efforts and the legal system. The chapter outlines how HIV/AIDS became part of the human rights framework and how the criminalization laws undermine the health, well-being and rights of PHAs.

Chapter 4 will explore the trajectory of HIV/AIDS over the past three decades. It will analyze how the disease has been portrayed in the media and how news coverage of HIV/AIDS perpetuates stereotypes and stigmatizes people living with and affected by the disease.

Chapter 4

A Moral Crisis and Public Health Disaster

A friendly down-home accent identified the twenty-two-year-old patient from the South. He was an attendant in a San Francisco bathhouse and had been admitted to the hospital a few days ago with diarrhea and weight loss; the Kaposi's sarcoma diagnosis had been confirmed the day before. Emaciated and covered by lesions, the young man looked like a patient who was, perhaps, in the advanced stages of stomach cancer. It was hard to look more advanced than this fellow; . . . he looked like someone who was going to die.

—Randy Shilts, *And the Band Played On*

It was July 1, 1981, and the young man from the South was one of the first known gay men to suffer a long, lonely and excruciating death from a disease that later became known as HIV/AIDS, a disease that took the world by surprise. For the best part of the 1980s, HIV/AIDS was largely ignored by mainstream society until the death toll began to rise and the disease turned into a terrifying medical crisis. By the time HIV had crossed national and transnational borders, the disease had broken economic barriers, showing little regard for social class, sexual orientation, race, gender or age. In one decade, HIV/AIDS had become the world's greatest public health disaster, with prevention and treatment initiatives being undertaken as joint efforts between nations, newly created international agencies, health facilities, non-governmental organizations, philanthropic foundations, and biomedical institutions. In just three decades, HIV/AIDS transformed from an unknown disease into a worldwide pandemic affecting millions. The historical narrative of HIV/AIDS is complex and regards HIV as a political, health and

social problem. It is a narrative that has been followed intently by public health officials and by AIDS advocates, who charge that it has been mishandled by the media. Over the past three decades, news about the disease has been sporadic, fluctuating from sparse coverage to tabloid exposés that have perpetuated a climate of moral panic within North American society.

In the 1980s, HIV/AIDS was an illness associated with deviant behaviour that aroused fear and panic in citizens and threatened “societal values and interests” (Hall, Critcher, Jefferson, Clark, & Roberts, 1978, p. 55). In the 1990s, when it was more widely understood that the disease could affect anyone and new global efforts were concentrating on prevention and treatment, AIDS fatigue set in, media coverage waned, and what Hall et al. (1978) called “moral panic” subsided until the new millennium. Early in the 21st century, with HIV transmission rates holding steady in the Global North, the criminalization of HIV non-disclosure and transmission began to appear in government policies as an alternative way to prevent the spread of the virus. Coverage of HIV criminalization laws echoed the media rhetoric of the 1980s, and in true tabloid fashion the press once again reconstructed the AIDS narrative into sensational news items that served to stir up fear and moral panic in society.

Chapter 4 will analyze the social production of news by Western media within a cultural studies framework, where agenda setting, gatekeeping and news framing show how moral panic was, and is, incited in the public sphere. Cultural studies takes into account the socio-political ideologies of the dominant class, and as such, this chapter will examine how the media influences public opinion. Nesbitt-Larking (2007) shows

how the symbiotic relationship between the media and the reigning ideologies means that the media are more inclined to produce stories from a cultural perspective that is biased against certain members of the public. The chapter will elaborate on these ways of understanding the work of the media and how the evolution of HIV/AIDS has been mirrored by media coverage, from front-page news to the obituary columns, and back to breaking headlines—in short, a tale of tabloid hysteria. It will examine how HIV/AIDS non-disclosure cases are reported in the Canadian media, whether cases involving a person's non-disclosure of his or her HIV status are covered in a way that incites "moral panic" in society, and how fear and panic play a role in defining news around HIV.

Theoretical Background

News is an integral part of culture; it forms a system of production and distribution that reproduces the dominant ideologies whereby "the roots of media and cultural texts are consequently embedded in social reproduction and conflict, part and parcel of our social life" (Durham & Kellner, 2006, p. xiii). While it is the democratic duty of the media to keep the public informed, events are not by nature newsworthy. News is a socially constructed product geared for market consumption, and the result of a complicated set of processes involving "political, economic, ideological, cultural, and situational/organizational criteria that complexly generate stories" (Hall et al., 1978, in Nesbitt-Larking, 2007, p. 81). The overall structure of the news flow is controlled and regulated by corporate executives and managing editors, who determine news values and decide how the message should be framed. How the news is framed and

constructed is part of the agenda-setting process, where news articles are designed to be understood by the audiences and to have maximum impact on the public (Hall et al., 1978).

Agenda setting and news framing set the stage for storytelling and for editorial gatekeepers to determine what is newsworthy by assuming the “dominant interpretations of reality” (Nesbitt-Larking, 2007, p. 54). When issues that have news value have been selected, messages are then encoded in a particular way that incorporates the media organization’s professional values, political views, legal constraints and economic needs. Journalists producing the news articles help provide audiences with a narrative map, particularly in regard to extraordinary events, to help make sense of a situation outside their realm of consciousness. However, journalists are confined to their own biases and ideologies, as well as to ideologies of the media organization, and thus no news story can be completely objective. News output is, therefore “conditioned by, and then conditions, the broader culture and the particular dominant forms of ideology that emerge and decline through hegemonic struggle” (Nesbitt-Larking, 2007, p. 83).

In covering the HIV/AIDS crisis, the media have been governed by the ideologies of primary news definers, such as public health authorities, the scientific community, government officials, lawmakers and law enforcement officials. In the 1980s, at the onset of the HIV/AIDS epidemic, the media relied on public health officials to establish the risk parameters around HIV transmission. As the disease was newly discovered, officials were unable to provide information on how the victims contracted the virus,

how contagious it was, and if the disease could be treated. The media helped to perpetuate anxiety and, instead of reassuring the public, instilled a sense of moral panic that has kept the fear of HIV/AIDS alive for over three decades, even as scientific knowledge and treatment have advanced dramatically. From a cultural studies perspective, HIV/AIDS became a social construction of risk, of being treated differently or discriminated against because of being HIV-positive; and it was the consequences of this risk that societies feared (Waisbord, 2011).

The Cycle of Moral Panic in the HIV/AIDS Narrative

Throughout history, societies have fallen into periods of moral panic, which Hall et al. (1978) describe in *Policing the Crisis*:

A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereo-typical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce the diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible. (p. 16)

Although Hall's work focused on "mugging" as a social phenomenon, which through sensational news reporting incited a moral crisis in Britain during the 1970s, the tendency for the media to use risk as a scare factor still continues. June Kolata, in a June 1998 *New York Times* article entitled *AIDS Virus Found to Hide in Cells, Eluding Detection*

by *Normal Tests*, describes how the virus could “lurk” in the body’s macrophages for years, disrupting the cells’ function to fight disease; and as Susan Sontag (1990) observes, this condition persists “even when the macrophages are filled almost to bursting with virus” (p. 107). Sontag argues that the mainstream media use scare tactics when writing about AIDS and scientific discoveries about the disease. The *New York Times* example illustrates the cumulative power of the media: in any instance of moral panic it may be that the media reports on bad science correctly, on good science incorrectly, we may fail to check facts or commit to a complete investigation, or we may simply skip over investigative pieces for sensational stories; but as purveyors of news, the media have the power to influence public opinion for better or for worse.

In the 1980s, HIV was categorized as an illness associated with homosexuality and intravenous drug users and, as such, the disease was seen as an illness that affected “others,” and not members of mainstream society. HIV was regarded as a product of deviancy, and the media’s portrayal of the disease became a reflection of that public sentiment. Ignorance about HIV/AIDS was fuelled by misinformation and sensationalism; fear of the disease became the dominant paradigm, while stories around HIV/AIDS became harbingers of disaster and doom. As the disease spread and more people became infected, HIV/AIDS began to lose its “otherness” and became a disease without boundaries and a threat to all members of the public.

In the 1990s, as mainstream society began to experience the impact of HIV/AIDS, Western media focused on public health efforts, scientific advancements, and government policies. Fear of the disease began to fade with the discovery of an effective

treatment and, as HIV awareness spread beyond national borders into developing countries, moral panic in the Global North subsided and news stories migrated into the back pages. However, in the late 1990s and 2000s, as governments began to enact legislation that criminalized HIV non-disclosure and transmission, a new wave of fear began to rise. This new round of moral panic was exacerbated by the roles played by primary news definers: lawmakers who enacted legislation, police who had the duty to arrest PHAs suspected of trying to transmit a deadly virus, and prosecutors who were obliged to push for charges that could lead to the potential incarceration of an ill person. The press, having sensed another extraordinary situation, reframed HIV/AIDS as a 'new' threat to the public, and coverage, once again, became dominated by sensationalism and driven by ideas of morality.

As a disease, HIV/AIDS has upset economies, destroyed social structures and altered questions of morality. Failing to disclose one's HIV status to a sexual partner and risking transmission of the virus touches on the fundamental moral value of not harming another person. The fear that HIV could be used as a weapon is exacerbated by media coverage, which serves to "structure and mold" public opinion: the more public an issue like the criminalization of HIV non-disclosure and transmission becomes, "the more we can detect the presence of larger networks of meaning and feeling about it; the more we can discern the presence of a highly structured, though by no means complete, or coherent, or internally consistent, set of ideologies" (Hall et al., 1978, p. 136). These reigning ideologies are reflected in the media discourse around HIV/AIDS from the 1980s to 2015. The HIV/AIDS narrative is an example of how the media failed to use its

power to fully inform people about the disease—of how it was transmitted, how it could be prevented, and if it could be cured. Instead of disseminating information, the media coverage of the epidemic primarily served to promote widespread panic.

An Historical Account of the HIV/AIDS Narrative

Within a Western socio-cultural framework, HIV is intrinsically linked to sexuality and morality. As a news event, HIV has been a story of discovery and public reaction, public health intervention, biomedical and scientific quest and resolution, and a story of criminal offence. Epidemics are the epitome of a dramatic unfolding of real-time events; through media coverage, epidemics have the power to evoke widespread responses within the public sphere. As the media have long been associated with the public's fascination with drama, epidemics, war and terror, HIV/AIDS became a subject appealing to journalists, who have the tendency to focus on and illuminate the extraordinary in order to emphasize its newsworthiness (Hall et al., 1978).

The historical narrative of HIV/AIDS and the media, which can be monitored over three decades, covers the discovery of a new disease and its link to homosexuality; a global effort by public health and government officials to help prevent the spread of the disease; a scientific endeavour to find a treatment; and a transformation of the disease into an illness where the sick are regarded as potential criminals. Over the decades, three major thematic storylines emerged: AIDS as a gay disease, HIV prevention on a global scale, and the criminalization of HIV non-disclosure and transmission. The first theme began to develop in 1981, when information about a possible link between

“some aspect of homosexual life-style or disease acquired through sexual contact and pneumocystis pneumonia in this population” was released by the Centers for Disease Control and Prevention (CDC) in one of its weekly reports (Shilts, 1987, p. 67).

The 1980s: AIDS as a Gay Disease

On April 28, 1981, the CDC published its Morbidity and Mortality Weekly Report (MMWR) highlighting the discovery of pneumocystis pneumonia, a rare form of lung disease, in five previously healthy young gay men in Los Angeles. After releasing the report, the CDC received calls from doctors and clinics around the United States reporting similar cases, as well as other instances of young gay men with Kaposi’s sarcoma, an unusual form of cancer. It was the beginning of an epidemic that was to become known as HIV/AIDS (Figure 3).

As the years unfolded, more cases of HIV were discovered, but little was known about how the disease was transmitted until 1983 when the CDC published an MMWR suggesting that the virus was transmitted through sexual acts and exposure to blood. By the time the virus was isolated in 1984, AIDS was primarily associated with homosexual men and intravenous drug users. As the virus spread through at-risk communities—homosexuals, drugs users and hemophiliacs—public health officials implemented prevention efforts targeting these groups, while biomedical efforts concentrated on mitigating transmission. During the 1980s, while efforts were concentrated on health outcomes, public health officials and researchers did little to curb the social impact of HIV/AIDS on the hardest hit communities and the wider public. Public health and

government literature on the disease targeted communities most likely to contract HIV, while news stories primarily focused on AIDS as a gay disease.

Figure 3. HIV/AIDS Timeline 1980s

1981	CDC discovers rare lung disease in five gay men
1983	Health Canada bans men who have sex with men from donating blood
1984	HIV virus is identified. Hemophiliac Ryan White contracts HIV from a blood transfusion
1985	Rock Hudson dies. First AIDS conference.
1986	U.S. President Ronald Reagan mentions AIDS publicly for the first time
1987	United Nations holds global conference on AIDS epidemic
1988	December 1 declared World AIDS Day
1989	World Health Organization estimates 500,000 people are infected with HIV

The 1980s was not an era of enlightenment. Homosexuality was taboo, and the Lesbian, Gay, Bi-sexual and Transgender (LGBT) communities were ignored or castigated for their immoral activities by the law, society and the media. Western media portrayed HIV/AIDS as a cultural disease, “making possible the idea that infection was linked to identities located outside the ‘mainstream’; outside ‘proper’ heterosexuality. Media coverage in the 1980s and 1990s was marked by the demonization of gay men, drug users and other marginalized populations as culpable conduits of disease” (Persson & Newman, 2008, p. 633). In his 1987 book *And the Band Played On*, Randy Shilts writes that the American media’s initial reaction to HIV/AIDS was to remain silent, and that one year after the first AIDS cases were discovered, “editors were killing pieces . . . because they didn’t want stories about gays, and all those distasteful sexual habits littering their newspapers” (p. 110).

The initial lack of interest by the media reflected the reigning political and social ideologies: the U.S. Government saw the epidemic as an economic problem, public health officials saw it as a political problem, and the press saw it as a gay problem and, since homosexuality was a taboo subject, HIV/AIDS was not considered newsworthy. It was only when the death toll began to climb, and the country found itself in the midst of a national epidemic, that the media began to fulfil its role as a public custodian by covering news on the disease. Although individual stories were written on the disease—how the HIV virus was transmitted, and how the disease was responsible for the rising death toll—editorial gatekeeping and news framing skewed major stories towards a narrative that fuelled moral panic in society. From an agenda-setting perspective, the

early years of the HIV/AIDS epidemic were a missed opportunity for the media to inform the public about the disease. It was unfortunate that the apparent ethos of the press was that “unless the American media’s core constituency of middle-class individuals is perceived to be at risk, a rampant disease like AIDS does not constitute a news story with high news value” (Stevens & Hull, 2013, p. 365).

