University of Calgary, Cumming School of Medicine

The Honorable Mr. Justice Michael O'Byrne Lecture on Law, Medicine and Ethics

Stigma and the Role of Courts: The Disquieting Case of AIDS

By

Edwin Cameron,* Constitutional Court of South Africa

Tuesday, 20 March 2018

* I am indebted to my law clerks Martin Willner and Michel Djandji for help with this lecture, and to Juliet Guichon, Matthew Weait, Edwin J Bernard, Dustin Klaudt and Richard Elliott for perceptive comments that saved me from error.

Introduction

1. It is an honour to present this lecture in memory of Mr Justice Michael O'Byrne. My appreciation and thanks are due to the Cumming School of Medicine and, in particular, to Professor Juliet Guichon and her colleagues for inviting me to deliver this lecture, and for their efforts to make my journey here happen.

2. I speak to you as a white South African, whose first 40 years benefited from, and were scarred by, apartheid – a system that classified, discriminated, and denigrated people on the basis of their race. At least officially, that system ended in 1994. But its legacy and its baneful effects continue to today. This is obviously true not only in the spatial geography of how and where people live, but also in the fact that wealth accumulation and vested benefits continue to reflect deep racial patterns inherited from apartheid.

3. And there is a deeper truth about apartheid's damage. Apartheid as a system of exclusion and subordination did more than merely external, surface injury. Apartheid was pernicious because it was fundamentally premised on white racial pre-eminence. This led it to regulate rigidly the lives of millions of South Africans, spatially and politically – but it also marked individual humans, white and black, with a damaging brand of superiority and inferiority.

4. And that is the topic of this afternoon's lecture: stigma. Anti-apartheid activist Stephen Bantu Biko, who in September 1977 paid with his life for his resistance to apartheid, recognised the enormous power of stigma, beyond the suffocating constrictions and oppressions of racial subordination. He looked further and deeper. He explained that "the most powerful weapon in the hands of the oppressor . . . is the mind of the oppressed".

5. This afternoon, I explain the role stigma plays in HIV infection and AIDS, perhaps the most stigmatised conditions in human history. The story is not only intellectually arresting. It is also of daily practical significance. Official figures suggest that worldwide some one million people are dying of AIDS each year.[1] Many of them, roughly but accurately expressed, are dying of stigma.[2]

6. And this afternoon's lecture is deeply personal, for as a person living with HIV, I have experienced deep within myself the most invidious and intractable aspect of HIV-stigma. This aspect is the very internalisation of the stigma so that we who are living with the virus and are at risk of it define ourselves negatively.

7. In addressing this deeply personal subject, I am led to examine two judicial decisions, both judgments of the Supreme Court of Canada, which reflect this stigma, and powerfully help to perpetuate it. I note that I am a guest in your country – which should make me cautious in criticising decisions of this country's highest court. Yet three factors impel me to speak frankly: First, our countries share respect for John Stuart Mill's precept that by encouraging all views to

[1] See UNAIDS "Global Factsheets", http://aidsinfo.unaids.org/ (accessed 19 March 2018).
[2] As I prepared for this lecture, one of South Africa's best-known writers, Jonny Steinberg, published a column recounting the mysterious and unexplained death of the bridegroom in a marriage ceremonial he attended in a township near Johannesburg. It emerged later that the young man, who had previously been diagnosed with HIV and had successfully started anti-retroviral (ARV) treatment, was too ashamed to tell his fiancée, a new relationship partner, that he was living with HIV. Instead, he ceased taking ARVs, and died. Rather than speaking, and living in what he thought would be shame, he died in silence. Steinberg "Despair multiplies when we are silenced by secrecy" *Business Day* (16 February 2018), https://www.businesslive.co.za/bd/opinion/columnists/2018-02-16-jonny-steinberg-despair-multiplies-when-we-are-silenced-by-secrecy/ (accessed 19 March 2018).

be expressed, we all are afforded "the opportunity of exchanging error for truth".[3] Second, we share a legal heritage that induces lawyers and judges not to shrink from controversy, but rather to protect and to promote the rights of others even when risking controversy. And finally, the widely-reputed generosity of Canadians suggests that you and my judicial colleagues might be patient in countenancing strong views about decisions of your ultimate court.

Stigma theory and the irrationality of AIDS stigma

8. Stigma. A six-letter word. A visible brand of rejected otherness imprinted upon another. A social brand of judgment, an imprint of contempt and ostracism, a mark originating in difference, but seared into those who are devalued and rejected because of their difference.

9. In 1963, Alberta-born sociologist Erving Goffman produced a ground-breaking analysis of stigma. He described stigma as arising when an individual with "an attribute which is deeply discredited by his [or] her society is *rejected* as a result of [that] attribute".[4]

10. Common discrediting attributes throughout history include race, religion (Goffman was of Jewish descent), sexual orientation, or disability.

11. Stigma is distinct from, though the near-invariable precursor to, discrimination. Discrimination is carried out through actions and laws: it is the enactment, the performance, of stigma.

---

[3] Mill's argument for the freedom of thought and discussion is found in chapter 2 of *On Liberty*, where he argues that the assertion of an opinion, whether true or false, leads to debate, which in turn leads to greater understanding:

> "[T]he peculiar evil of silencing the expression of an opinion is, that it is robbing the human race; posterity as well as the existing generation; those who dissent from the opinion, still more than those who hold it. If the opinion is right, they are deprived of the opportunity of exchanging error for truth: if wrong, they lose, what is almost as great a benefit, the clearer perception and livelier impression of truth, produced by its collision with error."

Robson (ed) *The Collected Works of John Stuart Mill, Volume XVIII: Essays on Politics and Society Part I*, (University of Toronto Press, Toronto 1977) at 229.

[4] Goffman *Stigma: Notes on the Management of Spoiled Identity* (Prentice-Hall, Englewood Cliffs 1963).

12. Stigma, though always harmful, sometimes may seem rational. Stigma, ostracism, and fear associated with diseases like bubonic plague and Ebola arise from the fact that they are highly transmissible[5] – and deadly when transmitted.

13. AIDS is different. From very early on in the epidemic, within a few years of the first medical manifestations of the disease in the Morbidity and Mortality Weekly Report (MMWR) of the US Centers for Disease Control and Prevention (CDC) in June 1981,[6] it became clear that HIV was not contagious; indeed, it became clear that, outside very specific circumstances, it was very hard to transmit. These circumstances were the direct introjection from one human body into another of a sufficient quantity of infected bodily fluid to successfully convey a sufficient quantity of live virus from the virus-carrying person to the other.

14. Well before 1990, well-documented studies to this effect began to emerge.[7]

15. These established with scientific sufficiency and medical clarity that the risk of accidental transmission of HIV in the healthcare setting was very close to zero.[8] Extrapolated beyond the healthcare

[5] I am indebted to Professor Matthew Weait who has pointed out to me that leprosy, although also highly stigmatised, is relatively hard to contract: Suzuki et al "Current status of leprosy: epidemiology, basic science and clinical perspectives" (2012) 39 *Journal of Dermatology* 121-9, https://www.ncbi.nlm.nih.gov/pubmed/21973237 (accessed 9 March 2018).

[6] CDC "Kaposi's Sarcoma and Pneumocystis Pneumonia among Homosexual Men – New York City and California" (1981) *MMWR Weekly Report* 305-308.

[7] See Gerberding and Henderson "Design of rational infection control policies for human immunodeficiency virus infection" (1987) 156 *Journal of Infectious Diseases* 861-4; CDC "Update: acquired immunodeficiency syndrome and human immunodeficiency virus infection among health-care workers" (1988) *MMWR Weekly Report* 229-39; Gerberding et al "Risk of Exposure of Surgical Personnel to Patients' Blood during Surgery at San Francisco General Hospital" (1990) 322 *New England Journal of Medicine* 1788-193, http://www.nejm.org/doi/full/10.1056/NEJM199006213222506 (accessed 5 March 2018).

[8] See, for example, Henderson et al "Risk for occupational transmission of human immunodeficiency virus type 1 (HIV-1) associated with clinic exposures. A prospective evaluation" (1990) 113 *Annals of Internal Medicine* 740-6 (risk of HIV transmission from exposure to blood from a patient with HIV is approximately 0.3% per exposure (95% CI, 0.13% to 0.70%)); Hadley "Infection of the health-care worker by HIV and other blood-borne viruses: risks, protection, and education" (1989) 46 *American Journal of Hospital Pharmacy* S4-7 (risk of HIV infection for a single needle-stick exposure is about 0.4%); Gershon and Vlahov "HIV infection risk to health-care workers" (1990) 51 *American Industrial Hygiene Association Journal* A802-6 (risk of HIV infection for exposure to needles is 0.5%); Gerst et al "Risks of human immunodeficiency virus infection to patients and healthcare personnel" (1990) 18 *Critical Care Medicine* 1440-8 (risk of HIV infection from blood

setting, this finding entailed, and indeed established, that HIV was very hard to transmit even in situations of intimate contact, whether in the home, the workplace, or social engagement.[9]

16. Despite this evidence, from the very onset of the epidemic, stigma took a vice-like grip on the public response to HIV.

17. Goffman observed that stigma could be based on three types of "discrediting attributes".

a. "abominations of the body" – these include physical scars,[10] deformity, and suffering mental illness;

b. "blemishes of individual character" – for instance, being a gambler or an alcoholic; and

c. "tribal" attributes – such as belonging to a certain religion (being Jewish), or having racial characteristics (being black), or being associated with or part of some other group.

18. I said earlier that AIDS is possibly the most stigmatised disease in human history. This is true not only because AIDS has been connected with all three forms of stigma-manifestation:[11] AIDS is the most stigmatised disease despite being very hard to transmit.

19. From the outset, HIV was associated with those who were already stigmatised. In 1983, the CDC identified four risk groups that

---

transfusion varies from 0.0025% to 0.0004%); Friedland "Risk of transmission of HIV to home care and health care workers" (1990) 22 *Journal of the American Academy of Dermatology* 1171-4 ("The accumulated information on low rates of occupational transmission of HIV makes unwarranted the treatment of patients with [AIDS] or HIV infection as if they were highly contagious in the health care setting").

[9] See Gerberding "Current epidemiologic evidence and case reports of occupationally acquired HIV and other bloodborne disease" (1990) *Infection Control and Hospital Epidemiology* 558-60 (referring to studies indicating a low risk of HIV transmission among "noninfected persons [who] shared households with [HIV]-infected family members and friends, and had substantial though non-sexual contact with them").

[10] For an illuminating memoir of one born with a birthmark, and his parents' response, see Clingman *Birthmark* (University of Massachusetts Press, Amherst 2016) at 10 ("Birthmarks: the markings of birth. Everyone has them, but this one was to be taken away, so that it would live on only in its absence like all those half-remembered worlds").

[11] My lecture explicitly links the first two attributes to HIV and AIDS infection; the third arises from the outset of the epidemic, when Haitians were associated with AIDS, and then, since the mid-1980s, when it has been clear that about two-thirds of those with HIV or AIDS are black Africans.

became known as the "Four H Club": homosexuals, haemophiliacs, heroin users, and Haitians.[12]

20. And AIDS abounds in Goffman's "abominations of the body".

- The AIDS wasting syndrome, in which rampant HIV renders a person's immune system unable to counteract successive infections, leaves the human body etiolated and gaunt.
- One of the most common opportunistic disease presentations is Kaposi's sarcoma, which leaves starkly visible, highly coloured lesions on the body.
- Gastro-intestinal thrush, from which I suffered when I fell sick with AIDS in late 1997, leaves the tongue and mouth thickly marked with fungal growth. Abominations, indeed.

