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INJUSTICE AMPLIFIED BY HIV NON-DISCLOSURE RULING

This article notes that the Supreme Court's punitive approach in Mabior *and* DC *is out of step with recent scientific and medical advancements with respect to HIV transmission and treatment. It argues that while the Court set out a risk-based test to determine when HIV disclosure is legally required, it did not appropriately weigh the evidence regarding the risk of HIV transmission. It predicts that the judgment will have an unfair and disproportionate impact on already marginalized people, including newcomers, those in violent relationships, and those without access to treatment. Finally, it questions whether the new legal test for HIV non-disclosure cases reflects* Charter *values.*

Keywords: HIV, non-disclosure, consent, aggravated sexual assault, fraud, injustice

1 *Introduction*

In the fifteen years since the Supreme Court issued its decision in *Cuerrier*,[1] the many injustices emanating from the scope of the HIV disclosure obligation have become increasingly evident. In addition to the shocking situation of DC,[2] we have seen persons living with HIV (PHAs) sentenced harshly for non-disclosure in circumstances where there was clearly no intention to harm or exploit and where transmission risks were minimal. Individuals have also pleaded guilty where it is not certain that disclosure would have legally been required.[3]

Beyond the impact of prosecutions on individuals, an overly broad criminalization of HIV non-disclosure has had sweeping impacts on the HIV community and responses to the epidemic. Criminalization causes anxiety, confusion, and fear for PHAs.[4] For example, there have been false threats against PHAs who did disclose and also a great deal of

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1 *R v Cuerrier*, [1998] 2 SCR 371 [*Cuerrier*].

2 See Martha Shaffer, Isabel Grant, & Alison Symington, '*R v Mabior* and *R v DC*: Introduction' (2013) 63 UTLJ 462 [present issue] [Shaffer, Grant, & Symington], for a description of the facts and ruling in *R v DC*.

3 For summaries of many HIV non-disclosure cases, see HIV/AIDS Policy and Law Review, online: Canadian HIV/AIDS Legal Network <www.aidslaw.ca/review>.

4 See e.g. Barry D Adam, *How Criminalization Is Affecting People Living with HIV in Ontario* (2012) online: Ontario HIV Treatment Network < http://www.ohtn.on.ca>.

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uncertainty regarding when disclosure is legally required and how to prove that disclosure took place. Some women living with HIV who have been sexually assaulted (or have faced an attempted assault) have been 'reminded' by police of their obligation to disclose. Despite the fact that the disclosure obligation in Canada is already broader than that recommended by international agencies such as the UNAIDS,[5] some prosecutors have been pushing to expand the scope of the obligation and the severity of charges PHAs may face. The negative public health implications of overly broad criminalization have been discussed extensively and the chilling effect on communication with healthcare and other service providers has also been demonstrated.[6]

This unjust law is increasingly out of synch with the 'good news' stories of the HIV epidemic. In 1996, the benefits of 'highly active antiretroviral therapy' (HAART) were announced to great excitement at the 11th International AIDS Conference, held in Vancouver. Researchers had discovered that combining different ARVs (antiretroviral medications), thereby disrupting HIV's viral cycle at different points simultaneously, practically stops HIV from replicating.[7]

HIV infection remains a serious illness, but with access to quality healthcare, including ARVs, the lifespan of those newly diagnosed now approximates that of people who are HIV-negative.[8] Researchers have also confirmed that successful treatment with ARVs prevents onward

5 See e.g. UNAIDS, *Criminalization of HIV Transmission Policy Brief* (August 2008) online: UNAIDS <http://aidslex.org/site_documents/CR-0017E.pdf>; Global Commission on HIV and the Law, *Risks, Rights and Health* (July 2012), online: Global Commission on HIV and the Law <http://www.hivlawcommission.org/index.php/report>.

6 See e.g. Carol L Galletly & Steven D Pinkerton, 'Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV' (2006) 10 AIDS and Behaviour 451; Patrick O'Byrne, 'Criminal Law and Public Health Practice: Are the Canadian HIV Disclosure Laws an Effective HIV Prevention Strategy?' (2011) 9 Sexuality Research and Social Policy 70, online: <http://dx.doi.org/10.1007/s13178-011-0053-2>; Hon Justice Edwin Cameron, 'Criminalization of HIV Transmission: Poor Public Health Policy' (2009) 14:2 HIV/AIDS Policy and Law Review 1; and Eric Mykhalovskiy, 'The Problem of "Significant Risk": Exploring the Public Health Impact of Criminalizing HIV Non-disclosure' (2011) 73 Social Science and Medicine 668.