By the mid-1980s, fear of HIV/AIDS was rampant, and public reaction to people living with or associated with HIV was vitriolic. Students such as Ryan White, a young hemophiliac who contracted HIV through a blood transmission, were banned from attending school, and doctors treating AIDS patients were evicted from their buildings (Shilts, 1987). Lack of knowledge about how HIV was transmitted created pandemonium, and the risks of becoming infected were exaggerated in press coverage (Von Collani, Grumm, & Streicher, 2010). One example of the media’s mismanagement involved a study published in the *Journal of the American Medical Association* suggesting that “children living in high-risk households are susceptible to AIDS, and that sexual contact, drug abuse or exposure to blood products is not necessary for disease transmission” (Shilts, 1987, p. 300). The findings were misinterpreted by the Associated Press (AP), which issued a press release claiming that “children may catch the deadly immune deficiency disease AIDS from their families, [which] could mean the general population is at greater risk from the illness than previously believed” (Shilts, 1987, p. 300). The mass hysteria ignited by news stories based on the AP’s press release was further inflamed by stories on HIV being transmitted through “routine household contact,” as well as the media’s reluctance to use the word “semen” in news articles,

and the blood banks' disapproval of the use of the term "blood" in reference to HIV transmission. Instead of using the correct terminology, the media replaced "semen" and "blood" with the more general term "bodily fluids" in articles describing possible modes of transmission (Shilts, 1987, p. 300). The opacity of the terms did little to alleviate public terror or combat rising panic about the disease; instead, the use of imprecise terminology by the media added to the climate of fear surrounding HIV/AIDS. Tabloid headlines and stories of gays spreading the disease became part of the media's HIV/AIDS narrative, prompting a surge of moral panic throughout society. Until the closeted homosexual movie star Rock Hudson died in 1985 of AIDS-related complications, the disease was linked to deviancy and marginalized communities. The death of a celebrity (a primary definer of news) put HIV/AIDS on the map; in one instant HIV/AIDS became a disease that did not distinguish between race, gender or class. As knowledge about the disease became more widespread, the media—though adept in the art of "fashioning exaggerated fear and paranoia"—touted articles on cures and treatments, but even as the scientific community struggled to unravel the evolution of the disease, news stories continued to maintain an element of intrigue and mystery, referring, for instance, to the CDC as "disease detectives" (Shilts, 1987, p. 320).

Although media coverage of HIV/AIDS was, as Nesbitt-Larking (2001) writes in *Politics, Society, and the Media*, "negative, cynical, obsessed with strategy and tactics, and dependent on official sources" (p. 319), the 1980s was a time of uncertainty as there was no official government or medical stance on the disease. Politicians sidestepped the issue, the medical community struggled to find out exactly how the

virus was transmitted, and scientists were rushing to find a test for the virus—and a treatment and a cure, the latter of which has still not been achieved. Without official sources to draw from, the media turned to any number of credible, or less than credible, sources, and reframed HIV/AIDS as a terror story. Packaged as a story of drama and conflict, the disease became a news story with a huge audience that the media could “sell” to the public.

Editorial gatekeepers determined not only which stories about HIV/AIDS were newsworthy, but also how the stories were framed, so as to keep the momentum of fear going for a decade. However, HIV/AIDS could not be neatly bundled; as an unfolding story, it was “unexpected and dramatic, with negative consequences, as well as human tragedies involving elite persons” (Hall et al., 1978, p. 57). It was not a news story with a “beginning, middle, end, heroes and villains, conflict and resolution” (Nesbitt-Larking, 2007, p. 324); it was a story with no end and defined only by the ‘villains’ until the 1990s. As the disease exploded into a global pandemic with Africa at the epicentre, news metamorphosed into coverage that focused on the disease’s impact in sub-Saharan Africa. The subsequent denial of AIDS by African governments along with global prevention efforts and treatment of HIV/AIDS created a new focus for those North Americans interested in Africa, and a new sense of “otherness” for those who were not. With more coverage on the disease in distant places than at home, the 1990s saw a decline in moral panic within North America, and by the end of the decade, compassion fatigue had set in as AIDS was no longer timely or regarded as an extraordinary event—which brought its own set of problems. Although HIV/AIDS faded

from the headlines as the media chased different stories, the societal and public health problems associated with HIV/AIDS remained, but were now hidden from public view. The decline in news coverage and the ensuing compassion fatigue was the “consequence of rote journalism and looking-over-your-shoulder reporting. It is a consequence of sensationalism, formulaic coverage and perfunctory reference to American cultural icons” (Moeller, 1999, p. 2).

The 1990s: A Global Epidemic

At the beginning of the 1990s, when compassion fatigue had not yet set in, HIV/AIDS was still making headlines as the disease developed into a worldwide pandemic. Unlike in the previous tumultuous decade, HIV was no longer associated with deviancy; it was a disease that affected everyone and “despite the potential for hysteria and some examples of irrational response, science and reason prevailed; epidemiology and surveillance served as the foundation of society’s early response” (De Cock, Jaffe, & Curran, 2011, p. 3).

HIV/AIDS was no longer a rogue disease giving rise to panic in Western societies. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in 1996 as a credible global policy-making institution dedicated to monitoring global responses to HIV/AIDS. Public health efforts and government policies helped calm fears around the disease, and with the introduction of Antiretroviral Therapy (ART) in the Global North, which led to a decline in AIDS-related mortality, the disease was transformed from a death sentence to a manageable chronic illness. Prevention efforts and access to

treatment had successfully slowed the infection rates in the Global North, but once HIV/AIDS crossed transnational borders it became a worldwide concern.

Advocacy groups helped mobilize international responses to the HIV/AIDS crisis, and new global health and governmental partnerships were developed to combat the spread of the disease. However, by the mid-1990s, global HIV infection rates peaked at more than 30 million people, with 16,000 new infections being reported daily (Schwartlander & Sittitrai, 1998). HIV/AIDS had reached pandemic proportions, and sub-Saharan Africa had become the epicentre of the pandemic. By the end of the century, HIV prevention and treatment efforts by non-governmental and governmental organizations were targeting people living in developing countries. As the focus remained on containing the disease and slowing the rising infection rates, the media began to play a new role in disseminating information about HIV/AIDS to the public (Figure 4).

The 1990s saw a shift in Western media coverage of the AIDS epidemic from hysteria and moral outrage to HIV/AIDS as a public health crisis, a biomedical concern, and a social justice issue. However, when infection rates hit an all-time high in sub-Saharan Africa, HIV/AIDS stories again started to slip into the back pages of newspapers and AIDS fatigue set in for a number of reasons. First, HIV/AIDS stories had been circulating for years; they were no longer timely or interesting to the North American public who were saturated with news about the disease. HIV/AIDS was an old story, and as journalism and time have a symbiotic relationship, HIV/AIDS was no longer considered breaking news: “Journalists respond less to the pressing demand of issues

than to the relentless churn of the news cycle. The speed of the news cycle and the relentless search for fresh stories steer the journalist toward certain developments and away from others” (Traquina, 2004, p. 100).

Figure 4. HIV/AIDS Timeline 1990s

1991	U.S. Basketball star, Magic Johnson announces he is HIV-positive
1992	AIDS becomes the number one cause of death in the U.S. for men ages 25 to 44
1993	CDC includes pulmonary tuberculosis recurrent pneumonia and cervical cancer to indicators of AIDS
1994	U.S. Food and Drug Administration approves oral HIV test
1995	Treatment for HIV - Antiretroviral medicines
1996	Viral load test measuring amount of HIV in the blood
1997	UNAIDS estimates 30 million people affected with HIV
1998	Supreme Court of Canada: PHAs have a legal duty to disclose HIV-positive status
1999	World Health Organization: AIDS as fourth-biggest killer in the world

Second, proximity is important in the social production of news, and HIV/AIDS had once again become a disease of “others”—people living in developing countries. News stories that made headlines in the Global North focused on scientific advancements by Western scientists and the doings of celebrities such as basketball star Magic Johnson’s announcement he was HIV-positive (Brodie, Hamel, Brady, Kates, & Altman, 2004). Third, the political and scientific power elites, who were the primary news definers, were situated in the Global North and not at the epicentre of the disease. As the media operate under the dominant ideologies of these primary definers, “those who lack power are harder to reach by journalists and are generally not sought out until their activities produce social or moral disorder news” (Traquina, 2004, p. 102). Hence news stories on HIV/AIDS were either event-related, focused on medical advancements, or concerned with extraordinary cases, and thus international coverage on AIDS concentrated on AIDS conferences, the push for generic versions of antiretroviral drugs, and in the late 1990s, on South Africa’s President Mbeki’s denial that the HIV virus was the cause of AIDS. News about AIDS that was not dramatic or event-focused was pushed to the back pages, and coverage of the disease’s impact on the global population was put on the back burner.

As countries in the Global South continued to deal with the catastrophic effects of HIV/AIDS, populations in the Global North were buoyed up by the news that HIV infection rates were slowing down and that, with access to treatment, AIDS was no longer a deadly disease. As global public health efforts concentrated on slowing transmission in developing countries, Western governments began to enact laws that

criminalized HIV transmission. The implementation of these HIV criminalization laws shifted media coverage of HIV/AIDS into the territory of sensationalistic reporting reminiscent of coverage in the 1980s. With the shift towards tabloid news, a new wave of moral panic began to wash across the public sphere, where PHAs were regarded as potential criminals. In Canada, the criminalization of HIV non-disclosure and transmission came to light in 1998, when the Supreme Court of Canada ruled in the landmark case of *R. v. Cuerrier* that it was the legal duty of a PHA to disclose his or her HIV-positive status to a sexual partner. The ruling laid down the legal foundation for the potential prosecution of people living with a chronic communicable disease, marking a new era in the HIV/AIDS narrative.

The New Millennium: Towards the Criminalization of HIV Non-disclosure and Transmission

While governments in the Global North started moving towards punitive action as an HIV prevention method, the impact of the disease was still reverberating throughout the world. In 2001, UNAIDS reported that there were approximately 30 million people in the world living with HIV. The number of new infections in North America and Western Europe had slowed dramatically because of extensive prevention and treatment efforts, and the number of deaths due to AIDS-related illnesses continued to drop as more PHAs had access to ARTs. This was not the case, however, in Africa. Sub-Saharan Africa had become the epicentre of the AIDS pandemic and, according to the World Health organization (WHO), approximately 3.5 million new

infections worldwide had been reported by the end of 2001. The global escalation of the pandemic continued to galvanize governments in the Global North into promoting prevention and treatment campaigns in Africa (Figure 5).

In 2001, Western governments reached an agreement with pharmaceutical companies under the Doha Declaration that allowed the sale of generic antiretroviral medicines to developing countries, so that even the poorest of the poor could access treatment. In 2003, the WHO pledged to treat three million people with ART by the end of 2005. After a stormy two decades, AIDS had become a global disease with treatment efforts intensified in the countries hardest hit by the virus. In the Global North, however, legislation started to encroach on public health initiatives with a new form of “prevention”—the criminalization of HIV non-disclosure and transmission.

Figure 5. HIV/AIDS Timeline 2000s

2001	DOHA declaration: Big pharmaceutical companies agree to sell generic antiretrovirals to developing countries
2002	AIDS becomes the leading cause of death in sub-Saharan Africa
2003	World Health Organization commits to treating people with antiretrovirals by 2005
2004	UNAIDS launches campaign to bring visibility to the disease's impact on women and children
2006	Canada: Harold Williams found guilty of aggravated sexual assault for not disclosing his HIV status
2007	CDC reports over 565,000 people have died of AIDS-related diseases in the U.S.
2010	18 th International AIDS Conference
2012	Supreme Court of Canada rules on <i>Mabior</i> – broadens the criminal culpability of PHAs and non-disclosure
2015	Canada: Approximately 146 people charged for not disclosing his or her HIV-positive status

The Criminalization of HIV Non-disclosure and Transmission

The *Global Commission on HIV and the Law: Risks, Rights & Health* (2012) summarizes the unique public health, legal and political challenges that people living with HIV continue to face. The report finds that existing criminalization laws are “fundamentally unjust, morally harmful, and virtually impossible to enforce with any semblance of fairness,” and that “such laws impose regimes of surveillance and punishment on sexually active people living with HIV” (p. 22). The implementation of HIV-specific criminalization laws only continues to propagate the view of the “otherness” of this disease and of those who live and suffer with it. The report explores in detail how governments have failed to respond to the continued persecution and prosecution of people living with HIV, describing how the law arbitrarily and disproportionately impacts marginalized groups such as immigrants, men who have sex with men, prisoners, and the LGBT community. The report challenges activists and policymakers alike to review legal precedents, barriers and prevailing attitudes about issues surrounding HIV. Illustrating how media coverage is often sensational and how HIV stories exaggerate the alleged “evil and dangerousness of HIV perpetrators” (23), the report cites the example of a forty-three-year-old British single mother who was convicted in 2006 of grievous bodily harm for transmitting HIV to her former boyfriend, and sentenced to thirty months; and notes how the British press portrayed the woman as a wildly promiscuous “AIDS avenger” on a rampage against black men, like the father of her son, from whom she contracted HIV.

Currently, more than 60 countries in the world have HIV non-disclosure laws in place, with Canada having the dubious distinction of leading the world in the number HIV-related criminal prosecutions (*Global Commission on HIV and the Law*, 2012). In 1998, the Supreme Court of Canada, in a landmark case, ruled that it was a criminal offence not to disclose one's positive HIV status to one's sexual partners if there was a "realistic possibility" of HIV transmission. The ruling made the courts willing players in the field of HIV prevention. Canadian Supreme Court Justice Cory, writing on behalf of the majority, stated: "If ever there was a place for the deterrence provided by criminal sanctions, it is present in these circumstances. It may well have the desired effect of ensuring that there is disclosure of the risk and that appropriate precautions are taken" (Adam, Elliott, Corriveau, & English, 2013, p. 40). While there are no HIV-specific laws in place under which individuals can be charged for engaging in behaviour that might result in the transmission of HIV, people who are criminally prosecuted for not disclosing their HIV status are charged with other existing crimes as defined in the *Canadian Criminal Code*.

Although the stated purpose behind the criminalization of HIV non-disclosure and transmission is to reduce risky sexual behaviour and prevent the spread of HIV, the use of punitive measures provides a false sense of security. Instead of serving to protect the public, the laws "perpetuate discriminatory myths about individuals with HIV/AIDS that are rooted in an irrational fear of the virus and those who contract it—namely, that they are sexually promiscuous and even predatory" (Dej & Kilty, 2012, p. 59). In Canada from 2004 to 2009, there was a 69 per cent increase in the number of criminal cases

regarding HIV non-disclosure, and by the end of 2013 over 140 people had been charged with assault, aggravated assault, sexual assault, aggravated sexual assault, common nuisance, criminal negligence causing bodily harm, murder or attempted murder (Canadian HIV/AIDS Legal Network, 2014).

Although the legal system has the potential to better the lives of PHAs, the criminalization of HIV non-disclosure and transmission laws both creates and punishes vulnerability; instead of protecting people, “[the laws] promote risky behaviour [and] hinder people from accessing prevention tools and treatment” (Global Commission on HIV and the Law, 2012, p. 7). Public health officials fear that the threat of criminal prosecution may deter PHAs from disclosing their status to sexual partners, discourage people from being tested for HIV, negatively affect trust between patients and service providers, and instill a false sense of security that the law, rather than safe sex, will protect people from being infected with the virus. These fears are reinforced by the role the media plays through its portrayal and “monsterization” of HIV/AIDS, and the likelihood that press coverage of court cases “is likely to exacerbate the stigma already associated with HIV and create fear and paranoia among those who are infected” (Persson & Newman, 2008, p. 641). Although the media may believe articles on HIV cases are written in the public’s interest, the stories play into established historical narratives that link HIV with fear and anxiety and thus trigger episodes of moral panic.