21. Moreover, the way HIV is transmitted, in an overwhelming majority of cases – through sexual intercourse – inevitably meant that HIV would become stigmatised in societies that still freight sexual engagement with moral meaning.[13] Those with the "blemishes" of lasciviousness, "promiscuity", infidelity, or injecting drug use contract HIV.

---

[12] Katz "Did the AIDS Panic Make Trump Afraid of Haitians?" *Politico* (15 January 2018), https://www.politico.com/magazine/story/2018/01/15/aids-panic-trump-haitians-216324:

> "The CDC noted cautiously that 'very little is known about risk factors for Haitians with AIDS.' But the damage was immediate. In the summer of 1983, after years downplaying what had seemed like a story affecting only gay people, New York media were going into AIDS-scare overdrive with screaming tabloid headlines like, 'L.I. GRANDMA DIED OF AIDS' and 'JUNKIE AIDS VICTIM WAS HOUSEKEEPER AT BELLEVUE.' Journalists and scientists scrambled for evidence of a link to Haiti; and given the long-standing racist attitudes of many white Americans toward the black republic, no lead seemed too salacious. Many of the papers repeated idle speculation that the disease had something to do with 'voodoo practices' or, as Paul Farmer recounted in his 1992 book, *AIDS and Accusation*, 'that Haitians may have contracted the virus from monkeys as part of bizarre sexual practices in Haitian brothels.'"

[13] I am indebted to Richard Elliott for observing that, while the majority of new infections in Canada as in Africa arise through sexual transmission, outside sub-Saharan Africa a significant proportion of new infections. are associated with sharing drug injection equipment. While gay men and men having sex with men (MSMs) are the single largest group represented among new infections outside sub-Saharan Africa, and the large majority of those infections have been acquired sexually, even among gay men there are enough new infections associated with risky drug injection practices for epidemiologists to use a new category of "MSM-IDU" in case-tracking.

22. And sexual transmission provides the key to understanding stigma: a moment of intensely private, shared bodily union, which should be effusive, joyful, gratifying, exultant, and, in the case of an opposite-sex couple, potentially generative, becomes instead an occasion in which an infectious agent is passed: in HIV, a death-bearing agent. In this, there seems to lie for us, beings in thrall to sexual connection, something deeply distressful, mortifying, and ultimately shameful. From embarrassment and shame springs condemnation, and from condemnation spring ostracism and discrimination.

South Africa and AIDS

23. In my own country, South Africa, the first reported cases of AIDS were, like those in the United States and Canada, Western Europe and Australasia, of men identified as homosexual.

24. It was at this time that I myself made my intense carnal encounter with HIV. After an unsuccessful opposite-sex marriage, I had formed my first same-sex relationship shortly before turning 30; and, after it ended in 1984, for the first time engaged in successive same-sex sexual encounters. In doing so, though knowledge was nebulous, I knew about the risk of HIV. I was starting a human rights law practice in Johannesburg, directed at defending and supporting activists opposing apartheid. But part of my mission was also to translate my newfound self-assertion as a proudly gay man into political and legal activism for same-sex equality in South Africa.

25. All this meant that I was well aware of the terror of the growing epidemic of disabling disorders, enfeebling infections, bodily dysfunction, and disfiguring afflictions – culminating in death – that the dread new disease was inflicting on gay men in North America, Western Europe, and elsewhere.

26. I thought that my carnal exposures would be immune to the threat of transmission – that I would escape. They were not; and I did not. I became infected. This fact has proved salutary when I speak, as I often do, to groups of young people, including school children. I do so utterly without condescension. I do so in the full knowledge of how a mistaken assumption of immunity or a passion-filled moment of blind-willed ignorance, or hope, can turn into bodily catastrophe.

27. My own affliction was, as in almost all other cases of HIV infection, nearly as much psychological as bodily. That is a story to which I return later this afternoon, for I experienced in an acute form the internalisation of stigma that has become its most painful and disabling effect.

28. For now, it is enough to say that by the mid-1980s, almost exactly coincident with when I was infected, it became shockingly evident that the mass demography of AIDS in Africa would be radically different from everywhere else in the world. Instead of affecting preponderantly urban, relatively affluent, homosexual communities in the developed world, HIV spread with vicious speed and awesome force amongst poor, black, heterosexual populations in central and southern Africa.[14]

29. From the mid-1980s, the epidemic swept southward, through Uganda, Kenya, Tanzania, Malawi, Zambia, Mozambique, and Zimbabwe. When the end of apartheid was announced in February 1990, fewer than 1 per cent (0.8%) of the population were living with HIV:[15] but by 1994, when Nelson Mandela was inaugurated as South Africa's first democratic president, under an inclusive and far-

[14] By the mid-1990s, the global burden of disease in the epidemic was overwhelmingly black, heterosexual, and African. By a ghastly converseness, just as death from AIDS in affluent societies began to be defeated, the body count in Africa, and particularly in my country, South Africa, started to rise. See Monico, Tanga and Nuwagaba "Uganda: HIV and AIDS-related Discrimination, Stigmatization and Denial" (2001) UNAIDS at 6, http://data.unaids.org/publications/irc-pub02/jc590-uganda_en.pdf (accessed 19 March 2018). See also Alan Whiteside "Demography and Economics of HIV/AIDS" (2001) 58 *British Medical Bulletin* (2001) 73-88, http://bmb.oxfordjournals.org/content/58/1/73.full (accessed 19 March 2019).

[15] Thailand's estimated prevalence was slightly lower at 0.6%.

reaching Constitution, the national prevalence was already over 4 per cent.[16] By 1999, when Mandela had concluded his term of office and stepped down for Thabo Mbeki to succeed him, the prevalence was over 12 per cent (12.8%). Today, the prevalence amongst adults is nearly 19 per cent (18.9%).[17] Nearly one in five adult South Africans has HIV. To properly appreciate the catastrophe AIDS inflicted on the new democracy, one may contrast this statistic of 18.9% with the prevalence in Thailand today – which is barely over 1% (1.1%).[18]

30. In different ways, it is evident that the responses to AIDS of both President Mandela's and President Mbeki's governments were deeply marked by stigma.

31. President Mandela, himself, did not utter the word "AIDS" in public until February 1997. And then he did so not in a national intervention – aimed at prevention or stigma or care – but in a speech on economics at the World Economic Forum in Davos. His silence betokened the bewilderment of South Africa's first truly national government at how to deal with its first truly national calamity.

32. But worse followed. The country moved from avoidance under President Mandela – whose burdens were enormous in dealing with hundreds of other issues in the fraught and perilous transition from apartheid – to active, aggressive, and arrogant denialism under President Mbeki.

33. What was already a national tragedy of stunning proportions swiftly became a national disaster. At the end of 1999, the year in which President Mbeki took office, it was estimated that some

[16] See Simelela and Venter "A brief history of South Africa's response to AIDS" (2014) 104 *The South African Medical Journal* 3, http://www.samj.org.za/index.php/samj/article/viewFile/7700/5855 (accessed 5 March 2018) ("HIV prevalence subsequently rose from 0.8% in 1990 to 4.3% by 1994, and now [2014] rests at 12.3% of the total population").
[17] UNAIDS "Global Factsheets" (prevalence in Adults 15-49), http://aidsinfo.unaids.org/.
[18] Avert "HIV and AIDS in Thailand" (quoting UNAIDS data 2017), https://www.avert.org/professionals/hiv-around-world/asia-pacific/thailand.

100 000 people were dying annually from AIDS; in other words, nearly 10 000 per month, or 300 per day.[19]

34. At this time, I, too, faced the fearful prospect of death from the disease. At the end of 1997, three years after democracy, and three years after President Mandela appointed me as a judge, my body succumbed to the ravages of the virus. I had a rare pneumonia, PCP, in both lungs; an obstructive fungus beset my gastrointestinal system, making it near-impossible to swallow or to digest food; and I lost between 10 and 15 kilograms in weight. I was sick unto death: the median survival rate, at that time, for a well-tended male with AIDS in his early 40s, with good care and life projects, was between 30 and 36 months. These data predicted that I would suffer severely and then succumb to death some time during the year 2000.

The discovery of ARVs: A near-miracle supervenes

35. But at that very time, the astonishing, unexpected, unimagined, unimaginable gift of anti-retroviral (ARV) therapy became available. My income as a judge enabled me to afford the drugs, while across a deep swathe of central and southern Africa, poor people, who could not, died of AIDS. Within weeks of starting treatment, the miracle of life and energy was handed back to me. It was an unforgettable experience – one that has shaped my consciousness and actions ever since then.

36. In April 1999, I publicly stated that I was living with HIV, and that my life had been saved because I had access to treatment: I made this announcement hoping to enlarge treatment access and testing, and to counter stigma. I thought when I did so that before very little time others – leading politicians, soccer players, entertainers, cabinet ministers, and judges – would join me. That has not happened. I remain the only person holding public office on the continent of Africa who has spoken publicly about living with HIV.

[19] UNAIDS "Map: Number of AIDS-related deaths", http://aidsinfo.unaids.org/.

37. The reason is the six-letter word, stigma. Stigma continues, powerfully, malignly, to perpetuate silence, fear, and shame.

38. Despite stigma's power, a bigger, principled campaign was started. The campaign was initiated because without anti-retroviral drugs, some 30 to 40 million poor Africans faced certain death from AIDS. Yet the drug prices remained unaffordably, unimaginably high. There was no moral complexity about why: it was exclusively and simply for corporate gain.

39. To remedy this moral atrocity, and to secure anti-retroviral treatment for the "other" 90 per cent of those in the world who needed it, a battle of life and death commenced. The battle of drug pricing was won: the Treatment Action Campaign with its allies in Africa, North America, India and elsewhere, together with the Clinton and Gates Foundations, by 2002 secured a radical reduction in the cost of ARV treatment.

40. Suddenly, life-saving treatment for Africa's millions became feasible.

41. More specifically, treatment that radically reduced the risk of a mother transmitting HIV to her newborn infant had at that point already long been available at little or no cost.

42. But President Mbeki refused to make the ARV drugs available – even to pregnant women in public antenatal care clinics.[20] The treatment activists confronted him with dismayed fury, but also with inexhaustible courage. After an arduous and grievous struggle, the treatment activists triumphed. The courts ruled that the Mbeki government had to start making ARV treatment available.[21] The new

[20] Nattrass *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (University of KwaZulu-Natal Press, 2007).
[21] *Minister of Health v Treatment Action Campaign* (No 2) [2002] ZACC 15; 2002 (5) SA 72 (CC) (decided on 5 July 2002). See also Heywood "South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health" (2009) 1 *Journal of Human Rights Practice* 14-36.

democracy's combination of a strong Bill of Rights, redoubtable activists, and principled judges, secured a momentous victory.