7 AVERT, *History of HIV & AIDS*, online: AVERT <http://www.avert.org/hiv-aids-history.htm>.

8 See David McLay, 'Scientific research on the risk of sexual transmission of HIV infection on HIV and on HIV as a chronic and manageable infection.' Report prepared for the Canadian HIV/AIDS Legal Network (December 2011), online: Canadian HIV/AIDS Legal Network at 15–6 <http://www.aidslaw.ca/EN/lawyers-kit/documents/2a.McLay2010_s.3update-Dec2011.pdf>. Note this report is an update of section 3 of a report funded by the Ontario HIV Treatment Network: Eric Mykhalovskiy, Glenn Betteridge, & David McLay, HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario (August 2010), online: <http://www.catie.ca/pdf/Brochures/HIV-non-disclosure-criminal-law.pdf> [McLay].

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transmission of HIV by dramatically reducing the viral load present in a person's bodily fluids.[9] There is a certain irony that precisely when PHAs can celebrate this remarkable progress and get on with their lives – including safe, fulfilling sexual lives – that the law would become even more punitive toward them.

Given the benefit of years of experience with these laws, new scientific and medical evidence, and an understanding of the realities of living with HIV in our society today, the Supreme Court's revisiting the *Cuerrier* standard in *R v Mabior* and *R v DC* held promise that the injustices of these prosecutions would be addressed and the disclosure obligations in Canadian law would be modernized.[10] Writing for a unanimous court, Chief Justice McLachlin identified two primary problems with the *Cuerrier* test: its uncertainty and its breadth.[11] Once these flaws had been pinpointed, one would expect that the decision would provide at least some substantive redress to the injustices they produce. Unfortunately, the Court did not deliver.

II *Appropriately weighing the science of HIV transmission risk*[12]

In most sexual assault prosecutions, the statistical risk of physical harms resulting from the assault is not part of the equation. But HIV non-disclosure cases are not typical cases. As Martha Shaffer explains, these prosecutions are brought under section 265 (3)(c) of the Criminal Code.[13] The complainant did willingly consent to sex, based on the knowledge he or she had at that time. But he or she is asking the law to vitiate that consent retroactively on the ground of fraud – he or she would not have consented had he or she known the partner's HIV-positive status.

Parliament offered little guidance as to what in practice constitutes fraud vitiating consent and the jurisprudence on this provision is limited. Surely, not every lie or omission transforms a consensual sexual encounter into an assault. As Justice McLachlin (as she then was) noted in her minority judgment in *Cuerrier*, '[d]eceptions, small and sometimes large,

9 Ibid at 10–12.

10 See Shaffer, Grant, & Symington, supra note 2 for a description of *Mabior* and *DC*.

11 *R v Mabior*, 2012 SCC 47 at para 13 [*Mabior*].

12 Note that this discussion is limited to *Mabior* because the Court did not provide any analysis of the science in the other case at issue in this focus discussion, *R v DC*, 2012 SCC 48.

13 Martha Shaffer, 'Sex, Lies, and HIV: *Mabior* and the Concept of Sexual Fraud' (2013) 63 UTLJ 466 at 466 [present issue] [Shaffer], citing *Criminal Code*, RSC 1985, c C-46, s 265.

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have from time immemorial been the by-product of romance and sexual encounters.'[14]

What type of lies and omissions can reverse consent? The possibility of physical harm – specifically a '*significant* risk' of '*serious* bodily harm' – was identified in *Cuerrier* as a factor which makes certain information essential to consent. On their face, the terms suggest that the standard should be high – an important, substantial, notable risk and a dangerous, severe bodily harm.[15] In this way, the *Cuerrier* test made scientific and medical evidence pivotal to subsequent prosecutions.