The criminalization of HIV non-disclosure and transmission has become another extraordinary event for media, “and with it has come a revival and reframing of the old familiar discourse of ‘innocent victims’ and ‘guilty others’ so prevalent in early news

reporting” (Persson & Newman, 2008, p. 633). The disease has again become connected with sexual violence and assault, and the re-emergence of the rhetoric associating HIV with immoral behaviour has incited a new wave of moral panic, with “the moral case for criminalization polluted at its core by fear of HIV or disdain for those who are infected with it” (Francis & Francis, 2013, p. 529).

Media coverage of HIV/AIDS in the 2000s is reminiscent of that in the 1980s, when the mainstream media failed to disseminate information about the disease and how it was transmitted. The media have been unable to successfully educate the public about the criminalization of HIV non-disclosure and transmission, how the criminal code is used against PHAs, and how punitive measures hinder public health efforts and adversely affect people living with the chronic disease. News stories echo the legal and political ideologies governing the criminal justice system’s prosecution of individuals, rather than the expertise of public health officials, HIV/AIDS advocates and PHAs who want laws in place that “protect equality of access to health care and prohibit discrimination including that based on health or legal status” (Global Commission on HIV and the Law, 2012, p. 7).

Eric Mykhalovskiy, an associate professor of sociology at York University, says that the media genre, which has emerged with the Canadian media’s coverage of HIV non-disclosure cases, subsumes the issues within the logic of a crime story. “A large proportion of coverage is focused on sensationalizing the criminal aspects of stories—treating people with HIV as criminals,” said Mykhalovskiy. “A lot of [news] stories frame heterosexual black men as sexual predators who should be feared. And their sexual

partners are painted as victims”(interview, March 2015). By ignoring people directly affected by HIV, and by following the dominant policies, news stories are biased towards a hierarchical structure that skews the message towards a hegemonic discourse rather than opening a conversation with the public (Nesbitt-Larking, 2007).

The media have the power to shape and influence the way people think and make decisions, and in this respect the agenda-setting role of the media is important. By following the hegemonic discourse, the media have not provided the public with accurate information. Instead they have reinforced stigma surrounding HIV/AIDS, negatively influenced public opinion about behaviours associated with PHAs, and bolstered the concept that punitive measures trump public health efforts (Jones, 2013). HIV/AIDS as a risk to society has, once again, become a dominant frame in media coverage. The media's role in bringing attention to people's vulnerability to HIV emphasizes that the media "is a contact zone between the public and risk, the linchpin between objective and subjective risk. Media representations provide crucial information used to estimate the social distribution of risk and the identity of who is responsible for risk" (Zelizer & Allan, 2011, p. 275). In this respect, PHAs are no longer portrayed as vulnerable individuals but as perpetrators of risk. Mykhalovskiy states that, in most instances, any time HIV/AIDS is reported in the press as related to a person being arrested for HIV non-disclosure, "this has a massive impact in the sense that it produces a new circulation of a discourse of criminality that associates people with HIV with crime, so it is hard even by definition to suggest that does not stigmatize people with HIV" (interview, March 2015).

In 2012, during the trial of Steven Boone, an HIV-positive gay man from Ottawa who was found guilty of attempted murder for having unprotected sex without disclosing his HIV status, Canadian local and national newspapers described Boone as a “poz vampire,” a “sexual predator” and a “bug chasing HIV positive man who used his toxicity to try and kill sex partners” (Seymour, 2013; Spears, 2012) (Figure 6).

Boone’s arrest in May 2010, made headline news—local newspapers displayed tabloid-size headshots of a young man alongside taglines labelling him as a “sexual predator.” Overnight, Boone went from a man recently diagnosed with HIV to a degenerate individual intent on destroying people’s lives. In the days that followed, despite concerns from HIV advocates and the LGBTQ community, local mainstream newspapers continued to publish articles that cited Boone’s name, his HIV-positive status and his sexual orientation, and by doing so stripped Boone of his individual rights to medical privacy. The media’s propensity for sensationalism echoed the negative rhetoric of the 1980s. The portrayal of Boone as a deviant and immoral being evoked moral outrage and cast a shadow over HIV-positive people, who once again were seen as outcasts. Using discourse analysis, the following section examines key headlines, (listed in the chart above) from the *Ottawa Sun* and the *Ottawa Citizen* after Boone’s arrest in 2010, his criminal trial in 2012, and his segregation hearings in 2013 and 2014.

Figure 6. Headlines: The arrest, trial and appeal of Steven Boone ²

	Ottawa Citizen ¹	The Ottawa Sun ²
Steven Boone was arrested in May 2010. The Ottawa Police Services (OPS) released a media statement with the headline “sexual predator” and a colour photograph of Boone to the Ontario Wire Services urging anyone who has had sexual contact with Boone to seek medical attention and to contact the OPS.	May 2010 Police face growing rift with gay community; HIV-positive 'sexual predator' photo puts police on defensive	May 2010 Have you had sex with this man? If so, police say you need to see your doctor (Article accompanied by photo released by the OPS)
Steven Boone's trial in 2012. Boone was found guilty and convicted on charges of attempted murder, aggravated sexual assault, and administering a noxious substance.	October 2012 “Bug chasing” HIV positive man used his “toxicity” to try to kill sex partners: Crown Accused aggressively sought sex, victim reported; Video interview played at trial	October 2012 Poz lover lied to fulfill fantasy October 2012 Jury agreed Boone was trying to kill with HIV November 2012 Poz vampire Steven Boone not trying to kill court hears
In 2013 Steven Boone went to court to appeal the Ottawa Carleton Detention Centre's decision to keep him in segregation.		December 2013 'Poz vampire' Steven Boone wants out of segregation to get sex December 2013 Poz vampire Steven Boone not leaving segregation judge rules
In 2014 Steven Boone went to court to appeal against the Crown's efforts to have him designated a long-term offender.	September 2014 'Poz vampire' Steven Boone wants third psychiatric assessment	September 2014 HIV sex fiend seeks second psych assessment

² Sources:

¹ Nease, May 15, 2010; Seymour, 2012; Fedio, Nov. 14, 2012; Cobb, Sep. 4, 2014.

² Jackson, May 2010; Gillis, October 2012; Gillis, October 2012; Gillis, November 2012; Hofley, January 2014; Spears, December 2013; Spears, September 2014.

The first two examples of the headlines after Boone's arrest in 2010 by the *Ottawa Sun*, "Have you had sex with this man?" and the *Ottawa Citizen*, "Police face growing rift with gay community; HIV-positive 'sexual predator' photo puts police on the defensive," voiced the concerns of the Ottawa Police Services (OPS) and public health authorities. Although both headlines addressed Boone's HIV-positive status, the *Ottawa Sun* assumed the role of Ottawa Public Health ally by urging men who had had sexual relations with Boone to get tested for HIV. The *Ottawa Citizen*, however, released information about Boone's HIV-positive status to the public, while reinforcing the notion that Boone was a "sexual predator." The media's narrative did little to inform the public about the disease or the complexities of the HIV non-disclosure laws; "rather than recognizing the need to invest in treatment and prevention programs . . . media outlets metaphorize[d] HIV/AIDS as an evil, mysterious ailment whose sufferers have transgressed and should therefore be punished" (Fink, 2010, p. 417). After the commotion over Boone's arrest subsided, media coverage on Boone waned until his trial in 2012.

When Boone entered the courtroom in September 2012, he once again made headline news. News stories from the *Ottawa Citizen* and the *Ottawa Sun* followed similar narratives as each paper's reporter reiterated highlights from witness testimonies, expert opinions, arguments from the Crown, and Boone's defence lawyer. The headlines, however, reflected the sensational highlights of the trial and, as such, became a beacon for people with voyeuristic tendencies and a warning light for the morally upright. Each new headline from the *Ottawa Citizen* and the *Ottawa Sun*

involved “pragma-linguistic devices and semantic macrostructures that activated [the reader's] epistemic and emotional resources” and thus framed the reader’s understanding of HIV (Molek-Kozakowska, 2013, p. 174). The historical narrative of linking HIV/AIDS to lurid images resurfaced, and the headlines helped shape the public’s misunderstanding of the disease, reinforced social stigma against PHAs, and triggered an episode of moral panic in society.

Both media organizations drew on Boone’s association with the online chat room phenomena of “gift giving” and “bug chasing” and his participation in online discussions. The *Ottawa Citizen*’s headline, “Bug chasing HIV-positive man used his toxicity to try and kill sex partners,” played into the supposition that Boone was a depraved human being who longed to seroconvert so he could use the virus as a lethal weapon. The headline exposed the vulnerability of readers to the portrayal of the “ambiguities and perils of sexual interactions” (Persson & Newman, 2008, p. 638). The language used emphasized HIV as a disease of “others” and it allowed readers to make a moral judgement about “them”. Such rhetoric echoes the earlier narratives of the 1980s where HIV was “identified almost exclusively with homosexuality, and specifically the practice of sodomy” (Sontag, 1990, p. 153). The paper’s second headline, “Accused aggressively sought sex,” is another example of how “symbolic systems such as language reflect underlying social values” (Petty, 2005, p. 78). The headline reinforced the association between HIV, violence, and sexual deviancy, and also underlined the assumption that Boone was a sexual predator who engaged in non-consensual sex, when in fact Boone’s sexual activities with the partners named in the court case were

consensual. The language points to the media's treatment of desire and consent in relationships where sex between men is seen as deviant

The *Ottawa Sun's* headlines from October 15 to November 14, 2012, "Poz Lover lied to fulfill fantasy" and "Poz Vampire Steven Boone not trying to kill court hears," discarded the medical, social and politically correct terminology for referring to an HIV-positive person. Instead, the media adopted the word "poz," a slang term used almost exclusively by HIV-positive people themselves. In an October 2012 headline, "Jury agreed Boone was trying to kill with HIV," the virus was portrayed as a murder weapon—which is a far cry from the reality, where with treatment HIV is a manageable chronic illness. The headline distorted reality, provoked a feeling of fear, and perpetuated the notion of HIV as a deadly disease.

The word "vampire" made its entrance on the editorial stage with headlines from the *Ottawa Sun*. It is worth noting that in the accompanying articles, the reporters added the caveat that Boone was a "self described" poz vampire, another reference to Boone's association with 'bug chasing' and 'gift giving'. By adding the adjective "self-described," the paper could disown the act of labelling Boone a vampire, and in this way the headline served to confirm Boone's "otherness" and his association with deviant sexual activities. The continuous referral to Boone as a vampire had the subliminal effect of unearthing historical narratives and "antiquated metaphorical practices" that conjured up images of terror (Fink, 2010, p. 416).

The narrative of an HIV-positive person as a bloodthirsty vampire was reiterated in the *Ottawa Sun's* headlines during Boone's segregation hearing in 2013, "Poz Vampire

Steven Boone wants out of segregation to get sex,” and in 2014, “HIV sex fiend seeks second psych assessment.” Boone was portrayed not only as a blood-sucking monster, but one who would do anything to feed his perverted desires. The headlines relied on hyperbole to attract the reader’s attention, framing HIV as a moral threat to society rather than as a health or social concern. During Boone’s second segregation hearing in 2014, the *Ottawa Citizen* also adopted the vampire metaphor: “Poz Vampire Steven Boone wants third psychiatric assessment.” The headline possessed all the symbolic references needed to sustain moral panic. The allusion to vampires and madness provoked an emotional and psychological response in readers, which culminated in fear of the unknown and revulsion for Boone, who was perceived as violating all social norms and values.

In covering Boone’s case, neither news organization appeared intent on generating a genuine interest in the story; instead the headlines focused on sensationalism, which incited fear and revulsion in society. From news boxes, to newsstands, potential readers were subjected to headlines designed to promote disgust and misunderstanding. The continual use of the word vampire, and all its connotations with blood, evil and death, did little to promote an awareness of the disease or assist people in understanding the consequences of not disclosing one’s HIV-positive status. Instead, it linked “fear of difference to the narration of illness” (Fink, 2010, p.428), and it helped perpetuate moral panic and made it easier for the public to blame Boone, and other PHAs, for spreading the disease: “In tracing the vampire’s construction as a metaphor for illnesses preceding HIV/AIDS, we can begin to understand how our

contemporary health crisis is connected to historical practices of blaming individuals for their own medical conditions through the racializing and sexualizing of disease” (Fink, 2010, p. 424).

This analysis of coverage by two different news organizations, the *Ottawa Sun* and the *Ottawa Citizen*—one known for its penchant for sensationalism and the other for its news quality—highlights how the media have reframed HIV into “a new strain of crime” (Hall et al., 1978, p. 7). The reframing of the HIV news story has reignited the embers of moral panic surrounding the disease by raising the spectre of HIV as a lethal weapon. With the reframing of the HIV/AIDS narrative, the media have also changed public opinion about HIV/AIDS and people living with the disease. As news of the criminalization of HIV non-disclosure and transmission makes headline news, it incorporates the dominant ideologies, and the “more public—the more of a public issue—a topic becomes, the more we can detect the presence of larger networks of meaning and feeling about it; the more we can discern the presence of a highly structured, though by no means complete, or coherent, or internally consistent set of ideologies about crime” (Hall et al., 1978, p. 136). The end result is that news on the criminalization of HIV non-disclosure and transmission is a socially constructed production, where editorial gatekeepers assess the news value of an article by its oddity, unusualness and level of drama. Cases involving the criminalization of HIV transmission incorporate all the elements of a drama fit for the news— the fight between good and evil where the villain violates the laws of nature and the legal experts uphold the law to protect the greater good.

Upholding the law should mean protecting all citizens from harm, but the criminalization of HIV non-disclosure and transmission serves to marginalize and stigmatize people living with a chronic disease. In the 1980s, ignorance about HIV fuelled stigma, and without treatment the disease was deadly. It was only with the intensification of prevention efforts and the discovery of ART, which transformed AIDS from a death sentence into a manageable chronic disease, that the fear of AIDS began to subside. But as 2016 rapidly approaches, countries around the world are passing legislation that criminalizes HIV non-disclosure and transmission, and instead of subsiding, fear of HIV/AIDS is on the increase as the result of this kind of legislation that has the power to

perpetrate discrimination and isolate the people most vulnerable to HIV infection from the programs that would help them to avoid or cope with the virus. By dividing people into criminals and victims or sinful and innocent, the legal environment can destroy the social, political, and economic solidarity that is necessary to overcome this global epidemic. (Global Commission on HIV and the Law, 2012, p. 12).