43. South Africa, now, a decade and a half later, boasts the world's largest publically-provided ARV treatment program. Nearly four million of South Africa's seven million people living with HIV are on treatment – healthcare infrastructure and, more perniciously, stigma, as I shortly argue, impede full coverage.[22] Worldwide, some 19.5 of the estimated 36.7 million people living with HIV – just over half – are on ARVs.[23]

44. The near-miraculous properties of ARV treatment are everywhere on display. They enable a full and vigorous life and now appear to confer longevity, at least according to recent Danish studies,[24] in comparable measure to persons living without HIV. This scientific and medical advance should, logically, cause stigma to abate, and to some extent it has. And for good reason. HIV is no longer – and for a long time has not been – a death sentence.

45. Yet the reason for the Mbeki government's refusal to embrace treatment remains important and fatally operative. It is stigma. President Mbeki's public statements on AIDS indicated that he may

[22] These figures raise a question Professor Guichon posed to me. If 7 million of 56 million people live with HIV, then 12% of South Africa's population is living with HIV. In Canada, approximately 65 040 live with HIV of a population of approximately 36 million. Hence, about 0.18% of the Canadian population has HIV. Should there thus be different standards of disclosure in countries where there is a high chance a sexual partner is living with HIV, as opposed to where there is a tiny (0.18%) chance that a sexual partner lives with HIV? Should a person in South Africa assume a partner has HIV, but a person in Canada requires to be told that a partner has HIV? The answer is No. For at least 30 years, public-health messaging in North America and Western and Eastern Europe, as well as large parts of Asia, has emphasised that the risk of HIV infection is widespread. Every person with access to this information should assume that his or her sexual partners may have HIV.

[23] UNAIDS "Ending AIDS: Progress towards the 90-90-90 Targets" (2017), http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf (accessed 19 March 2018).

[24] Obel et al "Impact of non-HIV and HIV risk factors on survival in HIV-infected patients on HAART: a population-based nationwide cohort study" (2011) 6 *PLOS One* e22698, http://www.ncbi.nlm.nih.gov/pubmed/21799935 (accessed 3 March 2018) ("Mortality in patients without risk factors on a successful HAART is almost identical to that of the non-HIV-infected population"); see also Helleberg et al "Causes of death among Danish HIV patients compared with population controls in the period 1995-2008" (2012) 40 *Infection* 627-34, http://www.ncbi.nlm.nih.gov/pubmed/22791407 (accessed 3 March 2018) ("After the introduction of highly active antiretroviral therapy (HAART), the AIDS-related mortality has decreased substantially, but the long-term exposure to HIV and HAART has not translated into increasing mortality from malignancy, cardiovascular, and hepatic diseases").

have been expressing some of Goffman's stigmatic categories. Certainly, "tribal stigma" appeared to be present: the shameful sense to which President Mbeki gave expression that the world's only mass epidemic of sexually transmitted death from AIDS was in the world's only black continent, Africa.

46. He therefore suggested that the mostly white and Western scientists, epidemiologists, virologists, and AIDS activists were wilfully mischaracterising as a viral epidemic what were in fact the ailments colonialism had inflicted on Africa. What we all thought was a viral condition, remediable by anti-retroviral medication, he suggested, instead, was largely environmentally caused, and specifically by poverty.

47. President Mbeki also seemed to give expression to stigma based on "blemishes of individual character". These same white Western scientists and activists, whom he accused of wilfully mischaracterising the epidemic, attributed the spread of HIV to sex: this, on a continent whose dark-skinned people had, for centuries, been the object of stigmatising, prurient preoccupation degrading stereotypes about their mental abilities, physical capacities, and sexual proclivities.

Internalised stigma

48. Mbeki's Presidency is long past, but his legacy of deeply stigmatising misconceptions about HIV lives powerfully on. His denialism enmeshed the notion that HIV, itself, and the mass epidemic in Africa are sources of shame. In multiple ways, he reinforced the internalisation of HIV-stigma for those South Africans living with or at risk of infection with the virus.

49. The internalisation of stigma is a powerful, terrible, and destructive phenomenon. It causes us to view ourselves as smaller, less desirable, unworthy. Most disablingly, externalised stigma – the

discrediting of a human attribute by society – strips those it targets, when it becomes internalised, of human agency.

50. Internalised stigma has long been a familiar trope in other settings. The "self-hating Jew", the "self-loathing gay" are readily recognisable constructs of literature and psychological study. And "colourism", prejudice against those with darker skin tone by others of the same race, is well recognised as the internalisation of centuries-old white superiority and black subordination.

51. The internalisation of HIV-stigma has no ready name. It is the deeply internal state of shame, fear, and self-blame that arises from feelings of contamination, pollution, and defilement with a socially reviled virus that has lodged in the body in consequence of sexually concourse.

52. Internalised HIV stigma is not only understudied; it has been mischaracterised as "felt", "apprehended", or "perceived" stigma.[25] Yet, for those in its grip, internalised stigma is a phenomenon that goes beyond any perception,[26] for it becomes lodged within the agent's own self-conception.

53. When I received my diagnosis with HIV in 1986, I was a young man in my early 30s. I was conducting a vigorous law practice in human rights at a trying but exhilarating time. My diagnosis meant

[25] Greeff et al below n 30; Hasan et "Internalized HIV/AIDS-related Stigma in a Sample of HIV-positive People in Bangladesh" (2012) 30 *Journal of Health, Population and Nutrition* 22-30; see also Parker and Aggleton "HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action" (2002) *Horizons Program*, Population Council at 8, who refer to internalised stigma as "fear of HIV/AIDS-related [stigma and discrimination]". Mahajan et al "Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward" (2008) 22 *AIDS* (Suppl 2) S67-S79 refer to internalised stigma only once, and in passing, saying, "Public participation of PLHA [people living with HIV and AIDS] at community and social levels would not only promote individual level responses to internalized stigma on the part of PLHA, but could also prove a powerful deterrent to stigmatizing impulses of the general population".

[26] I am indebted to Richard Elliott for noting, correctly, that internalized stigma is inextricably a manifestation of, or at least linked to, apprehended or perceived stigma: since no one is born with innate stigma, and it is acquired, stigma's source must be outside the mind of the person experiencing it, whether directly in the form of ill-treatment by others, indirectly through the fear or apprehension of experiencing such treatment by others, or through its internalization by the person who cannot, at least for some period of time, escape its overpowering force in the person's social, political and legal environment and so accepts on some level that their identity is "spoiled" (in Goffman's formulation).

certain death. Before I turned 40, before South Africa could become a democracy, before I could realise any personal or professional ambitions, I would quite surely be dead from AIDS.

54. But worse, far worse – worse even than the apprehension of a calamitously foreshortened life – was the shame I felt.

55. It was intense, all-encompassing, and overpowering. It disabled me from talking to my closest friends and my beloved family. It forced me to retreat into a frozen inner wasteland of isolation and desolation. It precluded even contemplating help from others, still less calling for or accepting it. It transcended and overpowered the capacity for rational thought.

56. Internalised stigma operates harmfully in three distinct ways – through shame, fear, and depression:

- The shame of infection, stemming from the certain knowledge that many people regard HIV with revulsion and fear, operates as a powerful internal construct.
- The fear of evoking adverse reactions, like condemnation or disapproval or pity, even among close family and friends and colleagues, however ungrounded, leads to muting.
- Most powerfully, the internalisation of external stigma disables through depression – as an increasing conviction takes hold within of self-unworthiness, discredit, and worthlessness.

57. Internalised stigma's greatest power lies in its capacity to disable constructive action and rational thought.

58. For persons living with HIV, the consequences remain deadly. Last year in South Africa, more than 110 000 people are estimated to have died of AIDS.[27] Some of these deaths may be due to poor

[27] Statistics South Africa (STATS SA) "Mid-year population estimates 2017" (released 31 July 2017) at 7 (reporting 126 755 AIDS-related deaths in 2017), http://www.statssa.gov.za/publications/P0302/P03022017.pdf.

medical outreach, to treatment unavailability, and to late starts on treatment. A very few – a tiny handful – may be due to treatment failure or to rare drug reactions.

59. But, overwhelmingly, the cause of continuingly high AIDS deaths must, I believe, be sought internally. It is the self-disabling fear of diagnosis that keeps hundreds of thousands of people from being tested, from accessing treatment, and from being restored to health.

60. Fezekile Ntsukela Kuzwayo (Khwezi), former president Jacob Zuma's rape accuser in the 2006 trial which acquitted him of her rape, was to his knowledge living with HIV. (One of the features of his trial that haunted Mr Zuma was that he had intercourse with her without a condom. To minimise the risk of contracting HIV, he testified that he took a shower afterwards.) In due time, Khwezi gained access to anti-retroviral therapy; and according to her biographer, Redi Tlhabi, regained strength and wellness from the effects of HIV.[28] But she then stopped taking her ARVs. She died in October 2016. Her cause of death was her inability to sustain her ARV regimen. Instead of embracing the certitude of a scientifically-established path to strength and wellness, she took recourse to "alternative therapies".[29]

61. A lesser-known but equally poignant instance of deviation from health-seeking options because of internally driven stigma about HIV is AIDS activist Prudence Mabele. She died just months before

---

See also UNAIDS "Country factsheets: South Africa 2016" (reporting 110 000 [88 000-140 000] AIDS-related deaths in 2016), http://aidsinfo.unaids.org/.

[28] Tlhabi *Khwezi: The Remarkable Story of Fezekile Ntsukela Kuzwayo* (Jonathan Ball Publishers, Jeppestown 2017).

[29] Professor Guichon suggests that this case might not illustrate fear of diagnosis but fear of or disdain for treatment. People who seek alternative treatment do not necessarily do so because of stigma. Sometimes they are the group called "Smart stupid" in vaccine hesitancy literature: smart about some things but "stupid" about science. Richard Elliott also questions whether stigma is the underlying cause of Ms Kuzwayo's and Ms Mabele's deaths. No doubt they, he concedes, like the majority of people living with HIV, struggled with the insidious effects of stigma, just as many who have been out, proud LGBT activists for many years still struggle with the deeply-embedded shards of internal homophobic stigma. But asks: could it really be that HIV stigma would leave these persons to discontinue her medication? My answer is, probablyYes.

Khwezi, in June 2016. She, like Khwezi, died because she stopped taking ARV medications.[30] Why would a highly visible and vocal advocate for women living with HIV stop taking treatment? One can but surmise; but self-negation because of the damaging impact of internalised stigma seems to me powerfully suggested.

62. These sad deaths do not instance an idle debate or an academic divergence. To me, they indicate that stigma and its internalisation have the urgency of death. That urgency speaks with anguish in a country where, every day, over 300 people are estimated to die of AIDS, needlessly, when diagnosis of, and treatment and support for, their condition are readily available.[31]

63. The motive force underlying treatment non-adherence is, I believe, internalised stigma. Stigma's power is to suggest and convince the person subject to it that he or she is unworthy of intervention, unworthy of treatment, unworthy of health: unworthy of life itself.

Externalised stigma, discrimination, and HIV criminalisation

64. But to focus solely on internalised stigma is to ignore the deadly role of externally enacted stigma in inflicting suffering and death in the AIDS epidemic. People with HIV and AIDS are still denied employment, dismissed from their jobs, evicted from their homes, beaten by their partners, and sometimes killed, simply because of the disease.[32]

---

[30] See "Did Prudence Mabele quit her ARVs?" *Health24* (25 July 2017), https://www.health24.com/Medical/HIV-AIDS/News/did-prudence-mabele-quit-her-arvs-20170725 (accessed 21 February 2018).