In *Mabior*, the Court evaluated the scientific evidence to determine whether Mabior's non-disclosure vitiated the complainants' consent to have sex with him. The Court's lack of detailed analysis makes it unclear whether it did not give sufficient weight to the science or whether it understood a 'realistic possibility' as an *extremely small* possibility. On the one hand, it stated that '"significant risk of serious bodily harm" cannot mean any risk, however small.'[16] On the other hand, it suggested that anything 'non-negligible' is realistic.[17] It is difficult to understand the Court's reasoning, given such vague and almost contradictory statements. The *Mabior* test ultimately over-criminalized non-disclosure, even while the Court itself cautioned against this:

> The danger of an overbroad interpretation is the criminalization of conduct that does not present the level of moral culpability and potential harm to others appropriate to the ultimate sanction of the law. A criminal conviction and imprisonment, with the attendant stigma that attaches, is the most serious sanction the law can impose on a person, and is generally reserved for conduct that is highly culpable – conduct that is viewed as harmful to society, reprehensible and unacceptable. It requires both a culpable act – *actus reus* – and a guilty mind – *mens rea* – the parameters of which should be clearly delineated by the law.[18]

Condoms are a key safer sex measure recommended the world over because they are highly effective. The Court nonetheless ruled that there is a 'realistic possibility' of transmitting HIV when condoms are used for vaginal intercourse,[19] despite recognizing that '[i]t is undisputed that HIV does not pass through good quality male or female latex

14 *Cuerrier*, supra note 1 at para 47.

15 For example, Steel JA for the Manitoba Court of Appeal stated that '"[s]ignificant" means something other than an ordinary risk. It means an important, serious, substantial risk'; *R v Mabior*, 2010 MBCA 93 at para 127 [*Mabior* CA].

16 *Mabior*, supra note 11 at para 85.

17 Ibid at para 99.

18 Ibid at para 19.

19 Ibid at para 99.

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condoms'[20] and that condom use reduces the probably of HIV transmission by at least 80 per cent.[21]

What does an 80 per cent reduction mean? A 2009 analysis of existing studies found a transmission risk of 0.08 per cent per act for unprotected vaginal sex.[22] An 80 per cent reduction in risk puts the chance of HIV transmission at 0.016 per cent; that is, one transmission if 6 250 couples have unprotected intercourse. If the woman is the HIV-positive partner, the rate falls to 1 in 12 500 encounters. If condoms are used consistently, carefully, and correctly, even fewer transmissions are expected because incorrect condom use is accounted for in the 80 per cent figure.[23]

The Court devotes a mere two paragraphs to the complex issues of viral load and treatment. It is now widely accepted that a lower viral load reduces infectivity. The risk of sexual transmission from a person on effective treatment has been described by experts as 'approaching zero.'[24]

Viral load varies naturally over the course of disease progression in an untreated PHA and it is dramatically reduced, often to the point of undetectability, through successful ARV treatment. In *Mabior*, the Court noted that the most recent wide-scale study concluded that the risk of HIV transmission is reduced by 89 to 96 per cent when the partner is treated with ARVs.[25] In practice, this means that, with treatment, if

20 Ibid at para 98.

21 Ibid.

22 Marie-Claude Boily et al, 'Heterosexual Risk of HIV-1 Infection Perper Sexual Act: Systematic Review and Meta-analysis of Observational Studies' (2009) 9 Lancet Infectious Diseases 118.

23 Canadian HIV/AIDS Legal Network, *HIV Non-disclosure and Canadian Criminal Law: Condom Use* (November 2011) online: Canadian HIV/AIDS Legal Network <www.aidslaw.ca>; McLay, supra note 8 at 10.

24 Notably, the strongest evidence on this issue was published after Mabior's trial and therefore the evidence presented by the medical expert at trial did not fully reflect the 'treatment as prevention' phenomenon.