The appearance of HIV in the 1980s aroused a climate of fear exacerbated by media coverage that conveyed the disease as a horror story. During the first decade after the discovery of the virus, the power of the media to disseminate accurate and thorough information on HIV, influence government policies on the disease, reduce stigma, mold public opinion and educate the population in a positive way was never realized. Instead the power was squandered and the media dismissed HIV as a gay

disease, until the death toll became too high to ignore the fact that North America was facing a public health epidemic and African economies were being destroyed. By the time the media began to pay attention to the devastating effects of the disease, thousands of lives had been lost and thousands more were infected with the virus. Fear was at an all-time high and news stories did little to alleviate the fear; on the contrary, coverage of HIV contributed significantly to the moral panic about the disease. Even as HIV/AIDS became a global pandemic with the number of worldwide AIDS-related deaths reaching an all time high during the mid-1990s, the media continued to fail as an important source of information. As the disease reached pandemic proportions, AIDS stories in the Global North started to slip into the back pages and obituary columns, and AIDS fatigue set in as reporters struggled to find stories that were timely and pertinent. In the 1990s, HIV was a disease of others—people living in sub-Saharan Africa—and thus the disease was no longer newsworthy. As the twentieth century came to an end, Western governments began to enact laws that criminalized HIV transmission, and HIV once again became newsworthy. Media coverage of HIV/AIDS became reminiscent of the sensational slant given to stories on the disease in the 1980s, blaming the victim and exaggerating mostly unfounded fears. With the re-emergence of tabloid-inspired news about HIV, moral panic again began to creep into the public domain, where PHAs were demonized and regarded as potential criminals, creating a policy environment more favourable to punishment than prevention. Thus, the 2000s have witnessed a new wave of moral panic that reinforces an unfounded fear of HIV that is perpetuated by the justice system's use of punitive laws to protect society

from a communicable disease, by the demonization of PHAs, and by the media's penchant for using sensationalism to reach their audiences.

As 2016 approaches, HIV/AIDS is still the world's greatest public health disaster in modern history, and although with treatment the disease is no longer a death sentence, being infected with HIV traps a person between the medical world, where they are hopefully treated and cared for as a patient, and the criminal justice world where they can be unprotected and even treated as a sexual predator or a murderer. This is the trajectory of the story of HIV/AIDS in North America—a narrative that begins with HIV patients stigmatized and isolated in hospital rooms and brings us to the current day, where PHAs are isolated in dark prison cells. As Shilts (1987) writes, HIV is ongoing and "politics, people, and the AIDS epidemic is, ultimately, a tale of courage as well as cowardice, compassion as well as bigotry, inspiration as well as venality, and redemption as well as despair" (p. xxiii).

This chapter examined the historical narrative of HIV/AIDS; a story with plots that twist and turn, and a tale packed with villains, but few heroes. While HIV is no longer considered a death sentence, people living with the virus have become, once again, outcasts and social pariahs in a climate where HIV portrayed as both a communicable illness and a lethal weapon. In the new millennium, media coverage echoes the rhetoric of the 1980s, and AIDS has, once again, become a sensational news item that instills fear and incites moral panic in society.

Chapter 5 will analyze where Canada stands in the global trend towards the criminalization of HIV non-disclosure and transmission. The chapter will examine the

justification for implementing criminal laws, the policy statements of the Joint United Nations Programme on HIV/AIDS (UNAIDS) with regards to the HIV specific laws, and the effects the laws have on PHAs.

Chapter 5

The Global Environment: Criminalizing HIV Exposure and Transmission

If lawmakers do not amend these laws so that all resources are marshalled against the same enemy—HIV, not people living with HIV—the virus will be the victor and the world’s people, especially its most vulnerable, the vanquished.

—Global Commission on HIV/AIDS, 2012

The HIV/AIDS epidemic is the most devastating humanitarian crisis that the modern world has ever experienced. There is not a country in the world that has not acknowledged or reported HIV infections in its population. HIV/AIDS is a disease that has traversed national borders, crossed international waters, and touched every continent. It has transformed from a biomedical incident to a sociological phenomenon, highlighting the inequity between the Global South and the Global North. The United Nations Programme on HIV/AIDS (UNAIDS) estimates that, since the start of the epidemic, nearly 78 million people have been infected with HIV, and another 39 million people have died from AIDS-related illnesses. At the end of 2013, approximately 2.3 million HIV-positive people were living in Europe and North America; in contrast, 24.7 million HIV-positive people were living in sub-Saharan Africa, with women accounting for 58 per cent of the total number of HIV-positive people.

In the 1980s, the rapid onset and proliferation of HIV, combined with the lack of a foreseeable cure, meant that the disease was linked to stigma, denial and reluctance to get tested. In the absence of a cure, the public health discourse focused on prevention and treatment of the disease. Raising public awareness, HIV education and encouraging behaviour change was, and still is, perceived by public health experts as the only method to contain the pandemic. With the arrival of Antiretroviral Therapy (ART) in

the 1990s, countries in the Global North and South were able to provide HIV-positive individuals with access to ART, and HIV was no longer a death sentence but a manageable chronic illness. Yet the problem was not solved in either hemisphere. Even though ART was available, infrastructure improvements were required, economies and health systems were taxed, drug access was inequitable, and PHAs continued to be reluctant to face the rampant stigma associated with the disease. Although the rates of worldwide HIV transmission have decreased through universal access to ART, the HIV/AIDS epidemic remains a global concern, and HIV prevention initiatives continue to be critical for controlling HIV infection rates.

The last decade has seen a new emphasis in the implementation of laws that criminalize HIV exposure³ and transmission as an HIV prevention strategy. The justification for holding an HIV-positive individual responsible for disclosing his or her HIV-positive status when participating in risk-associated sexual activities stems from societal expectations, where “exposing others to the risk of a fatal disease is morally indefensible conduct that merits sanction, both to punish obviously dangerous behaviour, and to deter others from engaging in similar conduct” (Klein, 2009, p. 253). Over the past decade, despite policy recommendations from international health and human rights organizations such as UNAIDS, there has been a worldwide proliferation of punitive laws, policies and practices with regard to HIV criminalization. This global trend

³ Internationally these laws refer to someone being exposed to the HIV virus. In this chapter I will, therefore, refer to the criminalization of HIV exposure and transmission, and not the criminalization of HIV non-disclosure and transmission as used in the Canadian context.

toward the utilization of criminal statutes and the enactment of HIV-specific laws to criminalize HIV exposure and transmission has become a vital human rights issue.

Chapter 5 will demonstrate Canada's position on the criminalization of HIV non-disclosure and transmission in a global context. It will examine how the principles governing criminal theory are used to justify the criminalization of HIV non-disclosure, exposure and transmission. This chapter will investigate UNAIDS's stance on the global increase of HIV criminalization laws and highlight how countries in the Global North—namely, England, Wales and the United States—have implemented policy and legal pathways for regulating HIV disclosure and transmission.

The Global Trend toward the Criminalization of HIV Exposure and Transmission

Since the turn of the millennium, governments and legal systems around the world have gradually introduced HIV-specific legislation criminalizing the actual, or potential, exposure to and transmission of HIV. In countries where there were no HIV-specific laws, the criminal code has been extended to prosecute HIV-positive individuals who transmit or expose others to HIV. Applying legislation from a country's criminal code is not unusual and, in theory, any court of law could prosecute an individual for HIV exposure and transmission under a country's assault laws as specified in that country's criminal code:

In many countries, criminal prosecutions relating to HIV are being brought under laws that have only recently been enacted, or under old laws that have only recently been applied to HIV transmission or exposure. The full extent of the

impact of these laws has not yet been played out, and the landscape is changing with each new law and each new case that is investigated. (International Planned Parenthood Federation, 2012, p. 5)

The principle justification for the criminalization of HIV exposure and transmission has been to prevent an increase in HIV-infection rates. However, the rationale supporting this line of reasoning falls within two broad classifications: judicial and socio-political. The former falls under the philosophical framework of retribution and deterrence, while the latter rests on socio-political reasoning.

The judicial justification for implementing HIV criminalization laws is grounded in denunciation arguments that punish harmful and deviant conduct by imposing criminal penalties, and thus preventing HIV transmission by deterring or changing risk behaviours of HIV-positive individuals. As such, the laws are seen to “promote public health by stopping HIV transmission or exposure by incapacitating, or rehabilitating, a particular person, and/or by deterring the specific individual, or others more generally, from the conduct that is criminally prohibited” (Bernard, 2015, p. 144). Alana Klein (2009), in her paper *Criminal law, Public Health and Governance of HIV Exposure and Transmission*, maintains that the denunciation arguments are based on a retribution and deterrence philosophy (Klein, 2009). Klein argues that the Supreme Court of Canada’s ruling in *Cuerrier* was validated by Justice Cory’s statement supporting deterrence as an effective HIV prevention method:

If ever there was a place for the deterrence provided by criminal sanctions it is present in these circumstances . . . public education alone has not been

successful in modifying the behaviour of individuals at risk of contracting AIDS. It follows that, if the deterrence of criminal law is applicable, it may well assist in the protection of individuals and it should be utilized. (Klein, 2009, p. 262)

Within the denunciation arguments there are five judicial criteria—incapacitation, general and specific deterrence, rehabilitation, retribution and denunciation—that constitute the framework for the justification of HIV criminalization laws, and which are based on a common set of assumptions about the effectiveness of criminalization: (1) incapacitating an HIV-positive individual serves public health interests by keeping the offender out of the public, thus eliminating any chances of HIV being transmitted to other individuals; (2) the threat of incarceration deters people from engaging in harmful behaviour for fear of prosecution; (3) incarceration serves to rehabilitate individuals and stops them from harming others after they been released from prison; (4) only through retribution will the victims be fully compensated; and (5) incarceration reflects society's disapproval of certain acts.

While the judicial rationale for the criminalization of HIV exposure and transmission falls under a retribution and deterrence philosophical framework, the socio-political reasoning combines public interests with political gain. First, the laws are seen as an intrinsic part of HIV prevention efforts. Second, the criminalization of HIV exposure and transmission is seen by governments as a legal way to protect vulnerable minorities, including prisoners, intravenous drug users, sex workers, men who have sex with men, and women and children. Protecting women and children is a motivating

argument in countries where women are seen as vulnerable, and where HIV infections remain high.

In 2007, a member of the Zimbabwean parliament, Priscilla Misihairabwi-Mushonga, urged parliament to adopt HIV criminalization laws in order to protect women: "The concerns of women's organizations that are pushing for criminal law approaches to HIV need to be addressed clearly and positively. In particular, action needs to be taken against domestic violence and women's subordination" (UNAIDS, 2007, p. 167). Third, policymakers may introduce and enact HIV-specific laws for various reasons, such as the influence of "public opinion following a particularly egregious case; perceptions of widespread intentional transmission; and/or be required to pass laws to receive federal funding for HIV-related services" (UNAIDS, 2012, p. 21). Lawmakers, therefore, adopt laws to appease the majority, or may follow precedents set by other governments as they fashion their own laws. For example, a Member of Parliament for Guyana told the National Assembly that the country should implement HIV-specific laws because "nations, including the U.S. and Australia, have passed laws making the wilful spread of HIV a criminal offence" (UNAIDS, 2007, p. 22). And finally, in some instances, judicial decisions can also influence policy and lawmaking. The Lesotho government included their adaptation of the Supreme Court of Canada's ruling in *Cuerrier* in the Sexual Offences Act of Lesotho, which states: "Sexual intercourse by an HIV-positive person without disclosure is tantamount to an unlawful sexual act conducted under 'coercive circumstances' which may be punishable by death" (UNAIDS, 2007, p. 27).

Although the judicial and socio-political rationales behind the implementation of the criminalization of exposure and transmission are succinct, logical and, to some people, morally laudable, there is growing global concern that the laws are too broad to be applied in a fair and consistent manner.

Defining Weaknesses in the HIV Criminalization Arguments

International health and human rights organizations, as well as HIV advocates, legal scholars, sociologists and public health researchers, oppose HIV criminalization from two main viewpoints. The first is that the criminalization of HIV exposure and transmission is not an effective HIV prevention method; and the second, that the judicial justification behind the implementation of the laws is misleading.

The fundamental principles of the retribution and deterrence framework are inappropriate approaches to dealing with cases involving HIV exposure and transmission. According to anti-criminalization campaigners, the “retributive and denunciation arguments do not rely on any individual or public health consequences of criminalisation. Instead, they posit that the purpose of imposing criminal sanctions is to punish offenders and express society’s disapproval for conduct that is deemed morally blameworthy” (Klein, 2009, p. 262). The criminalization of HIV exposure and transmission is viewed as poor policy, and concerns are growing that “framing the problem of the spread of HIV in terms of criminal behaviour does nothing to stop the epidemic, and does a great deal to undermine the supportive social environment needed to stop the spread of HIV (Burris & Cameron, 2008, p. 580).

UNAIDS's position against HIV criminalization, which has evolved over time, is based on the premise that the arguments of incapacitation, deterrence, and rehabilitation focus on changing behaviour rather than on education. As such, the laws are believed to be ineffective.

Incapacitation does not necessarily change sexual behaviour. High-risk behaviour in prisons is not unusual, and at some stage, people serving sentences will be released back into society. There is no empirical evidence supporting the assumption that individuals released from prison will practice safer sex, and although an individual's behaviour can affect HIV rates in a local environment, the current number of global prosecutions and incarcerated people living with HIV (PHAs) is not high enough to have an effect on the larger population. Furthermore, harm reduction interventions are, for the most part, unavailable, and prison systems "continue to reject the introduction of evidence-informed prevention measures such as condoms and sterile injecting equipment, and fail to undertake measures to reduce the prevalence of rape and other forms of violence" (Jürgens et al., 2009, p. 165).

Again, there is little scientific evidence to suggest that deterrence has any impact on HIV risk behaviour. The premise behind deterrence as a preventive measure is that an individual will disclose his or her HIV-positive status for fear of being incarcerated. However, this is not necessarily the case. Steven Boone, for example, practiced unsafe sex even though he was aware of the non-disclosure laws, yet the full impact of not disclosing his HIV-positive status did not become clear to him until he was incarcerated.

The purpose of rehabilitation in criminal theory is to change an individual's future behaviour so that no harm will be inflicted on other individuals. Although the rehabilitation model is based on an affirmative action approach, it does not take into account the understanding that "most people living with HIV who have unsafe sex without disclosing their HIV status fail to disclose or avoid risky conduct for a complex set of psychosocial reasons" (Klein, 2009, p. 262). Most HIV non-disclosure cases are related to sexual activity and/or drug use, human behaviours that are "complex and very difficult to change through the blunt tool of criminal penalties" (Jürgens et al., 2009, p. 265).

The fundamental argument against incapacitation, deterrence, and rehabilitation is that there is very little empirical evidence suggesting that punitive measures have any impact on HIV risk behaviour. It is also argued that criminal sanctions only serve to support society's predilection for moral fortitude; that the HIV criminalization laws are vague and misleading; that the laws reinforce stigma against people living with the disease, are discriminatory and violate human rights; and finally, that the laws undermine public health HIV prevention efforts.

Public Health, Stigma and Discrimination

One of the central arguments against the laws criminalizing HIV exposure and transmission is that they undermine public health HIV prevention efforts. Substantial evidence collected over the three decades since the AIDS epidemic began strongly indicates that public health initiatives, such as voluntary testing, counselling and HIV

education, are effective in promoting disclosure and safer sex practices (UNAIDS, 2013).