[31] This is based on the lower figure UNAIDS gives. The STATS SA figure suggests closer to 350 per day: Statistics South Africa (STATS SA) "Mid-year population estimates 2017" (released 31 July 2017) at 7 (reporting 126 755 AIDS-related deaths in 2017), http://www.statssa.gov.za/publications/P0302/P03022017.pdf (accessed 19 March 2018). Compare UNAIDS "Country factsheets: South Africa 2016" (reporting 110 000 [88 000-140 000] AIDS-related deaths in 2016), http://aidsinfo.unaids.org/ (accessed 19 March 2018).

[32] The effect of externalised stigma is well documented. See Greeff et al "Experiences of HIV/AIDS Stigma of Persons Living with HIV/AIDS and Nurses Involved in their Care from Five African Countries" (2008) 10 *Africa Journal of Nursing and Midwifery* 78-108 at 79-81 (itemising (1) internal stigma, (2) received stigma, and (3) associated stigma). See also Mahajan et al "Stigma in the HIV/AIDS epidemic: A review of the

Externally enacted and apprehended stigma operates in ways akin to the Ronald Reagan era in the 1980s,[33] the Mandela era in the 1990s, and the Mbeki era in the early 2000s. Externally apprehended, realised, and enacted stigma still plays all too culpable a part in the management of the epidemic.

65. Today, the fiercest and most harmful manifestation of external stigma is found in criminal law books.

66. In the United States, 39 states have HIV-specific criminal statutes. Under them, at least 442 people with HIV have been prosecuted[34] – often where there has been no transmission or even risk of transmission. No fewer than 24 states criminalise non-disclosure, again, even where there is no risk of transmission.[35]

67. On my own continent, at least 29 countries have enacted HIV-specific criminal laws.[36] These laws are intrinsically bad, for they are overbroad and muddled. Their application has also been punitive in the extreme.

68. For instance, section 79 of Zimbabwe's penal code purports to criminalise the "deliberate transmission of HIV".[37] But the language

---

literature and recommendations for the way forward" (2008) 22 *AIDS* (Suppl 2) S67-S79 at 5 (citing Link and Phelan "Conceptualizing stigma" (2001) 27 *Annual Review of Sociology* 363-85: "stigma exists when the following four interrelated components converge: 1) individuals distinguish and label human differences, 2) dominant cultural beliefs link labelled persons to undesirable characteristics (or negative stereotypes), 3) labelled persons are placed in distinct categories to accomplish some degree of separation of "us" from "them," and 4) labelled persons experience status loss and discrimination that lead to unequal outcomes").

[33] [Cameron, Okpaku] "President Ronald Reagan, who held office in the US as the epidemic became a deathly nightmare in the gay male communities of the east and west coasts, refused even to mention the word 'AIDS' until 1987 (Sayler 2004)".

[34] To check with Schott Schoetes at Lambda Legal, Sean Strub at Sero Project, Catherine Hanssens at the Centre for HIV Law & Policy.

[35] NAM "HIV and the Criminal Law: North America", http://www.aidsmap.com/law-country/North-America/page/1445031/#item1445038; CDC "HIV-Specific Criminal Laws", https://www.cdc.gov/hiv/policies/law/states/exposure.html; HIV Justice Network "Advancing HIV Justice 2: Building momentum in global advocacy against criminalisation", http://www.hivjustice.net/advancing2/; Global Criminalisation Scan, Global Network of People Living with HIV "United States of America", http://criminalisation.gnpplus.net/country/united-states-america (accessed 5 March 2018).

[36] The figure of 29 is from personal communication on 21 February 2018 with Edwin J Bernard.

[37] Criminal Law (Codification and Reform) Act of 2004, section 79(1), https://www.unodc.org/res/cld/document/zwe/2006/criminal_law_codification_and_reform_act_html/criminal_law_codification_and_reform_act.pdf (accessed 22 February 2018).

of crime-specification does much more than this, for it is overbroad and contradictory in that transmission is not in fact needed at all.[38] "Transmission" embraces anyone who intentionally "does anything" which he or she realises "involves a real risk or possibility of infecting a person with HIV". "Anything" is not defined, nor is "do". "Real risk or possibility", likewise, is broadly defined.[39] The law punishes deliberate transmission of other sexually-transmitted diseases with up to five years in prison. It punishes deliberate "transmission" of HIV with up to 20 years. There is no recognised defence for low or no viral load.[40]

69. In a judgment as pugnacious as it is short, the Zimbabwe Constitutional Court in June 2016 ringingly declared the provision valid.[41] "Public policy", the Court stated, requires of a person aware that he or she has HIV[42] "to make full disclosure to [an] intended partner in order to afford that partner the opportunity to make an informed decision". The Court appeared to include persons with HIV who use condoms in this duty of disclosure.[43]

70. In my own country, general criminal laws have been applied against persons living with HIV even without proof of transmission.[44] Mr Lovers Phiri, an HIV counsellor was convicted of attempted

---

[38] Richard Elliott notes that the Zimbabwe offence seems at least until recently more or less the statutory equivalent of the Canadian sexual assault law as evolved through the Supreme Court of Canada and other jurisprudence. The chief deficiency, in both, seems to be no recognition of a defence (or exclusion from liability) on the basis of low or undetectable viral load or on the basis of condom use, or similarly low risk of transmission.

[39] Section 15 of the Code requires "a component of" awareness and "a component of" recklessness. "Remote risk or possibility" are excluded.

[40] Section 79(2) creates a limited defence of if "the other person" knew that "the accused was infected with HIV" and consented, "appreciating the nature of HIV and the risk of becoming infected". See Criminal Law (Codification and Reform) Act of 2004, https://www.unodc.org/res/cld/document/zwe/2006/criminal_law_codification_and_reform_act_html/criminal_law_codification_and_reform_act.pdf (accessed 22 February 2018).

[41] *Pitty Mpofu, Samukelisiwe Mlilo v The State*, judgment of Ziyambi JCC, on behalf of a nine-judge bench, http://zimbabwelawreports.com/pdf/constitutional-court/S_v_Mpofu.pdf (accessed 22 February 2018).

[42] The Court used the unscientific and inaccurate parlance of persons "infected with the HIV/AIDS virus": *Pitty Mpofu, Samukelisiwe Mlilo v The State* at para 12.

[43] Id.

[44] See Furlong and Geffen "Should you be prosecuted for exposing someone to HIV?" *GroundUp* (11 August 2016), https://www.groundup.org.za/article/should-people-who-transmit-hiv-be-prosecuted/ (accessed 22 February 2018).

murder and sentenced to six years' imprisonment for having unprotected sex with his then-former girlfriend without informing her of his HIV status. The High Court in considering an appeal in 2013 held that it was not necessary to prove that HIV was indeed transmitted[45] for a finding of guilt.[46]

71. Let us then turn to Canada, which has a reputation worldwide – one generally well-deserved – as a caring, compassionate, and empathetic country. And its courts, particularly its Supreme Court, have been lauded worldwide as beacons of rationality, fair-mindedness, and justice. The court in which I am privileged to sit, the South African Constitutional Court, regularly draws on the jurisprudence of the Canadian Supreme Court, since the structure of our constitutions' fundamental rights provisions are similar.[47]

72. Yet there is a discord. Canada has a dubious distinction. Globally, after the United States and Russia and East European states,[48] Canada has prosecuted more cases for non-disclosure of HIV

---

[45] See *Phiri v The State* 2014 (1) SACR 211 (GNP). The High Court (Makgoka J and Baloyi AJ) held at para 9:

> "It was further argued that the appellant should not have been convicted of attempted murder, but of a [lesser] count such as assault with intent to do grievous bodily harm. There is simply no merit in this contention. It is to be borne in mind that the appellant was not convicted of having in fact transmitted HIV to the complainant. The State did not have to go that far. It was sufficient for a conviction on the count of attempted murder, to establish that the appellant, knowing that he was HIV positive, engaged in sexual intercourse with the complainant, whom she knew to be HIV negative, without any preventative measures."

The Court also observed at para 15 that "Although the State did not prove that he transmitted the complainant with HIV virus, his conduct remains reckless".

[46] In *S v Nyalungu* 2013 (2) SACR 99 (T), the High Court upheld a conviction of attempted murder where the accused, knowing he had HIV, raped the complainant, even though the prosecution did not prove transmission. (The headnote of the reported case wrongly indicates that transmission was in fact established.) Somewhat poignantly, the evidence the High Court cited indicated that the accused was on treatment for HIV; the question of viral load and transmissibility was, regrettably, not raised or discussed.

[47] See, as just one early instance, *Prinsloo v Van der Linde* 1997 (3) SA 1012 (CC).

[48] In a personal communication (email dated 4 March 2018), Edwin J Bernard, assessing the number of prosecutions over the past two years, reports at least 278 reported prosecutions in the past two years in 39 countries:

- 108 in the United States (notably in Florida, Ohio, Tennessee, and Michigan)
- 58 in Belarus
- 23 in Russia
- 18 in Canada
- 11 in Zimbabwe
- 8 in the United Kingdom
- 7 in the Czech Republic

These data have not yet been published (though they have been submitted to the XXII International AIDS Conference in July 2018 in Amsterdam in a number of abstracts). Edwin J Bernard includes them in part in a

than any other country.[49] It lags behind only a handful of jurisdictions in absolute number of convictions.[50]

73. A recent scholarly study notes, correctly, that Canada has "one of the strictest legal standards criminalizing HIV non-disclosure worldwide".[51] To this it ascribes the high rate of prosecution of Canadians living with HIV.

74. People with HIV have been charged even when they did not intend to transmit the virus, when they engaged in conduct that posed little or no risk of transmission and did not, in fact, transmit HIV to their sexual partners.[52] To this there may be a disturbing racial edge: black people may be disproportionately represented in the prosecutions and are certainly over-represented in media coverage of HIV prosecutions.[53]

75. In addition, Canada's immigration policy seems hostile to people living with HIV.[54] It appears, in general, to deem them

---

blog post, Bernard "The repercussions of prosecuting HIV" *International AIDS Society* (8 December 2017), http://www.iasociety.org/The-latest/Blog/ArticleID/166/The-repercussions-of-prosecuting-HIV (accessed 5 March 2018).

[49] Canadian Coalition to Reform HIV Criminalization "Developing a Community Consensus Statement on Ending Unjust Prosecutions for HIV Non-disclosure", http://www.aidslaw.ca/site/wp-content/uploads/2017/07/CCRHC_Backgrounder-and-Draft-Community-Consensus-Statement_final_EN_25July2017.pdf. At least 184 people have faced charges related to HIV non-disclosure in 200 cases in Canada since 1989. Figure 1 shows the yearly number of HIV-related criminal cases in Canada up to the end of 2016. The vast majority of known cases (82% [163/200]) has occurred since January 2004, with a significant proportion (76% [151/200]) of all cases occurring in the 10-year period from 2004 to 2014. There were roughly 10-15 cases per year over this 10-year period. Since the *Mabior* decision in 2012, there have been 35 criminal cases related to HIV non-disclosure. In 2013 and 2014, the annual number of cases remained steady at 10-15 per year; however, fewer cases were reported in 2015 (seven cases) and 2016 (five cases). Continued monitoring of the annual number of criminal cases related to HIV non-disclosure in Canada will determine if this reduction is a temporary or more stable trend.