25 *Mabior*, supra note 11 at para 101, referring to Myron S Cohen et al, 'Prevention of HIV-1 Infection with Early Antiretroviral Therapy' (2001) 365 New Eng J Med 493. It should be noted that the results of this study are more commonly cited as a 96 per cent reduction as opposed to the range noted by the Court. Furthermore, it should be noted that this study reported data on HIV transmission rates and ARV treatment but did not report on the viral load of the HIV-positive partner. A study presented at the Third International Workshop on Women and HIV, January 2013, looking at HIV transmission rates, ARV treatment *and* viral load concluded that the transmission rate is essentially zero if the HIV-positive heterosexual partner has an undetectable viral load as a result of treatment; see Mark Mascolini, 'HIV Transmission Risk Essentially 0 if Heterosexual Partner Has Undetectable Viral Load' (Conference report of paper delivered at the Third International Workshop on Women and HIV, January 2013) online: National AIDS Treatment Advocacy Project <http://natap.org/2013/HIV-women/HIVwomen_01.htm>. The transmissions that took place in prior studies,

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10,000 couples had unprotected vaginal intercourse, we would expect no HIV transmissions.[26] These significant findings would seem to suggest that the Court created unnecessary evidence requirements and uncertainty by requiring evidence that the person's viral load was low or undetectable *at the time of the sexual encounter,* as suggested by Martha Shaffer.[27] Minor fluctuations in viral load (sometimes referred to as 'blips' or 'spikes') would presumably have been occurring in the study populations. For PHAs on stable ARV treatment, a rebuttable presumption of a lowered viral load, reducing infectiousness, could have sufficed.

Beyond the onerous evidentiary burden on a defendant – to prove that condoms were used and that viral load was low at a particular point in time – does the Court really feel that protected sex or sex with a partner on ARVs truly poses a 'realistic possibility' of transmission, considering the above mentioned probabilities? In this case, the Court ruled that it is 'realistic' enough to justify an aggravated sexual assault conviction, with the serious penal consequences that follow. But this area of science is developing rapidly, with successive studies reporting ever more impressive results. The Court's failure to provide a detailed and nuanced analysis of the scientific evidence presented by the parties and the interveners makes it difficult to understand how this information informed the Justices' decision regarding where to draw the line for legal liability. Unfortunately, the line they did draw is, in my view, out of step with the science and the approaches to HIV prevention, care, treatment, and support that are critical to controlling this epidemic.

III *Disproportionate impact*

Some believe the obligation to disclose is fair and appropriate, requiring only that PHAs provide sufficient information for their partners to make a so-called 'informed choice.' They may say it is just and fair because the obligation applies equally to all PHAs, is reasonable, and there is a defence available if the transmission risk is negligible. To my mind, however, people make choices about the risks they run in having sex, particularly unprotected sex, all the time. While a person might like to know whether his or her partner has an STI (sexually transmitted infection), that does not necessarily mean it should be a crime not to disclose nor that it is impossible to take precautions to protect oneself without

including that of Cohen, may have occurred before the HIV-positive partner had achieved an undetectable viral load.

26 McLay, supra note 8 at 11.

27 *Mabior*, supra note 11 at paras 104–5. Shaffer, supra note 13 at 472–473 [present issue].

disclosure. Moreover, to be just, a law cannot have a disproportionate impact on vulnerable or marginalized populations, nor can it require people to do something unreasonable or that may put them at personal risk.

As Isabel Grant points out,[28] PHAs are marginalized within our society, subject to significant stigma and discrimination. To declare that you are a member of this group is understandably difficult. Moreover, once information has been shared with another person, control is lost over how and with whom it is further shared.

Experiences of disclosure are affected by many aspects of social location, such as race and ethnicity, sexual orientation, nationality, age, and gender.[29] Personal experiences also have a significant impact on a person's willingness and ability to disclose. For example, one study found that victims of sexual abuse are six times less likely to disclose.[30] And, of course, the fear of rejection and violence upon disclosure is not unfounded. The deaths of Cicely Bolden, who was allegedly stabbed to death after revealing her HIV status to a man she had sex with, and Stuart Mark, who was bludgeoned to death allegedly after his boyfriend found out he was HIV-positive, are poignant reminders that the risk is real.[31] Disclosure is complicated, and it is seldom completely safe.

While only time will tell how the 'realistic possibility' test will be applied, the history of non-disclosure prosecutions gives reason to believe that certain segments of the population of PHAs will bear a disproportionate and unfair burden of threatened charges, investigations, prosecutions, and convictions, as well as related anxiety and stigma.[32] Consider, for example, newcomers to Canada – in particular, those from racialized communities. Newcomers confront many practical challenges, from finding a home and a school for their children to accessing medical and social services. If they are living with HIV, they also need to

28 Isabel Grant, 'The Over-Criminalization of Persons with HIV' 63 UTLJ 475 at 476 [present issue].

29 Ontario HIV Treatment Network, *Rapid Review no 9: HIV Disclosure* (September 2009), online: Ontario HIV Treatment Network <http://www.ohtn.on.ca/Documents/Knowledge-Exchange/Rapid-Responses/Rapid-Response-09_Disclosure_2009.pdf>.