On the other hand, there is no concrete evidence to support the position that the criminalization of HIV exposure and transmission is an effective HIV prevention tool. The criminalization of HIV exposure and transmission may, in fact, divert public health HIV prevention initiatives. Indeed, in many countries, including Canada, HIV advocates claim that public health authorities have become complicit in enforcing criminalization laws.

In countries that have enacted HIV-specific laws or use criminal law in HIV cases, medical staff and social workers such as HIV counsellors are obliged to caution individuals who are newly diagnosed with HIV about their criminal culpability. In several countries, including Canada, public health officials may be required to provide evidence of a person's HIV-positive status and other private medical records in the courts. This symbiotic relationship between the law and public health authorities has created animosity between HIV-positive individuals and advocates on one side and healthcare providers on the other, and is reportedly causing concern that individuals will avoid or delay getting tested for HIV, preferring to remain ignorant about their HIV-positive status so as not to be held criminally liable (Cameron, 2009).

HIV criminalization laws have inadvertently blurred the line between what is regarded as criminal versus noncriminal behaviour. This is of particular concern as an overwhelming number of new HIV infections do not occur within a crime scene, but happen between "consensual participants in a sexual act, neither or whom know their HIV status, in short, acting in ways that most would recognize as ordinary" (Burris & Cameron, 2008, p. 580). The majority of people agree that an individual who

intentionally seeks to infect someone with HIV is blameworthy, and therefore criminally liable. However, determining guilt is not always so straightforward, especially in cases where people commonly engage in risky behaviour but avoid getting tested for HIV, where PHAs engage in unsafe sexual practices regardless of the risk level, or where PHAs have sexual encounters without disclosing their HIV-positive status.

Under the criminal umbrella, the burden of responsibility for preventing HIV transmission rests solely on the HIV-positive individual. The assumption that fear of criminal liability for not disclosing one's HIV-positive status will encourage PHAs to disclose as well as avoid unsafe sexual practices creates a false sense of security, and undermines public health messages that everyone should act responsibly by engaging in safer sex practices. The failure of a PHA to assume full responsibility casts the individual into a role defined by deviance and "reinforces the stereotype that people living with HIV are immoral and dangerous criminals, rather than, like everyone else, people endowed with responsibility, dignity and human rights" (Jürgens et al., 2009, p. 166).

Since the 1980s, people living with and affected by HIV have experienced stigma and discrimination. The stigma surrounding the disease includes "prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV or AIDS, and the individuals, groups, and communities with which they are associated" (Von Collani, Grumm, & Streicher, 2010, p. 1747). Eliminating the stigma surrounding HIV has been, and still is, a dominant theme in public health prevention efforts and human rights responses to HIV prevention interventions. There is a palpable fear among many who are sensitive and knowledgeable about non-disclosure that HIV criminalization often

misrepresents and overstates the risks associated with HIV, and thus contributes to myths about transmission. The Canadian laws governing the criminalization of HIV exposure and transmission cast PHAs as perpetrators of a disease, and only serve to strengthen—not eradicate—stigma and fear of HIV among the general population. Criminal law thus discriminates against PHAs and actively undermines “the very pillars of justice and equality that it strives to achieve” (International Planned Parenthood Federation, 2012).

The HIV/AIDS pandemic has had a global impact, and public health efforts globally continue to introduce initiatives to lower HIV infection rates and to make antiretroviral medicines accessible to everyone, including the poorest of the poor. However, the endeavour to achieve equity in HIV prevention and treatment cannot be realized if criminal law supersedes public health efforts. The laws governing the criminalization of HIV exposure obstruct public health efforts and discriminate against PHAs, despite warnings from global authorities such as UNAIDS that the criminalization of HIV exposure and transmission could potentially have a negative effect on HIV infection rates, rather than the positive effect intended.

Global Voices and Human Rights

The mandate of UNAIDS is to design and implement HIV strategies, policy and advocacy for worldwide cooperation and collaboration in the effort to combat HIV/AIDS. UNAIDS tracks, monitors and strengthens responses, including those of prevention, care, support and access to medication for HIV/AIDS on a global scale. Since 2002,

UNAIDS has released a number of policy statements on the criminalization of HIV exposure and transmission. While UNAIDS has been effective in policy engagement on many levels, the organization's achievements are hampered by the lack of a mechanism for accountability and global recourse.

Policymakers at UNAIDS have repeatedly documented their concerns about repercussions in the areas of law, public health and human rights that follow the implementation of HIV criminalization laws (UNAIDS, 2013). The organization is steadfast in its assertion that the criminalization of HIV exposure and transmission disregards the realities of living with HIV and the nature of exposure and risk. As a global leader in the efforts to combat both infection rates and non-disclosure laws, UNAIDS, in its policy statements, argues that the criminalization of HIV ignores the scientific limitations of being able to prove who infected whom, highlights the possible collateral harm that follows the implementation of the laws, and points out that the laws ultimately hinder efforts to achieve universal access to prevention, treatment, and care (UNAIDS, 2013). However, their principal criticism about the criminalization of HIV exposure and transmission is that the laws are overly broad and go "beyond intentional transmission to cases involving unintentional HIV transmission, non-disclosure of HIV status, or exposure to HIV where HIV was not transmitted" (UNAIDS, 2013, p. 2).

UNAIDS contends that non-disclosure clauses within HIV laws disregard consensual sex and instead treat intimate sexual encounters as physical and sexual assault, despite the absence of intent to harm; they also argue that people should not

be prosecuted when there is a low risk of transmission and/or transmission did not occur.

UNAIDS has voiced concerns that people have been charged with “bodily fluid assault” where either biting or spitting have occurred (both acts involve zero risk of transmission). Such laws “disregard generally applicable criminal law principles” and “have resulted in disproportionately harsh sentences in several cases” (UNAIDS, 2008, p. 9). The failure of criminalization laws to distinguish between what is deemed high-risk sexual behaviour and what constitutes low or zero risk behaviour removes the requirement to show intent to expose and/or transmit the virus. In addition, many laws do not take into account the medical advancements that have generally lowered the viral load (the amount of HIV in the blood) of a PHA on ART: “The reach of the criminal law may not track the real likelihood of HIV transmission reflected in scientific research for a number of reasons. Legislators creating HIV-specific statutes setting out prohibited acts may fail to attend to real levels of risk” (Klein, 2009, p. 258) (Figure 7).

Figure 7: Relative Risk of HIV Transmission by Sexual and Non-sexual Behaviours⁴

Spitting	Oral Sex	Vaginal Sex	Anal Sex
Zero risk of transmission	Minimum risk of transmission	High risk of transmission	Highest risk of transmission
HIV virus cannot be transmitted through saliva.	<p>Highest risk is on HIV-positive man when ejaculation in the mouth occurs.</p> <p>Factors increasing risk include: ulcers, bleeding gums, genital sores and presence of other sexually transmitted infections.</p>	<p>In women, HIV can be absorbed through membranes lining the vagina and cervix. Lining in vagina may also tear and possible allow virus to enter the body.</p> <p>In men, HIV can enter through urethra or small cuts or open sores on penis.</p> <p>Uncircumcised men are at greater risk of HIV transmission than uncircumcised</p>	<p>The <i>bottom</i> is at greatest risk as rectum lining is thin.</p> <p>The <i>top</i> is also at risk as HIV can enter through urethra or small cuts or open sores on penis.</p>
Zero risk of transmission	Risk lowered if partners wear condoms or dental dam, if HIV-positive partner is taking ART consistently and correctly, if the HIV-negative partner is taking pre-exposure prophylaxis (PrEP) consistently and correctly	Risk lowered if male partner uses a condom correctly, if HIV-positive partner is taking ART consistently and correctly, if the HIV-negative partner is taking pre-exposure prophylaxis (PrEP) consistently and correctly	Risk lowered if a condom is used correctly, if HIV-positive partner is taking ART consistently and correctly, if the HIV-negative partner is taking pre-exposure prophylaxis (PrEP) consistently and correctly

⁴ Source: Centers for Disease Control and Prevention.

In line with many other national-level advocacy organizations, UNAIDS policymakers also assert that the criminalization of HIV exposure and transmission does not protect at-risk communities. The organization's viewpoint is that the broad application of criminal law in cases of HIV exposure and transmission is a miscarriage of justice, which extends criminal liability beyond cases of intentional transmission to those involving reckless conduct:

Such broad application of the criminal law could expose large numbers of people to possible prosecution without their being able to foresee their liability for such prosecution. Prosecutions and convictions are likely to be disproportionately applied to members of marginalized groups, such as sex workers, men who have sex with men, and people who use drugs. (UNAIDS, 2008, p. 12)

Although lawmakers claim that HIV criminalization laws protect the rights of vulnerable minorities including women and children, this has been disputed by UNAIDS and HIV advocates who do not regard the criminalization of HIV exposure and transmission as "an effective way of protecting vulnerable populations from coercive or violent behaviour" (Burris & Cameron, 2008, p.580). Women are often subject to domestic violence, sexual assault and marital rape, with little chance of justice being served. UNAIDS policymakers have expressed concern that criminalization laws endanger and oppress women because of their status and power differential relative to men. As women access the healthcare system more often than men, they are more likely to know their HIV status. It is increasingly common for women to receive HIV tests and counselling in antenatal settings, both in the Global North and South. In settings

where disclosure laws are in place, women are legally obliged to disclose their status to sexual partners and healthcare workers. Additionally, in order to prevent potential exposure or transmission, they must either insist on a condom or refuse to have sex; although this appears on the surface to be a moral obligation as well as a health decision, for some women “these actions carry the risk of violence, eviction, disinheritance, loss of their children, and other severe abuses” (Jürgens et al., 2009, p. 167). The laws also target and discriminate against women in cases where mother-to-child transmission occurs.

There is a 30-per-cent risk of transmission from an HIV-positive mother who is not on ART to her child during pregnancy and delivery or while breastfeeding. The risk of transmission is lowered if the woman is receiving ART; however, not every woman is able to access treatment, and it is these women who are most affected by the criminalization of perinatal HIV exposure and transmission (UNAIDS, 2013). Women who are unable to access reproductive health care and family planning and become pregnant could theoretically—and in reality have been—prosecuted for HIV transmission. UNAIDS policymakers have expressed concern that the criminalization of HIV exposure and transmission has a negative effect on the wellbeing of PHAs, and that these laws further undermine human rights. The organization notes particular areas of concern, such as how investigations are carried out by police unfamiliar with how these laws relate to HIV exposure; how the selective enforcement of the laws focuses on marginalized people; how the laws infringe on rights to privacy, freedom from

discrimination and equality; and how this turn affects the realization of an individual's right to health (UNAIDS, 2012).

In 2010, UNAIDS established the Global Commission on HIV and the Law to “identify and analyze the complex framework of international, national, religious and customary law shaping national responses to HIV and the well-being of people living with HIV and key populations” (Global Commission on HIV and the Law, 2012, p. 7). Over a two-year period the commission reviewed a large body of international public health and human rights research, including 700 testimonials from individuals and organizations across more than 130 countries. The report, published in 2012, outlined the impact of the criminalization of HIV exposure and transmission on HIV stigmatization and discrimination, prevention and treatment, and made recommendations for change at the national and international levels.

The Commission focused its enquiry on four areas: (1) laws, policies and practices that criminalize people living with and most vulnerable to HIV; (2) laws and practices that mitigate violence and discrimination experienced by women; (3) laws and practices that facilitate or impede access to HIV treatment; and (4) issues of law relating to children and young people in the context of HIV (Global Commission on HIV and the LAW, 2012). The Commission found that the application of criminal law to consensual adult sexual activities was counterproductive to the promotion of health, rights, and well-being of people living with HIV, noting that “countries that view sexual and reproductive health as matters best dealt with by their education and health systems, reserving the criminal law for cases where harm is deliberately inflicted on others,

achieve better HIV-related outcomes than those that pursue anti-HIV initiatives through their criminal justice systems” (Global Commission on HIV and the LAW, 2012, p. 9).

In its investigation, the Commission concentrated much of its research on the effects the HIV criminalization laws have on minority communities, including drug users, sex workers, men who have sex with men, women and children, and prisoners. In its analysis, the Commission contends that all countries have a legal framework— and the moral obligation—to protect human rights and to challenge discriminatory policies, and that “for people living with HIV, for their families and communities, for key populations and those vulnerable to HIV, the law is neither abstract nor distant. It is police harassment or clean needles, prison cells or self-help groups—the law is the torturer’s fist or the healer’s hand” (Global Commission on HIV and the LAW, 2012, p. 9). The commission calls on governments, civil society and international bodies to “repeal punitive laws and enact laws that facilitate and enable effective responses to HIV prevention, care and treatment services for all who need them” (Global Commission on HIV and the LAW, 2012, p. 97).

While holding that non-disclosure laws are counterproductive and impede public health HIV prevention, counselling, and treatment efforts, both UNAIDS and the Commission agree that criminalization of HIV exposure and transmission is justified in cases where “individuals maliciously and intentionally transmit or expose others with the express purpose of causing harm” (Global Commission on HIV and the LAW, 2012, p. 23). UNAIDS and the Commission recognize that the criminalization laws will not fade from the global stage, and that over time more governments will likely follow the global

trend in criminalizing HIV exposure and transmission. UNAIDS recommendations are based on the pillars of human rights and the importance of public health efforts that focus on HIV prevention, counseling and treatment. The Commission maintains that laws can play a powerful role in broadening access to prevention and health care services, improving the quality of treatment, and strengthening the social support systems for people affected by HIV/AIDS. Finally, the Commission reminds us simply that HIV is the “human immunodeficiency virus: its first name is ‘human’. To defeat it, the world and its laws must embrace and promote what every living person shares: the fragile, immensely potent human rights to equality, dignity and health” (p. 89).

Country-Specific Laws Governing HIV Exposure and Transmission

Laws criminalizing HIV exposure and transmission differ greatly across countries and continents. Some governments have implemented laws that specifically deal with HIV, while others have borrowed assault charges from the country’s criminal code. The construction of the laws is varied. Some laws are aimed at prosecuting a PHA for exposing another person to HIV and potentially or actually transmitting HIV. Others prosecute people for intending to expose an individual to HIV, or engaging in reckless behaviour that could endanger the life of another person. All laws, however, require disclosure from a person who is aware of his or her HIV-positive status. The penalties associated with criminalization laws also vary extensively, from designation as a registered sex offender, to life imprisonment and, in extreme cases, to the death penalty. Although many governments in the Global South have begun to implement

HIV-related laws, it is governments in the Global North who are the leaders in creating and implementing legislation criminalizing HIV exposure and transmission.