[50] Patterson et al "The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence" (2015) 18 *Journal of the International AIDS Society* 20572, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689876/ (accessed 27 February 2018).

[51] Id.

[52] Hastings, Kazatchkine, and Mykhalovskiy "HIV Criminalization in Canada: Key Trends and Patterns" (17 March 2017) at 1, http://www.aidslaw.ca/site/hiv-criminalization-in-canada-key-trends-and-patterns/?lang=en (accessed 26 February 2018).

[53] Id at 4-5.

[54] The new federal immigration minister, Ahmed Hussen, appears sympathetic to attempts to reverse this stance. On Canada's currently hostile immigration laws, see the Canadian HIV/AIDS Legal Network's exposition through question-and-answer at http://www.aidslaw.ca/site/canadas-immigration-policy-as-it-affects-people-living-with-hiv-questions-and-answers/?lang=en (accessed 19 March 2018).

inadmissible, on medical grounds, on the premise that they might impose "excessive demand" on health or social services.[55]

76. How can it be that Canada places so injurious a brand-mark of stigma on people living with HIV – more so than most other Western countries?[56] At the heart of the explanation lie two decisions by the Canadian Supreme Court, in 1998 and in 2012.

Cuerrier and *Mabior*

77. The root of Canada's extreme position on criminal prosecution of people with HIV lies in *R v Cuerrier*,[57] which the Supreme Court decided 14 years before *R v Mabior*.[58]

78. In *Cuerrier*, the Court upheld a conviction of aggravated assault[59] where a man with HIV had consensual but unprotected sex[60] on different occasions with two women. The Court held that the man's failure to disclose his HIV status constituted fraud.[61] This

[55] While HIV is not specifically mentioned as a basis of exclusion, this seems to be the practice, since only immigration applicants in the family and dependent refugee class "may not be assessed as medically inadmissible due to excessive demand on Canada's health care system". See Government of Canada "Medical Requirements", https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/standard-requirements/medical-requirements.html (accessed 19 March 2018). I am indebted to Richard Elliott for pointing out that in the case of a conviction for (sexual) assault for HIV non-disclosure, a non-citizen very likely faces deportation, an additional consequence of the severe charge used for prosecuting HIV non-disclosure.

[56] Rawluk "HIV and Shared Responsibility: A Critical Evaluation of *Mabior* and *DC*" (2013) 22 *Dalhousie Journal of Legal Studies* 21-33 at 29, https://ojs.library.dal.ca/djls/article/viewFile/3623/3332 (accessed 27 February 2018) (noting that stigma surrounding HIV/AIDS is still prevalent in Canada, citing a 2012 survey in which nearly half of respondents said that they would not be comfortable drinking from the same restaurant glass as someone with HIV, and 24% said they would not be comfortable with even wearing a sweater that was once worn by someone with HIV. More than one-third stated that they would not be comfortable with their child attending the same school as someone with HIV).

[57] *R v Cuerrier* [1998] 2 SCR 371 (SCC) (*Cuerrier*), https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1646/index.do (accessed 22 February 2018).

[58] *R v Mabior* 2012 SCC 47, [2012] 2 SCR 584 (SCC) (*Mabior*), https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/10008/index.do (accessed 22 February 2018).

[59] The Criminal Code was amended in 1983; rape and indecent assault were replaced by the offences of aggravated sexual assault and sexual assault: section 265(1) and (2).

[60] I am indebted to Richard Elliot for noting that the term "unprotected" sex as used in *Cuerrier* has become superseded in the light of scientific knowledge about the protective effect of ARVs (whether as prevention lowering the viral load of a person with HIV or as PrEP in the case of the HIV-negative person): hence "condomless sex" or "sex without a condom" is more accurate.

[61] Section 265(3)(c) provides that no consent is obtained where the complainant "submits or does not resist" by reason of "fraud".

vitiated his sexual partners' consent, rendering their sexual intercourse the crime of aggravated assault.

79. When the judgment, by Cory J,[62] was handed down in 1998, the remarkable effects of ARV treatment had not yet become universally established. The judgment shows this.[63] It is redolent of the fearful language of HIV that was employed at the time.[64]

80. The judgment also established an imprecise test[65] – in order for non-disclosure of HIV to vitiate consent to sexual intercourse, there had to be a "significant risk of serious harm".[66] This test was required to be applied "to the facts of each case".[67] The Court conceded that "the careful use of condoms might be found to so reduce the risk of harm [from HIV] that it could no longer be considered significant".[68]

---

[62] Of the seven judges who sat in the case (L'Heureux-Dubé J, Gonthier J, Cory J, McLachlin J, Major J, Bastarache J, and Binnie J), a majority of four (Cory J, Major J, Bastarache J, and Binnie J) established the "significant risk of serious harm" standard.

[63] Richard Elliott nevertheless notes that the interveners in *Cuerrier* provided the argument underlying the one concession by Cory J for the majority, namely that careful use of condoms "might" reduce the risk of transmission sufficiently that it could preclude criminal liability for non-disclosure. *Cuerrier* at least established, first, that there was no blanket duty to disclose (as later endorsed in *Mabior*, and, second, that condom use might exclude liability. It is also is worth noting that most of the lower court decisions after *Cuerrier* in fact honoured the suggestion of Cory J regarding the use of condoms – until *Mabior* destroyed this progress, with McLachlin CJ deviating unaccountably from the clear position she had articulated in *Cuerrier*.

[64] Cory J said at paras 141-2 that—

> "the criminal law does have a role to play both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities. This case provides a classic example of the ineffectiveness of the health scheme. The respondent was advised that he was HIV-positive and on three occasions he was instructed to advise his partner of this and not to have unprotected sex. Nevertheless, he blithely ignored these instructions and endangered the lives of two partners.
>
> Where public health endeavours fail to provide adequate protection to individuals like the complainants, the criminal law can be effective. It provides a needed measure of protection in the form of deterrence and reflects society's abhorrence of the self-centered recklessness and the callous insensitivity of the actions of the respondent and those who have acted in a similar manner. The risk of infection and death of partners of HIV-positive individuals is a cruel and ever present reality. Indeed the potentially fatal consequences are far more invidious and graver than many other actions prohibited by the Criminal Code. The risks of infection are so devastating that there is a real and urgent need to provide a measure of protection for those in the position of the complainants. 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."

[65] As McLachlin CJ noted for the Court in *Mabior* above n 53 at paras 14-9.

[66] *Cuerrier* above n 52 at paras 137-9.

[67] Id at para 139.

[68] Id at para 129.

81. The result of *Cuerrier* was inconsistent lower court decisions. *Cuerrier* required trial courts to apply what the Supreme Court later called "a complex calculus", one that, as McLachlin CJ later pointed out in *Mabior*, made it "impossible, in many cases, to predict in advance whether a particular act is criminal" or not.[69] So Canadian courts sometimes convicted persons of aggravated assault on the basis of HIV non-disclosure; and sometimes not.

82. The worst aspect of *Cuerrier* was its overbroad application of the criminal law in the way it overruled a notorious 19th-century decision by a nine-judge panel of the Court of Queen's Bench in England.[70] There, the accused husband had sexual intercourse with his wife when he knew that he was infected with gonorrhoea – which then, in the pre-antibiotic era, was an untreatable condition. He passed the infection to her. The trial court convicted him of unlawfully inflicting grievous bodily harm on her. On appeal, his conviction was reversed. The majority of the English judges held that fraud does not vitiate consent to sexual intercourse, which would otherwise be an assault, unless the mistake goes to the nature of the act or the identity of the partner. Fraud as to what the majority judgment called "collateral aspects" of a consensual encounter – like the risk of contracting a serious sexually transmitted infection – does not vitiate consent.[71]

83. This doctrine was rooted in the subordinating 19th-century conception that a wife was deemed – by the all-male judiciary that invented this doctrine – to consent to sexual intercourse with her

[69] McLachlin CJ in *Mabior* above n 53 at para 19.
[70] *R v Clarence* (1888) 22 QBD 23, [1886-90] All ER Rep 133 (judgments of Wills J and Stephen J, with whom, it appears, Lord Coleridge CJ, Pollock J, Matthew J, Smith J, Grantham J, Huddleston J, and Manisty J concurred).
[71] Hawkins J dissented. Even he premised his judgment on the husband's "irrevocable privilege to have sexual intercourse" with his wife – but he considered there were limits. The privilege did "not justify a husband in endangering his wife's health and causing her grievous bodily harm, by exercising his marital privilege when he is suffering from venereal disorder."

husband:[72] this is why whether she knew of the infection – or whether she would have refused consent had she known – was irrelevant.

84. *Clarence* was a 1888 case where sexual intercourse was virtually certain to transmit the sexual infection – and where it was in fact transmitted. Mrs Clarence became infected with an untreatable infection because her husband deceived her. Despite this fact, the judges held her consent to the intercourse with her spouse valid – for outmoded reasons of female subordination to men.

85. Rightly, *Cuerrier* regarded this result as untenably outdated. But to overrule *Clarence*, *Cuerrier* should have laid down a practicable standard that *certainty or high risk* of transmission voided consent. *Cuerrier* could, for instance, have adjusted the criminal law to apply in cases of actual transmission, where, a high risk of exposure would obviously be established, and criminal liability would follow.

86. Indeed, in the English cases that overruled *Clarence*, in the decade after *Cuerrier*, actual transmission of HIV had in each case occurred.[73] There was no imposition of post-*Clarence* criminal liability merely for exposing another to risk, even "significant" risk.[74] Nor should there have been.

---

[72] As Judge LJ observed in *R v Dica* [2004] 3 ALL ER 593 (Judge LJ and Forbes J) (*Dica*) at para 19, http://www.bailii.org/ew/cases/EWCA/Crim/2004/1103.html (accessed 26 February 2018), "[T]he artificial notion that sexual intercourse forced on an unwilling wife by her husband was nevertheless bound in law to be treated as if it were consensual sexual intercourse permeated much of the reasoning of the majority, and was fundamental to the outcome".

[73] See *Dica* id; *R v Konzani* [2005] EWCA Crim 706, (Judge DCJ, Grigson J and Radford J) (*Konzani*), http://www.bailii.org/ew/cases/EWCA/Crim/2005/706.html (accessed 26 February 2018); *R v Adaye*, where the accused claimed not to have had actual knowledge of his HIV (though he had been warned to have a test), which I have been able to access only from this report: "HIV bigamist jailed for infections" *BBC* (12 January 2004), http://news.bbc.co.uk/2/hi/uk_news/england/merseyside/3389735.stm (accessed 26 February 2018). Even the limited form of criminal liability *Dica* and *Konzani* imposed are trenchantly criticised by Matthew Weait, "Criminal Law and the Sexual Transmission of HIV: *R v Dica*" (2005) 68 *Modern Law Review* 121-34; "Knowledge, Autonomy and Consent: *R v Konzani*" (2005) *Criminal Law Review* 763-772. See also Weait *Intimacy and Responsibility: The Criminalisation of HIV Transmission* (Routledge-Cavendish, Abingdon 2007), which critically considers the cases and the moral context.