30 Anita Raj et al, 'Sex Trade, Sexual Risk, and Nondisclosure of HIV Serostatus: Findings from HIV-Infected Persons with a History of Alcohol Problems' (2006) 10 AIDS and Behaviour 149.

31 Teresa Woodard, 'HIV Revelation leads to Dallas woman's murder' WFAA.com (7 September 2012), online: WFAA TV <http://www.wfaa.com>; Mike McIntyre, '7-year sentence for Winnipeg man who killed HIV-positive boyfriend' *Winnipeg Free Press* (5 September 2012), online: Winnipeg Free Press <http://www.winnipegfreepress.com>.

32 Eric Mykhalovskiy & Glenn Betteridge, 'Who? What? When? Where? And With What consequences? An Analysis of Criminal Cases of HIV Non-disclosure in Canada' (2012) 27 CJLS 31.

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determine their legal rights and responsibilities. Add to this, the racial discrimination that persists in our criminal justice system and the high level of stigma related to HIV and sexuality within many racialized communities. For many, openly discussing sex is taboo, let alone disclosing an STI or negotiating condom use. Disclosure is particularly challenging in close-knit communities where disclosure may affect one's family and community, in contrast to disclosure that has only personal ramifications.[33]

Taken together, these factors suggest that we can expect a disproportionate impact on black and newcomer PHAs under the *Mabior* test. Criminal charges will do nothing to address the reasons why disclosure is so difficult or to encourage HIV testing, condom use, or equality in these communities. The sensational media coverage accompanying the charges can only add to HIV-related stigma, misinformation about the law and HIV, and fear of one's status becoming known.

Consider also those who are vulnerable to violence or in coercive relationships. DC is a perfect example. Charges were brought against her by a man who had engaged in a sexual relationship with her – aware of her status for the entire period of their relationship apart from their first sexual encounter – but then used the law as a weapon of further abuse against her when she sought redress for the violence he had perpetrated against her and her son. (He was given a discharge because of the case against her.) How many women will remain in abusive relationships because their partners threaten to go to the police with non-disclosure allegations if they leave, whether the allegations are true or not? How many will face counter-charges for non-disclosure if they report their abusive partners to the police? How many women will be beaten, abandoned, threatened, or degraded for disclosing their status, as is required of them by the law? These situations are all realistic examples of how criminalizing HIV non-disclosure has affected women to date, unjust results which I expect will be multiplied by the stringency of the *Mabior* test.

The condom requirement is particularly problematic when considered from a gendered perspective. While female condoms exist, they are not as common as male condoms and not so discreet that a woman can

33 Erica Lawson et al, *HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People from African and Caribbean Communities in Toronto* (2006), online: The African and Caribbean Council on HIV/AIDS in Ontario and the HIV Social, Behavioural and Epidemiological Studies Unit, University of Toronto <http://www.accho.ca/pdf/hiv_stigma_report.pdf>; Akim Adé Larcher & Alison Symington, *Criminals and Victims? The Impact of the Criminalization of HIV Non-disclosure on African, Caribbean and Black Communities in Ontario* (2010), online: The African and Caribbean Council on HIV/AIDS in Ontario <http://www.accho.ca/pdf/ACCHO_Criminals_and_Victims_Nov2010.pdf>.

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use them without her partner knowing. The male partner in a heterosexual encounter has significant power not only in relation to a key HIV prevention measure but also in relation to a critical component of the defence a PHA has to this serious criminal charge. Faced with possible violence, rejection, and loss of privacy, some women living with HIV may reasonably fear disclosure, but if the men refuse to wear condoms, the women have no options that will not expose them to the possibility of prosecution.