Canada is second only to the United States in terms of number of prosecutions and convictions of PHAs. Although Canada has no HIV-specific laws, PHAs are prosecuted under assault charges defined in the *Criminal Code of Canada*. In the U.S. there are also no federal laws governing the criminalization of HIV; however, state legislators have enacted their own HIV-specific laws under which to lay criminal charges against PHAs who know their HIV-positive status and who potentially expose others to HIV. In U.S. states with no HIV-specific laws, charges under the state's criminal code are used to prosecute PHAs accused of non-disclosure and transmission. In both Canada and the U.S., the actual transmission of HIV is not required for prosecution. Neither country has adopted any form of prosecutorial guidelines to govern the legal system, law enforcement or the judicial process for HIV criminal cases. Prosecutorial guidelines have, however, been adopted in England, Wales and Northern Ireland, where the law criminalizes only intentional transmission where a PHA has purposefully engaged in a sexual activity knowing with some certainty that HIV transmission is likely to occur, and where actual transmission has occurred.

England, Wales and Northern Ireland

Prosecutions in England, Wales and Northern Ireland follow common law and are centred on the purposeful intent to transmit HIV and the actual transmission.

Scotland, though part of the United Kingdom, does not follow the same legal protocol,

but like Canada focuses on behaviours that potentially expose someone to HIV. In the rest of the United Kingdom there are no HIV-specific laws targeting the criminalization of exposure and transmission, and HIV-positive people accused of non-disclosure and transmitting HIV are charged under the *Offences Against the Person Act 1861* (OAPA).

The OAPA has been engineered to fit criminal acts of the 21st century with 19th century sensibilities. The charges of “intentional transmission” are derived from Section 18 of the OAPA, which equates a person transmitting infected semen with one who commits physical assault or fires a gun—“whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person, or shoot at any person, or, by drawing a trigger or in any other manner, attempt to discharge any kind of loaded arms at any person with intent” (p. 822). In the same manner, the charge of “reckless transmission,” taken from Section 22, equates the transmission of infected semen through unsafe sexual practices with the administering of “stupefying” drugs used in order to have non-consensual sex—“whosoever shall unlawfully apply or administer to or cause to be taken by, or attempt to apply or administer to or attempt to cause to be administered to or taken by, any person, any Chloroform, Laudanum, or other stupefying or overpowering drug, matter or thing” (p. 822). It is important to note that people have also occasionally been prosecuted under the OAPA for intentionally transmitting other sexually transmitted infections such as Hepatitis B and C, although most prosecutions have focused on HIV transmission. The precedent for prosecuting an individual accused of transmitting HIV under the OAPA was set in 2001, when Stephen Kelly became the first person to be found guilty of

transmitting HIV and the first person to be successfully prosecuted for sexually transmitting a disease in over a century (AIDS Map, 2015). The fundamental difference between England and Canada is that in England transmission of HIV has to occur before an individual can be prosecuted, and the process, beginning with an HIV-positive individual's arrest up to his or her appearance in court, is governed by prosecutorial guidelines.

In 1986, the Crown Prosecution Service (CPS) was established to prosecute HIV criminal cases in England and Wales. The CPS's role is to advise the police on cases prior to possible prosecution, review cases submitted by the police, determine the charges in the most serious and complex cases going to court, and to prepare and present HIV criminalization cases in the courts. The CPS introduced guidelines for prosecutors involved in cases when a PHA has been accused of allegedly infecting a sexual partner with the HIV virus with the intent to cause harm. Under CPS guidelines, an individual in England, Wales and Northern Ireland can only be prosecuted if he or she fits the following criteria:

A person knows he or she is HIV-positive; a person understands how the virus is transmitted and that he or she may be infectious; a person engages in sexual activities with a person without disclosing his or her HIV-positive status; no condom was used; and the HIV-positive person is the only individual who could have transmitted HIV to his or her sexual partner. (Crown Prosecution Service, 2015)

The prosecutorial guidelines established by the CPS are comprehensive. They advise prosecutors to take into account evidential issues including medical and scientific advances, the sexual history of the defendant, and cooperation of the defendant in the release of his or her medical records. If the CPS determines that the defendant is responsible for transmitting HIV, the prosecutor has to then consider whether recklessness can be proven.

The stringent guidelines established in the United Kingdom have meant that the number of prosecutions in HIV-related cases is far lower than in Canada and the U.S. Since the prosecutorial guidelines were implemented, there have been only 13 “reckless transmission” prosecutions (although many individuals have been arrested and investigated), which have resulted in 11 convictions (AIDS Map, 2015). The sentences handed down in cases where the defendants have been found guilty of transmitting HIV to another person also reflect the circumspect way HIV-related cases are treated: the longest sentence for any individual charged with HIV transmission has been ten years—a stark contrast to convictions and sentencing in Canada and the U.S., where convictions have resulted in sentences from 30 days to life imprisonment in maximum security prisons.

The United States of America

The U.S. legislation surrounding the criminalization of HIV non-disclosure and transmission is arguably complex. Some states have adopted HIV-specific laws, while others have utilized the criminal code for prosecutions. The move towards HIV

criminalization in the U.S. began when the AIDS epidemic was at its peak, a time when the disease was linked to deviant behaviour, no treatment for AIDS was available, fear of contagion was rampant, and when even hemophiliacs were ostracized. It was the death of a young boy, Ryan White, a hemophiliac who contracted HIV through a blood transfusion, that prompted the U.S. government to enact a major piece of AIDS legislation that paved the way for the criminalization of HIV non-disclosure, exposure and transmission.

In 1990, the U.S. Congress passed the *Ryan White Comprehensive AIDS Resource Emergency Act (Ryan White CARE Act)*, which provided funds to improve the quality of care for low-income families affected by the AIDS epidemic. The legal obligation to disclose was a result of the *Ryan White CARE Act*, which required that states, in order to be eligible for funding, demonstrate their capability to prosecute potential cases of HIV exposure and transmission. In 2000, the requirement that a state demonstrate the ability to criminalize HIV exposure and transmission was dropped from the *Ryan White CARE Act*; however, 33 states had already adopted HIV-specific laws for prosecuting PHAs. By 2011, a total of 67 HIV-specific laws had been adopted by 33 states and two U.S. Territories. These laws are based on perceived exposure to HIV, rather than actual HIV transmission. Eleven of these states have passed laws that make spitting or biting a felony, even though HIV cannot be transmitted through saliva, a fact known for more than two decades (Centers for Disease Control and Prevention, 2014). Most of the state HIV-specific laws were the result of political compromise and do not take into account actual levels of risk; therefore, they often criminalize low risk behaviour, including oral

sex and even sharing sex toys. For example, in Michigan and Arkansas, the HIV-specific statutes define sexual penetration as including “any other intrusion, however slight, of a part of a person’s body or of any object into the genital or anal openings of another person’s body” (Klein, 2009, p. 258).

In states where there are no HIV-specific laws, prosecutors have used the existing assault or homicide laws to prosecute PHAs in a number of sexual and non-sexual HIV exposure or transmission cases. The most common charge brought against PHAs is reckless endangerment, which is globally defined as “recklessly engaging in conduct which places or may place another person in danger of death or serious bodily injury” (UNAIDS, 2012, p. 20). Prosecutors have also laid charges of assault, attempted murder, aggravated prostitution, bioterrorism, and terrorism. Penalties have ranged from 30 days to 30 years imprisonment, and in some states even the death penalty is possible, though it has not yet been applied.

In 2010, the U.S. Federal Government introduced the National HIV/AIDS Strategy, which maintained that HIV criminalization laws obstruct public health efforts and only serve to discriminate and stigmatize PHAs, and which resulted in the aforementioned changes to the *Ryan White CARE Act*. The strategy went further and recommended (but could not mandate) that state legislatures consider reviewing their HIV-specific laws in order to ensure that they are consistent with current scientific and medical knowledge of HIV transmission, and that they support public health approaches to preventing and treating HIV (White House Office of National AIDS Policy, 2015). In a further attempt to change the course of HIV criminalization in the U.S., a new Act, the

Repeal Existing Policies that Encourage and Allow Legal (REPEAL) HIV Discrimination Act, which reiterated many of the motions put forward in the National HIV/AIDS strategy, was introduced and reintroduced in Congress in 2011, 2013 and 2015. Although the *REPEAL Act* has repeatedly died in U.S. Congress, some states have amended legislation in response. In 2014, the Governor of Iowa signed legislation that modernized Iowa's "criminal transmission statute to make the statute consistent with contemporary science, improve public health and lessen the stigmatization of people with HIV" (Lee, 2015, p. 2). However, until the U.S. Congress passes the *REPEAL Act* into law, many states will continue to use outdated laws to criminalize HIV non-disclosure and transmission.

Chapter 5 demonstrated Canada's position on HIV non-disclosure and transmission in a global context. The chapter analyzed UNAIDS policymakers' stance on the global increase in HIV criminalization laws and outlined the different initiatives and recommendations from the international organization and its affiliates. The chapter also demonstrated the differences in how the U.S. and the United Kingdom have adopted and implemented HIV criminalization laws.

Chapter 6 will analyze the complexities of the criminalization of HIV non-disclosure and transmission in Canada, where a disease is regarded as a weapon, and an ill person as the perpetrator of a crime. The chapter will advocate for a change in the criminalization of HIV non-disclosure and transmission laws in Canada. It will synopsise recommendations from global organizations on HIV criminalization, and argue that prosecutorial guidelines should be put in place to govern procedures around HIV

criminalization—guidelines that serve to protect PHAs, assist police services and Crown prosecutors in assessing potential cases, and provide the media with editorial guidelines.

Chapter 6

The Path Forward

It is now autumn of 2015. The days are getting shorter and the trees are rapidly losing their leaves, marking the countdown to the long winter nights. I arrive at the Ottawa Carleton Detention Centre the required 15 minutes before my scheduled appointment with Steven Boone. Although our last interview was in May, I have returned to visit one more time before submitting this thesis. Boone has changed in the four months since I last saw him; although he still wears the same orange jumpsuit, his prison mohawk has gone, his beard is slightly unkempt, and he no longer wears his round black earrings. He does not greet me with his usual wide smile, but with a look of concern.

Boone is anxious about his upcoming sentencing hearing, scheduled for the end of October 2015. In a recent letter (October 19, 2015), written as always with a hard pencil in compliance with prison regulations, Boone spelled out his concerns regarding the Crown's decision to press for long-term offender designation and the possibility that he might be sentenced to life imprisonment. Boone also expressed fear of the reporters who will almost certainly be present in the courtroom, and of the stories and salacious name-calling that will inevitably follow. After chatting for five minutes or so about prison conditions, Boone talks about the upcoming hearing, and then he mentions the Crown. He stares at me for some seconds before saying, "I am very nervous about the Crown; she can be very inflammatory."

Boone has every right to be nervous. He was arrested in May 2010 for not disclosing his HIV-positive status to his sexual partners and has since been labelled as a “sexual predator” and “poz vampire” by the Ottawa Police Services, the Crown, and the local media. Boone’s infamy escalated in 2012 when he was found guilty on three counts of attempted murder, three counts of aggravated sexual assault, and two counts of administering a noxious substance.

Boone is not an innocent victim. He engaged in several types of unprotected sexual behaviour, when there was both a low and a high risk of HIV exposure, without explicitly declaring his HIV-positive status to his sexual partners. Fortunately for Boone’s sexual partners, none acquired HIV, and although one former partner did become HIV-positive, he had engaged in unprotected sex with five other men after having sex with Boone and it is unclear how and when he seroconverted. What Boone did was morally questionable and, without doubt, irresponsible, but without proof of transmission of the virus, the punishment of the maximum sentence of life imprisonment, registration as a sex offender, and long-term offender designation seems extremely harsh. Boone continues to be desperately unlucky. Perhaps worst of all, he tested HIV-positive six months before his arrest, which gave him very little time to come to terms with being HIV-positive and fully understand the complications associated with the disease, much less understand the legal consequences of not disclosing his HIV-positive status. He needed to learn the nuances of disclosing and develop the self-efficacy to communicate clearly with sexual partners. He needed to negotiate with the medical system to begin Antiretroviral Therapy (ART), but had not yet done so. Boone’s arrest on non-disclosure

charges, and his trial and subsequent convictions, provide a stark lesson about the hazards of using criminal law to prosecute HIV non-disclosure cases and set new precedents for both charges and penalties for future HIV criminalization cases in Canada.

This thesis has examined the complexities of the criminalization of HIV non-disclosure and transmission in Canada, describing how HIV/AIDS is treated under the Canadian criminal code, the policy context surrounding the criminalization of HIV non-disclosure and transmission, the rationale behind the criminalization laws, and how past precedents have shaped court rulings. This thesis has also examined how HIV criminalization cases are covered by the media in a way that incites moral panic in society, Canada's position on HIV non-disclosure and transmission within a global context, and how the laws affect HIV-positive people when the disease is regarded as a weapon and an ill person as a perpetrator.

The Legal Path to the Criminalization of HIV Non-disclosure

Steven Boone is an example of an individual paying a very high price for not disclosing his positive status in a country where the legal system has taken priority over public health HIV prevention efforts, and where individual rights have been swept aside in favour of public morality. Boone's case is one of the latest legal manoeuvres in a judicial game of chess that came into the public sphere in 1998 with the Supreme Court of Canada's historic ruling on *R. v. Cuerrier*. The Court's ruling set a precedent for the future of HIV non-disclosure and transmission cases by legally requiring PHAs to disclose

their HIV-positive status before engaging in any sexual activities that pose a “significant risk” of transmission. The Court’s decision on *Cuerrier* specified that unprotected vaginal or anal intercourse posed enough of a “significant risk” to be considered criminal, but also suggested that the correct use of a condom might lower the risk sufficiently that sexual intercourse would no longer pose a significant risk, and therefore disclosure would not be required (Adam, Elliott, Husbands, Murray, & Maxwell, 2009). However, the Court failed to clearly define the legal parameters for the lower courts to establish whether risk, in a particular case, may or may not be significant. Thus, in the absence of clear jurisprudence, the lower courts continued to interpret the “significant risk” test on a case-by-case basis, which since *Cuerrier* has resulted in inconsistent rulings in HIV non-disclosure cases where PHAs have been charged with criminal offences ranging from aggravated sexual assault and administering a noxious substance to attempted murder and murder, where the Crown has proved, beyond a doubt, that transmission occurred. The result of such a miscellany of decisions was a nation-wide quagmire of legal confusion, which persisted until 2012, when the Supreme Court of Canada ruled on the next historic case, *R. v. Mabior*.

In the *Mabior* ruling, while the Court upheld the legal test of “significant risk” determined in *Cuerrier*, the justices added that the legal requirement to disclose is only applicable when there is a “realistic possibility” of HIV transmission (Adam et al., 2009). In its decision, the Court took into account current medical and scientific advances in asserting that if the HIV-positive partner has a low viral load (less than 1,500 copies per millilitre) and used a condom correctly, there was no “realistic possibility” of

transmission, and therefore no duty to disclose. Conversely, the Court determined that if a condom is not used and the viral load is not low, there is a legal obligation for PHAs to disclose their HIV-positive status; otherwise, they could face criminal prosecution.

The *Mabior* case fell short of establishing the guidelines needed to ensure that criminalizing HIV non-disclosure balanced the human rights of both PHAs and the general public. Although some prosecutions are warranted, particularly where transmission has occurred and the intent to harm can be proved, the legal mayhem surrounding the criminalization of HIV non-disclosure has resulted in the ongoing expansion of the use of criminal law against PHAs.