[74] Scots criminal law, unlike English law, permits prosecution for endangerment, but failing to disclose known HIV status does not attract criminal consequences either in Scotland or in England and Wales. See the discussion by Matthew Weait of the judgment of Lord Hodge in the case of *Giovanni Mola* in *Intimacy and Responsibility* id.

87. In fact, two of the judges in *Cuerrier*, McLachlin J, writing for herself and Gonthier J, differed from the approach of the majority. They considered that a "high" – not merely a "significant" – risk of infection should be required to vitiate consent[75] – and, indeed, "high risk" was the standard of the English common law before the judges in *Clarence* upended the law in 1888. In addition, McLachlin J and Gonthier J explicitly excluded sex with a condom from liability.[76]

88. In rejecting the 1888 judgment, it was quite unnecessary for the Supreme Court of Canada to expand the category of risks that vitiate consent by lowering the standard from "high" to merely "significant". The English courts' approach in overruling *Clarence* – namely to penalise actual transmission – was amply enough. If that standard was considered too narrow, only exposure of a sexual partner to a high risk of disease transmission should have been penalised.

89. But the *Cuerrier* majority was determined to go further. Its determination was to lower the standard from "high" to merely "significant", even though, according to the Manitoba Court of Appeal in the *Mabior* case, the *Cuerrier* Court had before it *no information at all* about infectiousness or risk of transmission.[77] It

---

[75] Gonthier J and McLachlin J in *Cuerrier* above n 52 at paras 70-4. McLachlin J at para 67 explained the difference between her judgment and that of Cory J lay in that, before *Clarence*, "the common law recognized that deception as to sexually transmitted disease carrying a high risk of infection, constituted fraud vitiating consent to sexual intercourse. Returning the law to this position would represent an incremental change to the law", whereas the judgments of Cory J and L'Heureux-Dubé J did not represent incremental change.

L'Heureux-Dubé J at para 16 dissented on the basis that the standard to be applied should be even wider than that in the judgment of Cory J – she held that fraud vitiating consent to sexual conduct occurs whenever any dishonest act induces another to consent, "*whether or not the act is particularly risky and dangerous*".

[76] McLachlin J in *Cuerrier* stated , stating that "only unprotected sex" [clearly meaning sex without a condom] "would not be caught" by the criminal law on the "high" risk test she advocated. This makes the subsequent about-turn by McLachlin CJ in *Mabior* all the more inexplicable and regrettable.

[77] As the Manitoba Court of Appeal tactfully but unambiguously pointed out in *R v Mabior* (CL) 2010 MBCA 93 (CanLII) (*Mabior* Court of Appeal) at para 72, https://www.canlii.org/en/mb/mbca/doc/2010/2010mbca93/2010mbca93.html, "[T]here does not appear to be any information about infectiousness or risk of transmission" in *Cuerrier*, adding, collegially, "not surprisingly given the trial evidence was adduced some 12 to 13 years ago", and that the *Cuerrier* Court merely "accepted that unprotected intercourse would clearly meet the test of significant risk with respect to the transmission of HIV" (accessed 19 March 2018). Richard Elliott points out that, as a matter of fact, the *Cuerrier* court had much information about infectiousness or risk of transmission before it, much of it provided by the interveners. The Manitoba Court of Appeal's assertion may thus be taken as a metaphorically justified critique of the *Cuerrier* court's illogical approach and outcome.

nevertheless accepted without more that unprotected intercourse with someone with HIV would clearly meet its test of "significant risk".

90. The reason doesn't seem hard to find. It appears to lie in the moral condemnation the *Cuerrier* majority considered should be meted out to the behaviour of the accused[78] – even though what the accused did in engaging in sexual intercourse left his sexual partners physiologically intact and physically entirely unharmed.

91. The effect of the *Cuerrier* expansion was to create a great category of criminal sexual assaults where there had been consent to sex, by one whom the sexual act left entirely physically injury-free, but which consent was retroactively vitiated by a legal conclusion regarding insufficient disclosure. In the old, pre-Code terminology, rape could now occur in Canada, despite consent to sexual intercourse, but simply because there was exposure to "significant risk" of an infection – despite the fact that this resulted in no adverse physical consequences.

92. Roughly put, the result was rape with no real rapist, but instead only a sexual partner who had a medical condition that was neither communicated nor transmitted to the other partner.[79]

93. *Cuerrier* punished those with HIV solely for having HIV and not disclosing it.

94. The severe consequences of this novel doctrine were acted out in *Cuerrier* itself. At the time of trial, neither complainant had tested positive for the virus.[80] They each had consented to sexual intercourse that inflicted no blemish or harm at all on them. Their

[78] The language of moral reproach emerges in *Cuerrier* above n 52 at para 133, where Cory J refers to "this dangerous and deplorable behaviour" of the accused, and at para 141, where Cory J describes the role of the criminal law "both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from irresponsible individuals".

[79] I am indebted to Richard Elliott for adding the observation that not only could you have, in law, a 'rape' by vitiating consent after the fact without there having been any adverse physical consequences of an ostensibly 'significant risk' of infection, but in practice the 'significant risk' test has since been applied in some circumstances where there was effectively zero risk or at most an exceedingly small risk.

[80] *Cuerrier* above n 52 at para 83.

sexual partner was criminally punished not for what he caused them, but solely for what he didn't tell them.

95. Because of this very fact – that the complainants were unharmed – the *Cuerrier* trial judge had entered a directed verdict acquitting the defendant. This meant he walked free. The British Columbia Court of Appeal endorsed this approach. It refused to set aside the acquittals and to fine or imprison the accused man.

96. But the Supreme Court intervened and reversed both lower courts' plain-sense doctrine. The principal problem it created was that, as a matter of practical effect, the interpretation and application of its standard set the threshold of risk-triggering liability far too low.[81]

97. In doing so, *Cuerrier* created a new, monster legal category of "aggravated assault", with no assault, except a notional exposure to an infectious disease, and no aggravation, except judicial enforcement of societal condemnation (or externalised stigma).

98. This criminal category – the most expansive *judicially-created* doctrine targeting HIV on the planet – is a uniquely Canadian monstrosity.

99. But 14 years later, in 2012, the Supreme Court had a chance to fix *Cuerrier*. By now, the landscape of HIV was dramatically changed. Sixteen years before, in 1996, at the 11th International AIDS Conference, which took place in Vancouver, scientists had announced the astonishing power of ARV treatment in repressing viral activity and, hence, in diminishing the risk of transmission.

100. *Cuerrier* was decided two years after these announcements, when their lessons of significant medical advance with the effect of reducing HIV transmission had not yet become manifest. Indeed, in my country, President Mbeki was able even after the Vancouver

[81] I am indebted to Richard Elliott for this point.

announcements to plunge the country, and indeed the world, into a dumb debate about the efficacy and side-effects of ARV treatment.

101. But when *Cuerrier* came round for review in *Mabior* in 2012, those days were long past. I took part in the Canadian debate.[82] And when I visited Canada in October 2011, my Canadian colleagues in the HIV field were preparing for argument in *Mabior* in a hearing that was to take place a few months later. They felt a real sense of optimism. They thought that reason would overtake irrationality in the application of criminal liability to persons with HIV. Their hopes were not realised.

102. The accused in *Mabior*, Mr Clato Lual Mabior,[83] stood trial on ten[84] counts of aggravated sexual assault involving nine different complainants. Over a period of more than two years,[85] he had sexual intercourse with various women. He did not disclose to them that he had HIV. In fact, he was on successfully maintained ARV treatment. During most of the sexual encounters, his viral load was undetectable. In others, though not undetectable, his viral load was low. He passed HIV to not one of the complainants.

103. From a moral point of view, Mr Mabior, like Mr Cuerrier, might have been unappealing. But it is not the courts' task to yield to vindictive moralism or to invent overbroad criminal doctrines to enforce it. That is what appears to have happened in *Cuerrier* and *Mabior*. Two consenting adults engaging in sexual conduct in private are not in the position of a health professional proposing to undertake

---

[82] See Canadian HIV/AIDS Legal Network "Criminalization of HIV transmission: poor public health policy" (2009) 14 *Policy and Law Review* 62, https://www.hivlawandpolicy.org/sites/default/files/Criminalization%20of%20HIV%20transmission%20Poor%20Public%20Health%20Policy-1.pdf (accessed 23 February 2018).

[83] The trial court and the Court of Appeal recorded that all the complainants referred to Mr Mabior as "K-Dog". See *R v Mabior* 2008 MBQB 201 (https://www.canlii.org/en/mb/mbqb/doc/2008/2008mbqb201/2008mbqb201.html, accessed 19 March 2018) (*Mabior* trial court) at para 27, https://www.canlii.org/en/mb/mbca/doc/2010/2010mbca93/2010mbca93.html (accessed 23 February 2018); *Mabior* Court of Appeal above n 69 at para 29.

[84] See the judgment of the trial court, https://www.canlii.org/en/mb/mbqb/doc/2008/2008mbqb201/2008mbqb201.html (accessed 19 March 2018).

[85] 1 January 2004 to 31 March 2006.

an invasive procedure on an uninformed patient. Sexual partners have moral and ethical duties to each other, but the role of the criminal law in enforcing them, when no harm in fact results, should be extremely limited.[86]

104. The trial court convicted Mr Mabior on six counts, and acquitted him on three. The trial judge found that "even with an undetectable viral load, there remains a risk of transmission of HIV with resultant endangerment of life".[87] The trial court concluded that, where the accused was regarded as infectious by the medical evidence, despite using a condom, a significant risk of serious bodily harm existed.[88] The trial court also concluded that using a condom during intercourse, even when viral load is undetectable, is indispensable so as not to place a sexual partner at "significant risk" of serious bodily harm.[89] Therefore, only where the accused's viral loads are undetectable ***and*** a condom is used does the risk of transmission fall below the *Cuerrier* standard of "significant".[90] The trial court sentenced him to 14 years' imprisonment.

105. Mr Mabior appealed against this outcome to the Manitoba Court of Appeal.[91] The appeal court came to a different conclusion. It noted that "At the very least, issues of condom usage and viral load raise difficulties of proof perhaps not contemplated or even known" when the *Cuerrier* test emerged.[92] The application of that test, it found, "must evolve to account appropriately for the development in the science of HIV treatment".[93] Hence, the Manitoba Court of

[86] Compare the rightly cautious approach the Supreme Court of Canada adopted to the enforcement of moralistic attitudes in determining rights infringements in *Canada (Attorney General) v PHS Community Services Society* [2011] 3 SCR 134, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do (accessed 20 March 2018) paras 102-105 and *Carter v Canada (Attorney General)* [2015] 1 SCR 331, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do (accessed 20 March 2018) para 79. I am indebted to Dustin Klaudt for this point.
[87] *Mabior* trial court (McKelvey J) at para 105.
[88] Id at para 116.
[89] Id at para 134.
[90] *Mabior* Court of Appeal above n 69 at paras 15 and 153, summarising the trial court's findings.
[91] *Mabior* Court of Appeal above n 69.
[92] Id at para 151.
[93] Id at para 104.

Appeal introduced a disjunctive, rather than conjunctive, test. It concluded that *either* low viral loads on ARV treatment *or* condom use negated significant risk. The Court held that "when careful and consistent condom use is present" or "effective antiretroviral treatment is undertaken", the risk is reduced to "low" or "very low". The appeal court emphasised that "There is no requirement that there be absolutely no risk of transmission".[94] As a result, the Manitoba appellate judges acquitted Mr Mabior on four counts: he could be convicted on only two counts, where the Court judged he had exposed his sexual partners to significant risk without disclosing his HIV status.

106. The Manitoba acquittals were soundly based in science and reason. They were consonant with elementary principles of empiricism that civilised approaches to the enforcement of criminal penalties in law have aspired to implement for some hundreds of years.[95]

107. But the Supreme Court of Canada disapproved of the Manitoba appeal court's approach. In a unanimous judgment,[96] it concluded that three of the four counts of which Mr Mabior had been acquitted should be reinstated.

108. The Court revisited the *Cuerrier* requirement of "significant risk of serious bodily harm".[97] This, it said, should be read as

---

[94] Id at para 155.

[95] The "realistic possibility" test *Mabior* developed is consistent with Supreme Court of Canada jurisprudence on informed consent to surgical and other medical procedures: see *Hopp v Lepp* [1980] 2 SCR 192, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2553/index.do (accessed 5 March 2018) and *Reible v Hughes* [1980] 2 SCR 880, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2563/index.do (accessed 5 March 2018). But the question is: *Should Canadian criminal law send a medical professional who failed to explain a risk with a realistic possibility of eventuating to a patient, and then performed a procedure in which the risk in fact never eventuated, to jail, merely for the non-harmful omission?*

[96] The *Mabior* Court consisted of McLachlin CJ, LeBel J, Deschamps J, Fish J, Abella J, Rothstein J, Cromwell J, Moldaver J, and Karakatsanis J.

[97] The Court's expressed purpose in doing so was to bring clarity to the uncertainties *Cuerrier* created: see *Mabior* above n 53 at paras 15-9. But as Rawluk above n 51 shows, *Mabior* itself brought little better clarity:

> "*Mabior* and *DC* leave important questions for those living with HIV unanswered. After *Mabior*, it is clear that a person has to disclose his or her HIV positive status before vaginal intercourse unless he or she has a low viral load and a condom is used. However, the Court failed to provide any such guidance with respect to oral or anal sex. The Court also failed to

requiring disclosure of HIV status if there is "a realistic possibility of transmission of HIV".[98] Only if there is no realistic possibility of transmission of HIV, failure to disclose that one has HIV will not constitute fraud vitiating consent to sexual relations.[99] The Court based this on the reasoning that "significant risk" in *Cuerrier* was informed both by the risk of contraction of HIV and the seriousness of the disease if contracted. "These factors", it said, "vary inversely. The more serious the nature of the harm, the lower the probability of transmission need be to amount to a 'significant risk of serious bodily harm'".[100]

109. The Court refused to accept the appeal court's conclusion that use of either condoms, alone, or ARV treatment, alone, precluded any "realistic possibility" of transmission. Consistent with the trial court's conclusion, the Court held that both condom use and ARV treatment had to be present together. It rejected the appeal court's disjunctive test and appeared to reimpose the trial court's conjunctive test.

110. The test the Court laid down was that only the "combined effect of condom use *and* low viral load" "precludes a realistic possibility of transmission of HIV".[101] It was on this basis that it reinstated three of Mr Mabior's convictions.

111. Though the Court did also specifically allow that advances in treatment might lead to an evolutionary advance in the application of this test in future, my Canadian activist friends were rightly appalled. What *Mabior* did was in some ways worse than what *Cuerrier* did. One could excuse *Cuerrier* on the basis of high levels of HIV

> clarify an HIV positive person's disclosure obligations where he or she has a low viral load and a condom is used but breaks during vaginal intercourse. Thus, for many living with HIV, the uncertainty caused by *Cuerrier*'s requirement of 'significant risk of serious bodily harm' continues to persist."

[98] *Mabior* above n 53 at para 91.
[99] Id.
[100] Id at paras 86 and 92.
[101] Id at para 103.

prejudice remnant from the 1980s, and low levels of understanding of the revolution that, by 1998, ARV treatment was already beginning to effect – together with the Court's complete lack of allusion to the low levels of risk of HIV transmission in heterosexual intercourse.

112. But all this was before the *Mabior* Court.[102] The expert for the Crown (the prosecution), Dr Richard Smith, testified that "the risk of HIV transmission per act of unprotected vaginal sex ranges from 0.05 per cent (1 in 2,000) to 0.26 per cent (1 in 384)".[103] The Court noted that a systematic review and meta-analysis of over 40 publications comprising 25 different study populations identified a male-to-female per-act transmission risk in high-income countries of 0.08 per cent – less than one chance in one hundred.[104]

113. It must be remembered that these low levels of risk are measured *without ARV treatment*. On treatment, the risk is even lower.

114. Against this background, the Crown's evidence in *Mabior* was unequivocal. Dr Smith stated that, on ARV treatment, low viral loads (below 1 500) "greatly decrease the chance of heterosexual transmission of HIV", which is decreased even more if it is undetectable.[105] Even when the accused's viral load was detectable, in the initial stages of his ARV treatment, this was consistent with "probably low but possible infectivity".[106]

115. The conclusion that this evidence invited seems to have been obvious: that low or suppressed viral load, even if not undetectable, on its own, was sufficient to negate any realistic possibility of HIV

[102] As pointed out earlier (footnote *** above), the interveners in *Cuerrier* in fact provided that court with ample information about the low risk of infectiousness.
[103] *Mabior* Court of Appeal above n 69 at para 75. A public health nurse testified that the Manitoba Health post-exposure protocol reflects "an average percentage of risk per act that ranged from 0.1 per cent (1 in 1,000) for receptive penile-vaginal intercourse to 0.05 per cent (1 in 2,000) for insertive penile-vaginal intercourse".
[104] Id at para 77.
[105] Id at para 106.
[106] Id at para 114.

transmission.[107] The Court in *Mabior* seemed to be moving, paragraph by paragraph, to this obvious conclusion;[108] yet somehow seems to lose its way on the path to fairness and reason and to stray instead into stigmatising legal error.[109]

116. The Supreme Court of Canada does so because it seems to have discounted the evidence before it in two ways.

117. First, it appears to have taken the *Cuerrier* test of "significant risk", read it to mean "realistic possibility" – but then, like the trial court, imposed a requirement that there actually be no risk at all. How else did the Court manage get from Dr Smith's "*low but possible*" to "*realistically possible*"? The problem with *Mabior* is that the Court contradicts itself in disclaiming overly broad, unjust criminalization in Canada – but then applies its "realistic possibility" standard so stringently that it ends up doing exactly what it professes to abjure.[110]

118. Second, the Supreme Court of Canada appears to have taken no heed at all of the life-saving effects of ARV treatment. I instance them myself, this afternoon, standing here. Last November, it was fully 20 years since I started taking ARVs. I stand here today because they work. Not only am I fully healthy, but I am able to live a full and vigorous life of sustained work stress because anti-retroviral medications work.

119. While HIV is still a potentially fatal infection – and, because of internalised stigma, still too often is – the condition is, in medical terms, fully manageable. HIV infection is no longer a physiological catastrophe. It is a well-manageable, and well-managed, chronic

---

[107] By the time *Mabior* was argued in the Supreme Court, Myron Cohen and others had published findings that appeared to establish that, with ARV treatment, risk of transmitting HIV was negligible: "Prevention of HIV-1 Infection with Early Antiretroviral Therapy" (2011) *New England Journal of Medicine* 365 at 493-505, which the interveners, the Canadian HIV/AIDS Legal Network and others, expressly cited.
[108] *Mabior* above n 53 at paras 81-92.
[109] Id paras 93-103.
[110] I am indebted to Richard Elliott for this observation.

condition, that impairs very few life appurtenances and ensures a lifespan virtually equal in comparable circumstances to someone without HIV.

120. This remarkable medical advance means that as far back as *Cuerrier*, in 1998, the "serious bodily harm" criterion should have been adjusted. The criterion should have been subject to a measure of medically sound and scientifically secure discounting because ARV treatment dramatically reduces the bodily harm that HIV inflicts. So much the more so in *Mabior*, by when the near-miraculous effects of ARV treatment were incontestably established.

121. Instead, the *Mabior* Court noted only that, although HIV can be controlled by medication, HIV "remains an incurable chronic infection that, if untreated, can result in death".[111]

122. The weasel words here are "*if untreated*". In high-income countries with universal health coverage, like Canada, HIV is rarely "untreated". The possibility that a sexual partner who contracts HIV in the circumstances at issue in *Cuerrier* and *Mabior* would not be treated with ARVs is negligible.[112]

123. This fact should, surely, have had *some* effect on the practical outcome of the Court's "realistic possibility" test. Although the Supreme Court of Canada motions toward the possibility of "future advances in treatment",[113] its gesture is ineffectual, for it ignored the plain advances that were already before it.

124. Before the hearing, prominent and distinguished Canadian HIV experts had published an analysis and summary in the *Canadian Medical Association Journal* (CMAJ), urging the Court "to embrace

---

[111] Id at para 92.

[112] The government of Canada estimated that as of 1 December 2016, 76% of Canadians diagnosed with HIV are on ARV treatment: see Government of Canada "Summary: Measuring Canada's Progress on the 90-90-90 HIV Targets", https://www.canada.ca/en/public-health/services/publications/diseases-conditions/summary-measuring-canada-progress-90-90-90-hiv-targets.html (accessed 28 February 2018).

[113] *Mabior* above n 53 at paras 92, 95, and 104.

the scientific evidence, recognize the ability of HAART [highly active antiretroviral therapy] to virtually eliminate the transmission of HIV, and do away with criminal prosecutions for HIV nondisclosure".[114] This plea by learned Canadian experts, published in the CMAJ, to accept the practical consequences of medical advances, was before the Supreme Court, but was ignored.

125. More disquiet about *Mabior* emerges from the fact that the coalition of AIDS organisations that acted as intervenors expressly urged the Supreme Court of Canada to clarify the state of mind required of people with HIV for HIV non-disclosure to be criminally penalised. The Court ignored their request. It chose not even to address the issue.[115]

126. Although the Supreme Court of Canada acknowledged in general terms that criminal law almost always requires a culpable state of mind, it failed to acknowledge an aspect of criminal consciousness that is crucial in relation to HIV. People with HIV on ARVs probably would not have the requisite "guilty mind" when having sex without disclosure of their HIV status. This is because, from at latest 2008, a well-informed person living with HIV would have had sound reason to believe that ARV treatment was sufficient to prevent transmission. By August 2011, this view would be based on incontrovertible evidence.

127. Why did the *Mabior* Court ignore all this? The question is particularly acute since at or about the same time as *Mabior* the Supreme Court of Canada delivered a trilogy of powerfully progressive decisions. These ended criminal law restrictions on safe

[114] All this is set out incontrovertibly in a lucid article that appeared in the *Canadian Medical Association Journal* in advance of the *Mabior* hearing: see Milloy, Kerr, and Montaner "Ending Canada's HIV Trials" (2012) 184 *Canadian Medical Association Journal* 264.