HIV/AIDS Narrative

Since its discovery in the early 1980s, HIV/AIDS has been associated with deviancy. The rapid onset and infectiousness of the disease and the predominantly sexual transmission, combined with the lack of a cure, meant that HIV was linked to stigma and discrimination. Early public health efforts concentrated on prevention and treatment of the disease, testing, raising public awareness, HIV education and encouraging behaviour change. In the early 1990s, HIV/AIDS was regarded as a public health and human rights issue, and strategies focusing on controlling the global epidemic adopted a holistic approach to HIV prevention and treatment. In order to encourage testing and contain the spread of the disease, public health initiatives focused on supporting the social environment by removing any legal or policy barriers, and on communicating the public health rationale for overcoming stigma and

discrimination against PHAs and survivors affected by the disease. With the advent of ART, HIV was no longer a death sentence, but a chronic manageable disease for people with access to affordable medicines. By the late 1990s, non-governmental and international health organizations were implementing global HIV prevention and treatment efforts that focused on lowering the cost of ART so that even the poorest of the poor had access to treatment, and to developing comprehensive care strategies for people living with the disease.

However, despite these advances in understanding how to effectively deal with the scope of the disease, and the success of global efforts in lowering HIV transmission rates, at the turn of the millennium governments in the Global North began enacting laws that made it the legal duty of PHAs to disclose their HIV-positive status to sexual partners. The principle reasoning behind the implementation of such policies was to provide an alternative HIV prevention method to control new infections; yet the laws do not stem from a health perspective, but rather from a societal attitude where the concept of exposing another person to HIV is deemed morally abhorrent and demands punitive action. The use of punitive measures to prevent an infectious disease only perpetuates the stigma and discrimination associated with that disease, as well as negating the efforts of health initiatives aimed at stigma reduction.

Criminalization laws have created a climate of fear for people living with HIV, for those who do not fully understand the intricacies and mechanisms of disclosure obligations, and for those who have difficulty or lack self-efficacy in negotiating their sexual behaviours. Having to negotiate sexual behaviours is not a new phenomenon; if it

were easy to negotiate with a sexual partner, we would not have, for example, so many unwanted pregnancies. Sexual behaviour associated with pregnancy is known, and although a woman or couple may not want to become pregnant, it takes more than just knowing that condoms prevent pregnancy; it takes negotiation skills to actually use them. Public health advocates fear that criminalization laws may drive vulnerable populations away from accessing the public health services they need, including testing, counselling and treatment, because of the possibility that their previously confidential health and medical records will be made public. People who have tested positive for HIV fear being subjected to criminal prosecution for non-disclosure, and to being stigmatized and discriminated against by law enforcement officials, legal professionals, the greater public, and last but not least, by the media. For the past three decades, the media have played an intrinsically important—if not unwittingly negative—role in the HIV/AIDS narrative.

HIV/AIDS and Moral Panic

Since the 1980s, the media have portrayed HIV primarily as an illness associated with homosexuality, intravenous drug users and sex workers. Through dramatic headlines and exaggerated story lines, the media have portrayed HIV as an illness that affects “others,” and not members of mainstream society. News about HIV has been sporadic, fluctuating from little or no coverage to tabloid-inspired articles that distort the realities around HIV transmission and trigger episodes of moral panic. When HIV transmission rates steadied in the Global North, the media turned away from

sensationalism to focus on public health efforts, scientific advancements, and governmental policies. Fear of the disease faded with the discovery of ART, stories on HIV were filed in the back pages, and moral panic subsided—until, once again, PHAs became villains as governments began to enact laws criminalizing HIV non-disclosure, exposure and transmission.

A new wave of moral panic began to rise. As the police, following new protocols, arrested PHAs on non-disclosure charges, and prosecutors charged PHAs with crimes defined in the Criminal Code, the perception of HIV—and in particular, of PHAs—changed. With the growing trend towards the criminalization of HIV, the media reframed the HIV/AIDS narrative, PHAs were portrayed as the latest threat to the public, and news coverage became dominated by melodramatic articles driven by moral outrage. The disease, once again, became an issue fit for a soap opera. Articles on PHAs arrested on HIV non-disclosure charges focused on deviant sexual behaviour and sexual violence, giving the impression that non-disclosure and unprotected sex were the norm for PHAs, rather than the exception. News stories perpetuated stigma surrounding HIV, negatively influencing public opinion about behaviours associated with PHAs, and reinforcing the perception that punitive measures were more important than public health efforts. Boone's arrest in 2010 on non-disclosure charges, and his trial in 2012, were prime examples of how media coverage helped trigger a new episode of moral panic in society.

The media had no qualms about repeatedly publishing Boone's photo, as well as his personal information, or about seeking out information from his past sex partners

and publishing chat messages he had posted on sites for HIV-positive people seeking casual “hook-up” sexual encounters. In covering news stories about Boone, the local media launched a running narrative that constructed a metaphorical connection between a vampire and a person living with HIV (Fink, 2010). In sensational headlines and news stories, the media portrayed Boone as a “poz vampire”— someone who is sexually aroused by the thought of infecting another person with HIV—conjuring up fears associated with sexuality, disease and death. The vampire narrative had all the makings of a horror story; it provoked an emotional and psychological response in the reader that culminated in fear of, and revulsion for, the protagonist who violated all societal values. Portrayals of Boone as an HIV-positive blood-sucking vampire within a disease narrative that highlighted the fear of difference served to perpetuate stigma and drive the public’s reaction to HIV (Fink, 2010). News on the criminalization of HIV non-disclosure and transmission became a socially constructed drama, where editorial gatekeepers assess the news value of an article by its bizarreness and level of drama, where the villain violates the laws of nature, and the legal experts uphold the law to protect the greater good.

Canada’s Current Position on the Criminalization of HIV Non-disclosure

The criminalization of HIV non-disclosure and transmission in Canada is a complicated issue that has been fraught with misunderstanding of how HIV is transmitted and the different risk levels associated with sexual acts. The sporadic and lengthy prosecutions have not kept pace with scientific and medical advances in the

management of the disease. The issue is a legal quagmire, where different charges against PHAs accused of not disclosing their HIV-positive status, and the varying decisions handed down by local and appeal courts, have been contradictory, without clarity, and without proper precedent. Instead of clearly outlining the legal, scientific and medical parameters to be applied in cases of HIV non-disclosure and transmission, the Supreme Court of Canada's rulings on *Cuerrier* and *Mabior* only added more confusion to the already complicated legal framework, rather than providing some hoped-for clarity.

The *Mabior* case was an opportunity for the Supreme Court to bring Canada in line with global policymakers concerned about the criminalization of HIV non-disclosure and transmission. Unfortunately, the opportunity was squandered. In 2000, the United States government rescinded the requirement in the *Ryan White Care Act* for states, in order to receive federal funding, to prove their capability to prosecute potential cases of HIV exposure and transmission. The government's decision to rescind the funding requirement was the direct result of the misuse of laws in states to prosecute PHAs for sexual and non-sexual behaviours. While there has been no impetus for Canada to enact any HIV-specific legislation, the Crown's continued use of various non HIV-specific charges from the criminal code has begun to approximate some of the worst examples of the application of non HIV-specific laws in some U.S. states, as the legal issues around non-disclosure cases evolve in the courts.

The confusion and misunderstanding around the criminalization of HIV non-disclosure and transmission goes beyond legal parameters into a sociological and

cultural maze, where the rights of people living with and affected by HIV are caught in the middle of a values-driven debate led by the general population's uncertainty and fear that HIV may also affect their lives. HIV criminalization does not take into account the impact that HIV has on a person's life. Even with access to ART, HIV is still a chronic disease that has to be managed on a daily basis, changing every aspect of one's personal life and resulting in a shorter life expectancy, even in the best of circumstances. Being HIV-positive is to have one's life ruled by a rigid medical regime that includes waking up each morning to a heap of drugs, bi-monthly or monthly blood tests, and annual physicals. Each round of testing evaluates the PHA's quality of life and expected life span. Coping with a medical ailment is a physical and mental burden that is made heavier by non-disclosure laws, a profound loss of privacy, and the threat of being labelled as a potential criminal.

The law is a blunt instrument to use in HIV non-disclosure cases where the accused has to medically manage a disease, live with the stigma of being HIV-positive, find a balance between living as person with sexual desires while trying to find a way to disclose his or her HIV-positive status, and negotiating sex that ensures the safety of both partners. A PHA embroiled in an HIV non-disclosure lawsuit has the added burden of dealing with unwanted media attention and ongoing legal battles. Applying rigid and rigorous guidelines to a majority of PHAs because of a small number of non-disclosure cases, most of which involved single incidents that were consensual though poorly negotiated and did not result in transmission, is counterproductive in the effort to change risk behaviours. The laws do not protect the public or PHAs—they place the sole

responsibility of disclosure on the PHA, even though awareness or knowledge about protection from HIV is nearly universal among adults in Canada. Also, the laws allow no recourse after a charge is laid, and the PHA must undergo a public trial where he or she is systematically stripped of privacy, dignity, and innocence.

Global Recommendations

UNAIDS (2013) has urged governments to limit HIV criminalization to cases of intentional transmission, where an HIV-positive individual who is aware of his or her status intentionally seeks to transmit HIV to another person and succeeds in doing so. UNAIDS has further recommended that criminal law should not be applied in cases where there is no significant risk of transmission. In addition, UNAIDS recommends that countries should limit prosecutions to cases where transmission can be proven to have occurred.

Although UNAIDS recommendations entail a reversal of the global trend towards the criminalization of HIV exposure and transmission, the organization remains cognizant of the reality that sweeping changes in the criminal laws of many countries are not likely to occur, and would in fact be pushing against a rising tide of legal precedents currently being established in many countries. As such, the organization stipulates that if governments continue to criminalize HIV exposure and transmission, then the legal system should adopt measures to mitigate harm from these statutes. Specifically, UNAIDS makes the following recommendations:

1. Take into account the scientific and medical advancements in HIV treatment. With the advent of antiretroviral therapy, HIV is a manageable chronic disease and PHAs can live a near normal life. Effective HIV treatment and low viral loads, should, therefore, be “recognized as defences to charges for HIV non-disclosure, exposure or transmission (2013, p. 31).”

2. Non-disclosure laws, when they exist, should uphold principles of legal and judicial fairness, such as legality, foreseeability, intent, causality, proportionality, and proof. In any HIV criminal case, there should be proof of intent to transmit HIV. When intent cannot be presumed, as is the case in many HIV non-disclosure cases, these cases should not be pursued; instead, a package of individually-focused interventions including education, medical assistance, and counselling should be offered to the defendant.

3. The laws should also be mindful of protecting human rights, and take into account that HIV is no longer a death sentence but a chronic illness, and therefore charges in HIV non-disclosure cases should not include murder or manslaughter (*Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013*).

4. Transmission must have occurred and evidence given that the defendant intended to inflict harm on another person.

Progressing Towards Legal Reform in Canada

The criminalization of HIV non-disclosure and transmission is a legal construction comprised of an amalgamation of criminal charges that no longer serve the original intent of protecting the public from an infectious disease. When the first high profile criminalization case, *R. v. Ssenyonga*, appeared in the Canadian courts in the early 1990s, scientists were frantically searching for a cure and endeavouring to define HIV transmission mechanisms. Since that time, scientists have learned more about, and indeed confirmed how, the virus is transmitted, have defined the risks associated with certain behaviours, and have developed a treatment to manage HIV as a chronic disease. Science has surpassed the law in expertise on HIV, and with these medical advances and those yet to come, HIV criminalization laws need to be reformed. However, the Canadian judicial workings are very slow and legal precedents have been set, and while medical discoveries continue to contribute to the development of treatments that lower the risk of infection, it appears that the criminalization of HIV non-disclosure and transmission will remain on the books as long as Canada's legal system continues on the current path.

For the past two decades, HIV criminalization cases in Canada have been mired in a confusing amalgamation of different charges and conflicting decisions, fluctuating legal parameters, and Supreme Court decisions that have broadened the criminal culpability of PHAs. This muddled legal history has earned Canada the dubious honour of being a global leader in HIV prosecutions—an unflattering distinction for a country otherwise known for its commitment to human rights and equality for all of its citizens

(Cameron, 2009). Criminalizing an infectious disease such as HIV increases stigma and discrimination around people living with and affected by the virus. Using criminal law to prosecute PHAs for non-disclosure may be necessary in situations where a person is blameworthy and the intent to harm another person through HIV exposure and transmission can be proved beyond a doubt. Creating a policy framework, either province by province or, preferably, federally, would allow for clarity, protection of individual rights, public education and consistency in the application of the law. Prosecutorial guidelines should be adopted by federal, provincial and territorial legislators to aid and assist police services and Crown prosecutors in assessing potential cases for criminal prosecution, and to provide the media with editorial guidelines. Guidelines should also be developed to assist defense lawyers who, because there are very few rulings on HIV non-disclosure cases, do not have the tools or expertise to handle these cases.

These guidelines need to be structured into a multifaceted framework that reaffirms the importance of public health in HIV education, evaluates potential HIV criminalization cases in a consistent, methodical and prudent manner, takes into account ongoing medical and scientific advancements, and acknowledges the media's role in disclosing and keeping confidential information to promote a fair trial and protect an individual's rights to privacy. My suggestions for such guidelines include the following.

Care and not incarceration. HIV/AIDS is a public health issue, and public health authorities play a vital role in protecting socially and economically marginalized people

most affected by HIV and least likely to be able to access healthcare. It is in the public's best interests if people who are at risk of contracting HIV are able to access healthcare services, including testing, counselling and treatment in a safe environment, where medical records are not readily accessible to police and legal officials. In many circumstances, the risk of transmission may be even greater during incarceration where condoms are not available but sexual behaviours are not uncommon. The tools necessary to negotiate their sexuality safely are simply not available to prisoners. In Boone's case, this has resulted in lengthy periods of isolation that are inhumane and have caused bouts of depression. Offering support and encouraging people to get tested is proactive and has the potential to achieve better results than the threat of incarceration.

Evaluation of individual cases. Canada's legal system should adopt the recommendation of UNAIDS to prosecute HIV non-disclosure cases only when transmission has occurred and intent to harm can be proven. The legal history of incarcerating PHAs for not disclosing their HIV-positive status is fraught with inconsistencies, from the moment of arrest to the closing arguments in a court hearing. The inconsistencies are in line with the widespread misunderstanding of the medical intricacies of HIV and the risks associated with specific sexual behaviours. Guidelines need to be adopted for the police to assess each non-disclosure claim before arrests are made, and each non-disclosure case should be carefully evaluated according to prosecutorial standards before the Crown proceeds with the prosecution. Defense lawyers, most of whom are unfamiliar with the nuances of HIV non-disclosure cases,

should have access to guidelines that outline the rights, obligations and protections for PHAs. The courts should take into account current and up-to-date medical and scientific advances.