[115] See Canadian HIV/AIDS Legal Network "HIV non-disclosure and the criminal law: An analysis of two recent decisions of the Supreme Court of Canada", http://www.aidslaw.ca/site/wp-content/uploads/2013/04/SCC_DecisionAnalysis-ENG.pdf (accessed 5 March 2018).

injection sites for drug users,[116] struck down criminal restrictions on commercial sex work,[117] as well as criminal restrictions on physician-assisted death.[118]

128. Some blame may lie at the lawyerly effect of precedent and doctrine.[119] *Cuerrier* and *Mabior* seem to be instances of legal reasoning that gets caught up in a commitment to its own seemingly inevitable logic but ends up in absurdity and gross injustice.[120] But why in *Mabior* – and not in the other important cases decided at about the same time?

129. But there is a further disquieting inference. The inference is that stigmatised conceptions of HIV played a motive part in the Supreme Court's decision. The first clue to this inference emerges early in the judgment, when the Court links Mr Mabior's HIV status to other societally discredited attributes – exhibiting stigma based on Goffman's "blemishes of individual character". The judgment notes that Mr Mabior's "house was a party place. People came in and out, including a variety of young women. Alcohol and drugs were freely dispensed. From time to time, Mr Mabior had sex with women who came to his house, including the nine complainants in this case."[121]

130. This inference that stigmatised conceptions of HIV moved the Supreme Court is reinforced later, when the Court reveals its

[116] *Canada (Attorney General) v PHS Community Services Society* [2011] 3 SCR 134, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do (accessed 20 March 2018).
[117] *Canada (Attorney General) v Bedford* [2013] 3 SCR 1101, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/13389/index.do (accessed 20 March 2018).
[118] *Carter v Canada (Attorney General)* [2015] 1 SCR 331, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do (accessed 20 March 2018).
[119] I am indebted to Dustin Klaudt for pointing out the significance of the three Supreme Court decisions roughly contemporaneous with *Mabior*, and for noting that *Mabior* was decided before the Court reconsidered precedent in *Bedford*, supra, paras 38f.
[120] Professor Matthew Weait suggests perceptively that the impact of a strong or more coercive tradition of public health (as also in the Nordic and Scandinavian countries) and a (rightly) robust feminist narrative may both have been influential in the stringent and uncompromising approach to disclosure and risk-taking in Canada (private communication dated 27 February 2018).
[121] *Mabior* above n 53 at para 5.

determination not to "condone", through a too-lax criminal standard, what it calls "irresponsible, reprehensible conduct".[122]

131. Let me be plain about what I am saying. I am saying that the Canadian Supreme Court in *Mabior* failed to rectify the erroneous criterion of criminal punishment *Cuerrier* created, and wrongly ignored scientific evidence and plain fact in evolving and applying the "realistic possibility" standard: and that it did so because of stigmatised conceptions about HIV.

132. The Justices of the Supreme Court of Canada apparently considered that what the accused did, merely in not disclosing his HIV to his sexual partners, was too horrible not to punish severely.

133. It is worth revisiting Goffman's portrait of the stigmatised person as one "who is disqualified from full social acceptance", one who is reduced in our minds "from a whole and usual person to a tainted, discounted one", in response to whom society constructs "a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity he represents".[123]

134. Yet there are increasing signs that a possibly warmer spring may be emerging over the frozen wastelands of Canada's HIV criminal punishment. Some trial and appellate judges, sensitized to the sustained criticisms of over-criminalization, have found a more flexible, less sweeping interpretation of *Mabior* and its "realistic possibility" test so as to permit acquittal on viral load alone, even without condom use. And some prosecutorial services have eventually been persuaded to stop insisting on the conjunctive requirement of both condoms plus low or undetectable viral load.

135. In May 2014, 72 Canadian doctors signed a consensus statement criticising the overly broad use of criminal law against

[122] Id at para 87.
[123] See Goffman above n 4.

persons living with HIV. They bluntly pronounce the empirical truth, which is "Scientific and medical evidence clearly indicate that HIV is difficult to transmit during sex".[124] "A poor appreciation of the science related to HIV", they said, "contributes to an overly broad use of the criminal law against individuals living with HIV in cases of HIV nondisclosure". These 72 Canadian physicians could have been directing their comments reproachfully at the *Mabior* Court.

136. And recent developments appear to limit the baneful practical impact of *Mabior* and to exploit the narrow interstices for beneficent interpretation it left.

137. Ontario's Crown Attorneys (prosecutors) have been instructed no longer to proceed with criminal prosecutions for HIV non-disclosure in cases where a person has maintained a suppressed viral load for six months. The Province's top justice and health officials have urged a return to reason, saying national government should take "immediate action".[125] British Columbia has taken similar steps.[126]

138. Ontario was responding to a federal government report,[127] which included the Canada's Public Health Agency's scientific analysis on the low sexual transmission risk of HIV. These scientific conclusions reflect the growing body of evidence that shows that there is no realistic possibility of transmission of HIV if a person

---

[124] See Loutfy et al "Canadian consensus statement on HIV and its transmission in the context of criminal law" (2014) 25 *Canadian Journal of Infectious Diseases and Medical Microbiology* 135-40, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4173974/ (accessed 27 February 2018).

[125] Ontario's attorney general, Mr Yasir Naqvi, and its then-health minister, Eric Hoskins (who resigned while this lecture was in preparation), in December 2017 urged Canadian Justice Minister Jody Wilson-Raybould to align the Criminal Code with current evidence, saying in a joint statement that:

> "The scientific conclusions reflect the growing body of evidence that shows that there is no realistic possibility of transmission of HIV if a person is on antiretroviral therapy and has maintained a suppressed viral load for six months."

The statement is available at http://clhe.ca/wp-content/uploads/Ontario-AG-and-MOHLTC-WorldAIDSDay2017statement.pdf (accessed 3 March 2018).

[126] Pawson "B.C. attorney general to rethink charging people who don't disclose HIV status prior to sex" *CBC* (1 December 2017), http://www.cbc.ca/news/canada/british-columbia/british-columbia-reaction-world-aids-day-hiv-nondisclosure-1.4429142.

[127] Department of Justice of Canada "The Criminal Justice System's Response to Non-Disclosure of HIV" (released 1 December 2017), http://www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/hivnd-vihnd.pdf (accessed 3 March 2018).

receives ARV treatment and has maintained a suppressed viral load for six months.[128]

139. These are promising developments. But this encouraging development does not go far enough: case analyses show that often those who are most vulnerable to prosecution (and who will remain so) are those not receiving ARV treatment, and who are afraid to, or unable to disclose their HIV status, or use (or ask to use) condoms.[129]

140. In *R v Thompson*, the Nova Scotia Court of Appeal on 15 February 2018 accepted evidence that "HIV is no longer a lethal infection".[130] For sound reason, it rejected the notion that merely not knowing of a sexual partner's HIV, where no transmission occurs, is bodily harm.[131] In the trial court in *Thompson*, the experts for the Crown and the accused were unanimous that there was a "negligible risk of transmission where either the viral load is low or a condom is properly used".[132] This Nova Scotia decision accords with sensible developments elsewhere in the world.[133]

---

[128] In response to the report, the Justice Minister undertook "to examine the criminal justice system's response to non-disclosure of HIV status", possibly reviewing existing charging and prosecution practices, as well as the possible development of prosecutorial guidelines. Id. She envisaged working with Randy Boissonnault, MP, Special Advisor to the Prime Minister on LGBTQ2 issues. See Department of Justice of Canada "Minister Wilson-Raybould Issues Statement on World AIDS Day" *MarketWired* (1 December 2016), http://www.marketwired.com/press-release/minister-wilson-raybould-issues-statement-on-world-aids-day-2180250.htm (accessed 3 March 2018).

[129] These very persons with HIV are experiencing internalised stigma, most often as denial, but sometimes through fear of anticipated stigma, including violence and/or loss of home/income. See NAM "Challenges associated with disclosing one's HIV-positive status", http://www.aidsmap.com/Challenges-associated-with-disclosing-ones-HIV-positive-status/page/1442642/ (accessed 6 March 2018) and NAM "Factors affecting HIV-related sexual risk-taking in people living with HIV", http://www.aidsmap.com/Factors-affecting-HIV-related-sexual-risk-taking-in-people-living-with-HIV/page/1442638/ (accessed 6 March 2018).

[130] *R v Thompson* 2018 NSCA 13 (CanLII) at para 44, http://canlii.ca/t/hqf6n (accessed 23 February 2018).

[131] Id at para 48: "Worry, stress, anger are natural emotions on learning of unwittingly being exposed to HIV. But absent a significant risk of serious bodily harm, satisfied by actual transmission or a realistic possibility of transmission, consent is not vitiated".

[132] Id at para 24.

[133] A unanimous decision of the 2nd Joint Court of Athens recently held that an undetectable viral load renders HIV transmission unlikely. It has been hard to find details of the decision. On 10 November 2017, the Court was said to have "acquitted" the person with HIV, though it is not clear from the media statement dated 15 February 2018 by the Athens Centre for Life for the support of people with HIV whether it was a civil or criminal proceeding.

141. But serious damage has been done. Many Canadians consider – intuitively, rightly, and quite rationally – that criminal prosecutions reduce willingness to access HIV testing.[134]

142. This assumption arises from the outcome in *Cuerrier* and *Mabior* – this is that people with HIV who do not transmit it to their sexual partners are convicted of serious crimes and sentenced to long jail terms, simply for not disclosing their HIV – is an affront to reason, justice, fairness, and good sense.

143. The affront springs from the HIV-stigma I have sought to describe in this lecture; and, in its turn, it acutely reinforces that stigma. As a matter of justice and plain sense, it should be remedied.[135]

144. *Cuerrier* and *Mabior* were distinctively different from the frenetic spurt of vindictive criminal legislation targeting HIV that characterised the states of the United States in the 1980s, and the states of Africa after the N'Djamena model law on HIV[136] was propounded in 2004. *Cuerrier* and *Mabior* were worse. They were not the product of irrational populist fear and anger. They were carefully deliberated decisions by Canada's top court.

---

[134] See Patterson et al above n 46. The authors report that, in two cross-sectional surveys in Canada in 2012, 31% of Canadians and 48% of gay, bisexual and other men who have sex with men considered that criminal prosecutions reduced willingness to access HIV testing. Further recent evidence has emerged that fear of prosecution for non-disclosure reduces willingness to undergo HIV testing. Though this was reported by a minority of HIV-negative MSM in Toronto, the reported reduction has the potential to significantly increase HIV transmission, with important public health implications. See Kesler and others, "Prosecution of non-disclosure of HIV status: Potential impact on HIV testing and transmission among HIV-negative men who have sex with men", PLOS-One, http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0193269 (accessed 19 March 2018).

[135] Only three of the judges who sat in the *Mabior* Court are still members of the Supreme Court: Karakatsanis J, Moldaver J, and Abella J.

[136] See NAM "The 'legislation contagion' of the N'Djamena model law", http://www.aidsmap.com/The-legislation-contagion-of-the-NDjamena-model-law/page/1442068/ (accessed 5 March 2018) and Global Commission on HIV and the Law "Fact Sheet: HIV and Criminal Law" Regional Dialogue: Africa (3-4 August 2011), https://hivlawcommission.org/wp-content/uploads/2017/06/Criminalisation-Factsheet-EN.pdf (accessed 5 March 2018).

145. It is not enough that Canada's democratic organs are ameliorating the effects of *Cuerrier* and *Mabior*. The decisions themselves are an affront to reason and justice, and a deep spur to destructive stigma of people with HIV. They should be reversed. Only then will reason and good sense begin to reassert itself in Canada's grappling with HIV.