Scientific and medical advancements. The HIV virus is not easy to transmit, and while certain behaviours are associated with a high risk of transmission, the risk is lowered by the correct use of condoms and compliance with ART, which if taken consistently suppresses the amount of HIV virus in the blood and stops progression of the disease. Although the Supreme Court acknowledged the efficacy of ART in lowering the HIV viral load of a PHA in *Mabior*, the justices did not take into account how rapidly science is evolving. For example, one of the biggest medical breakthroughs since the discovery of ART is a new antiretroviral drug, Pre-exposure Prophylaxis (PrEP). The drug, if used correctly and consistently, has been proven to reduce by up to 92 per cent the chances of an HIV-negative person contracting HIV, and is recommended for people who are HIV-negative and at substantial risk for contracting HIV (World Health Organization, 2015). The use of PrEP for HIV prevention could affect future court cases involving HIV non-disclosure, as the obligation to disclose could potentially be rendered unnecessary if a sexual partner is using PrEP, which would work in the same way as a vaccine to prevent further transmission in an at-risk population.

Aside from pharmaceutical breakthroughs, medical research has contributed to other changes in the HIV landscape. In September 2015, the World Health Organization announced that any individual newly diagnosed with HIV should begin ART immediately, as his or her risk of transmission may be highest immediately after seroconversion

(World Health Organization, 2015). The treatment protocol prior to this new recommendation was for physicians to counsel patients on the side effects of ART and the necessity of a lifelong commitment to taking the drug (HIV Guidelines, 2015). Hence, people like Boone, who tested HIV-positive in 2009, were not encouraged to take ART until a physician was satisfied that there were no barriers preventing a patient from taking the medication. In past cases, this process could have resulted in delayed treatment and increased risk of transmission during a highly infectious period of several weeks to months.

Catalyzing change through research. The role of research in promoting policy change and advocacy efforts is undeniable. Well-designed research describing the implications of non-disclosure laws on the majority— both in the general public and among those living with HIV—could have an impact on public health decision making. The reluctance of national or provincial policymakers to grapple with difficult issues and obligations around sensitive topics has resulted in fragmented and vulnerable guidance on, for example, abortion that has left much of Canada’s population unable to access this essential and protected maternal health service (LaRoche & Foster, 2015).

Editorial guidelines. As long as media organizations insist on reporting on HIV using the rhetoric of the 1980s and 1990s, HIV criminalization cases will continue to be covered in a sensationalistic manner that creates fear and misunderstanding about HIV rather than accurately informing the public about the disease. Media organizations should adopt editorial guidelines that cover HIV education, the use of appropriate and correct terminology associated with HIV, the importance of respecting the medical

privacy of accused individuals and the complainant in HIV cases, and how accuracy in reporting could help reduce stigma and discrimination. Guidelines could be adapted from existing protocols—for example, policies developed for protecting vulnerable and other at-risk groups such as minors and survivors of sexual assault. The current rhetoric of the media does little to promote the public's understanding of HIV, while negative coverage of non-disclosure cases only increases stigma and further marginalizes people living with and affected by the disease.

Boone's experience with the media during his arrest and trial was not an anomaly; the coverage, which highlighted the uniqueness and bizarre nature of his case, has had a negative impact on his life. Boone is the only person to have had electronic messages used as evidence against him and is the first person to be convicted of attempted murder for HIV-nondisclosure. As Boone writes in a letter on October 19, 2015:

It is hard being personally attacked in the media as a result of my court case. For the past five years I've been taunted, threatened and assaulted simply because of what the media has written about me. I find myself having nightmares about people trying to kill me and I have had several [nervous] breakdowns.

The Judge's Gavel

It is October 29, 2015, and I am sitting in Boone's sentencing hearing at the Ontario Court of Justice in Ottawa, Ontario. The courtroom is small and cramped. Boone's defence lawyer, Ian Carter, and the Crown prosecutor sit behind a long table

with legal books, bound testimonies and court documents piled high on either side of them. The judge sits on a podium just a few metres from Boone, who is seated behind a glass panel next to the security guard. There are a few chairs lined up along the back wall for members of the public to sit, and the room fills up quickly. It is three years after Boone's trial, and this is the final day of sentencing and consideration of the Crown's Long-Term Offender (LTO) application, which, if granted, will give Boone an additional ten-year probation period after his release from prison.

The Crown's submission is overwhelming. She stands behind a lectern and for two hours recounts damning evidence presented at Boone's trial. She argues that Boone's case was not just about his failure to disclose his HIV-positive status, but about his intentional and digitally well-documented desires to seroconvert men he had unprotected anal sex with. As in Boone's trial, the evidence presented by the Crown is focused on his active engagement in online discourse around "gift giving" and "bug chasing," terms that refer to HIV-negative men wanting to contract HIV, and HIV-positive men seeking to infect others with the virus. The Crown argues that Boone did not live in an online fantasy world, but that he had a maladaptive personality and a paraphilic desire to infect his sexual partners. In the Crown's opinion, the chat messages, which included Boone bragging about his ability to manipulate young men into having sex and his references to "being toxic," was evidence that Boone was intentional in his actions. The Crown summarized Boone's behaviour as "beyond reckless" and found that he was morally culpable in that he was aware that his actions could inflict harm on others.

In contrast to the Crown's lengthy submission, Carter's took only 45 minutes as he argued for a shorter sentence. Carter's central argument rested on the premise that Boone denied he meant to cause any harm, and that he was innocent of the charges against him. Carter refuted the Crown's argument that Boone manipulated men, stating that all of the complainants met Boone on gay hookup sites for the sole purpose of having sex. Carter acknowledged, however, that as a jury had found Boone guilty, the judge must sentence according to the verdict. In his closing statement, Carter appealed to the presiding judge for a shorter sentence than the 18 years requested by the Crown—essentially a life sentence and a harsh penalty for an HIV criminalization case where transmission could not be proven. Until the judge renders her decision in December 2015, Boone will remain in the Ottawa-Carleton Detention Centre. After his sentencing, he will move to a federal penitentiary where he expects he will spend the better part of his life behind bars.

I don't want to spend the rest of my life looking over my shoulder wondering if someone is going to try and kill me, which is why I need to keep fighting to clear my name. There is too much at stake. I can't have this black cloud hanging over me indefinitely. I want to be able to move on in a positive way, get married someday and have my own children through surrogacy or adoption. (Steven Boone, October 15, 2015)

Boone's case is an example of the complexities of HIV criminalization cases where the nuances of living with HIV are lost in the legal rhetoric of right versus wrong, guilty or not guilty. It is still unclear if Boone fully comprehends the harm he has caused or the

implications of his legal proceedings. Boone's failure to disclose his HIV-positive status and his guilty verdict has cost him his freedom. Boone wanted companionship and an active sexual life, but he went about it in a manner that defied the norms of society, and he engaged in sexual behaviours that are deemed morally deviant. There is no way we can understand why Boone failed to disclose his HIV-positive status, or know what he would have done had he understood the full consequences of his failure to disclose. But we do know that his life has been derailed, and that his dreams for the future have been shattered.

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Interviews

Steven Boone, inmate at Ottawa Carleton Detention Centre, Ottawa, personal interviews, March to May 2015. Letters dated May 1, 2015; May 8, 2015; May 18, 2015; August 2, 2015, September 25, 2015; October 16, 2015

Michael Burtch, HIV activist, person living with HIV, Toronto, personal interview, February 2015.

Ian Carter, criminal lawyer, partner at Bayne Sellar Boxall, Ottawa, personal interview, April 2015.

Paul Champ, human rights lawyer, Champ and Associates, Ottawa, personal interview, March 2015.

Richard Elliot, executive director of Canadian HIV/AIDS Legal Network, personal interview, February 2015.

Eric Mykhalovskiy, associate professor of sociology, York University, phone interview, March 2015.

**Semi-structured Question Guides for Legal Experts, Public Health Professionals,
Advocates and People Living with HIV/AIDS**

Open-ended semi-structured interviews were conducted with purposively selected members of the following target groups:

Legal experts (N=5)

Public health professionals (N=4)

Policymakers and advocates (N=5)

People Living with HIV/AIDS (PHAs), including PHAs incarcerated for violating non-disclosure laws (N=10)

Social Demographics collected from all key informants:

1. Name
2. Age
3. Gender
4. Profession
5. Number of years working with HIV issues
 - What advocacy/legal work do you do related to HIV?
 - Who do you work with – individuals or organisations?
6. HIV status

People living with HIV/AIDS, including incarcerated PHAs (N=10)

1. How long have you been HIV positive?
2. When did you find out?
3. How did you find out?
 - Did you go for voluntary testing?
 - Was it part of a medical exam?
 - Do you know how you contracted the HIV virus?
4. Can you tell me about the experience?
 - Where did you go for testing?
 - Did you receive pre-test and post-test counselling?
 - What was the counselling advice?
 - Were you told about HIV non-disclosure laws?
 - If so, what were you told about HIV non-disclosure laws?
5. Can you tell me about after you found out you were HIV positive?
 - Were you referred to a hospital?
 - Did you go onto antiretroviral treatment (ART) immediately?

- Was it explained to you what going on ARTs meant – how often you had to take the tablets, what the side effects may be etc.
- Can you tell me what you understood when the doctors or nurses talked about viral load?
- How often do you have to go to the Doctor for a check up and what is the routine?

6. Being told you are HIV positive is a life changing experience.

- Did you receive counselling at the hospital or clinic?
- What do they talk about?
- Can you tell me if you were given any advice on how to come out as being HIV positive?
- How easy was it to be able to come out to people?
- Has everyone you have told been able to accept your HIV status?
- What were the positive experiences?
- If you have had any negative experiences, are you able to share them with me?
- What did these experiences make you feel?
- Can you share with me how hard it is to tell a friend you are HIV positive?
- Can you share with me how hard it is to tell a sexual partner you are HIV positive?

7. When you found out you were HIV positive, did you understand the HIV non-disclosure laws in Canada?

- Were you told that you had a legal duty to declare your HIV status to your sexual partners?
- Where you were given this information?
- Can you share with me how you told?
- Did you understand what the HIV non-disclosure laws meant?
- Can you tell me what you think low-risk sexual activities are and what high-risk sexual activities are?
- Can you share with me what the law means?
- Has knowing about the laws altered the way you interact with sexual partners? If yes, how has it changed the way you act?
- Has it been easy for you to tell your sexual partners that you are HIV positive?
- Is there a particular way you like to share your HIV status with your sexual partners?
- Have you been rejected by someone because you have been open and honest with them? If so, what has that made you feel?

8. Do you think that having these laws helps HIV prevention efforts? Can you share with me why you feel that way?
9. Do you think these laws make it harder to share your HIV status with people?
 - Can you tell me if you feel that the law protects you as a person living with HIV/AIDS? Can you share with me why you feel that way?
10. Do you remember reading any media coverage about the criminalization of HIV transmission in Canada? If so, what was the coverage like?
11. Have non-disclosure laws affected your intimacy, relationships or sexual behaviour? If so, how? If not, why not?
 - Among your peers, how do people disclose their HIV status?
 - Are they afraid of rejection or of being prosecuted?
 - How does this affect sexual behaviour and search for a partner?

Legal experts (N=5)

1. Can you describe for me your perception of the legal framework and policy context around HIV/AIDS criminalization today in Canada?
 - Can you describe to me how you became interested in this topic?
2. Do you think that having non-disclosure laws help HIV prevention efforts?
 - Can you share with me why you feel that way?
 - Do you think there have been successes attributable to non-disclosure laws in Canada?
 - Do you think these laws make it harder to share your HIV status with people?
3. Can you tell me if you feel that the law protects people living with HIV/AIDS? Can you share with me why you feel that way?
 - Do you think that these laws protect members of the larger community who are not HIV-positive?
 - Do you think that these laws have reduced HIV transmission in Ontario?
4. Do you remember reading any media coverage about the criminalization of HIV transmission in Canada? If so, what was the coverage like?
5. Do you think HIV non-disclosure laws affect access to or costs of antiretroviral therapy?
6. Do you think these laws have any impact on rates of voluntary testing and counselling in Ontario?
 - Do you think that HIV non-disclosure laws have an impact on intimacy, relationships or sexual behaviour of PLHAs?
 - Do you think PLHAs are they afraid of rejection or of being prosecuted?
 - How does this affect sexual behaviour and searching for a partner?
7. Does your organization have any policy goals related to non-disclosure laws that you can share with me?

Public health professionals (N=4)

1. Can you describe for me your perception of the legal framework and policy context around HIV/AIDS criminalization today in Canada?
2. Do you think that having non-disclosure laws help HIV prevention efforts?
 - Can you share with me why you feel that way?
 - Do you think there have been successes attributable to non-disclosure laws in Canada?
3. Do you think these laws make it harder to share your HIV status with people?
 - Can you tell me if you feel that the law protects people living with HIV/AIDS? Can you share with me why you feel that way?
 - Do you think that these laws protect members of the larger community who are not HIV-positive?
4. Do you remember reading any media coverage about the criminalization of HIV transmission in Canada? If so, what was the coverage like?
5. Do you think HIV non-disclosure laws affect access to or costs of antiretroviral therapy?
 - Do you think these laws have any impact on rates of voluntary testing and counselling in Ontario?
6. Do you think that HIV non-disclosure laws have an impact on intimacy, relationships or sexual behaviour of PLHAs?
 - Do you think that these laws have reduced HIV transmission in Ontario?
 - Do you think PLHAs are they afraid of rejection or of being prosecuted?
 - How does this affect sexual behaviour and searching for a partner?
 - Do you think that HIV non-disclosure laws have affected stigma in Ontario? Why or why not?
7. Does your organization have any policy goals related to non-disclosure laws that you can share with me?
8. Can you share with me any evidence related to successes or setbacks in counselling and testing, transmission rates or sexual behaviour that you believe could be related to non-disclosure laws.
9. Do you feel that past legal cases and media coverage of non-disclosure cases have had an impact on sexual behaviour or transmission in Ontario?
10. What educational programmes have demonstrated successes in stigma reduction and what lessons can be learned from these?

Policymakers and advocates (N=5)

1. Can you describe for me your perception of the legal framework and policy context around HIV/AIDS criminalization today in Canada?
2. Do you think that having non-disclosure laws help HIV prevention efforts?
 - Can you share with me why you feel that way?

- Do you think there have been successes attributable to non-disclosure laws in Canada?
3. Do you think these laws make it harder to share your HIV status with people?
 - Can you tell me if you feel that the law protects people living with HIV/AIDS? Can you share with me why you feel that way?
 - Do you think that these laws protect members of the larger community who are not HIV-positive?
 4. Do you remember reading any media coverage about the criminalization of HIV transmission in Canada? If so, what was the coverage like?
 5. Do you think HIV no-disclosure laws affect access to or costs of antiretroviral therapy?
 - Do you think these laws have any impact on rates of voluntary testing and counselling in Ontario?
 6. Do you think that HIV non-disclosure laws have an impact on intimacy, relationships or sexual behaviour of PLHAs?
 - Do you think that these laws have reduced HIV transmission in Ontario?
 - Do you think PLHAs are they afraid of rejection or of being prosecuted?
 - How does this affect sexual behaviour and searching for a partner?
 7. Does your organization have any policy goals related to non-disclosure laws that you can share with me?