Access to HAART, HIV care, and viral load testing is a challenge for many PHAs. This is an important heath and equality issue. Now it is also a legal issue because not accessing and adhering to treatment may result in legal jeopardy. Little research exists on access barriers in Canada, but some studies suggest that marginalized PHAs face significant challenges accessing health and social services.[34] Many Aboriginal people, newcomers, and those living in remote locations, for example, face particular impediments. For example, a study of PHAs who inject drugs found that marginalization from health care is a barrier to HAART access and adherence. Because women who use drugs are more likely to be street involved and to engage in sex work, they are more likely than male drug users to face barriers in accessing HAART.[35] Another study of women sex workers found that only 15 per cent of those who were diagnosed as HIV-positive had ever initiated HAART; only 9 per cent continued on HAART.[36] Similarly, a recent study shows that women reporting recent trauma had over four times the chances of antiretroviral failure as compared to those who did not report trauma.[37] Furthermore, many PHAs do not undergo viral load and other testing according to medical guidelines. Most of those who have difficulty accessing continuous care belong to marginalized populations.[38]

34 Ontario HIV Treatment Network, *Rapid Review no 62: Demographic Characteristics Associated with Access to HAART, HIV Care and HIV Viral Load Testing* (November 2012), online: Ontario HIV Treatment Network <http://www.ohtn.on.ca/Documents/Knowledge-Exchange/Rapid-Responses/Rapid-Response-62-access-to-HAART.pdf> [*Rapid Review no 62*].

35 Christine Tapp et al, 'Female Gender Predicts Lower Access and Adherence to Antiretroviral Therapy in a Setting of Free Healthcare' (2011) 11 BMC Infectious Diseases 86, cited in ibid.

36 Kate Shannon et al, 'Access and Utilization of HIV Treatment and Services among Women Sex Workers in Vancouver's Downtown Eastside' (2005) 82 Journal of Urban Health 488, cited in *Rapid Review no 62*, supra note 34.

37 Edward L Machtinger, 'Recent Trauma Is Associated with Antiretroviral Failure and HIV Transmission Risk Behaviour among HIV-Positive Women and Female-Identified Transgenders' (2012) 16 AIDS and Behaviour 2160.

38 *Rapid Review no 62*, supra note 34.

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Under the *Mabior* test, those who do not have a low viral load must disclose or risk conviction for aggravated sexual assault. Is this a fair outcome? Whether or not to take potent medication should be a personal health decision, taken in consultation with one's doctor, not one's lawyer. Moreover, if access to treatment or testing is impeded by poverty, mental health or addiction issues, unstable housing, physical or psychological abuse, where one lives, or any number of other factors, individuals are deprived of the evidence to defend themselves in a prosecution.

IV *Consent in a world with STIs*

This brings us back to where this focus section began with Shaffer's question: what is fraud in the context of sexual assault?[39] The Court has suggested that the 'realistic possibility' test is consistent with the broad, purposive definition of consent required by *Charter* principles. It hasn't, however, explained how.

The Court cited some STI cases from the 1880s as evincing 'a generous approach to the issue of consent and when deceit might vitiate it, an approach that respected the right of the woman involved to choose whether to have intercourse or not.'[40] This era is not generally viewed as an exemplary time for women's rights, gender equality, or sexual autonomy. The facts of these cases suggest that factors other than a generous approach to consent may have been at play. The complainants were twelve and thirteen years old. According to the short reported decisions, one complainant was given liquor by her uncle and then slept unaware that he had sex with her. The other resisted the man's sexual advances but did not 'scream or cry.' It would seem that a rape conviction could not be made out in either case under the law of the time and therefore a conviction for transmitting an STI was as close to justice as could be obtained.

Oddly, while the Court relied on these 1880s cases, it did not address recent cases on consent, sexual assault, or equality, nor did it engage with the most recent jurisprudence on HIV non-disclosure. It was silent about how the *Mabior* reasoning is to be reconciled with these other cases. It is not clear to me that vitiating consent to sex because of HIV non-disclosure is consistent with sexual autonomy, dignity, and substantive equality in all cases. People have sex in many different ways, for many different reasons, under many different conditions. The Court has

39 Shaffer, supra note 13 at 467.

40 *Mabior*, supra note 11 at para 32, commenting on *R v Bennet* (1866), 4 F & F 1105, 176 ER 925 and *R v Sinclair* (1867), 13 Cox CC 28.

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provided hollow guidance for the continuing development of sexual assault law in a way that is protective of both equality and sexual rights.

Generally, sexual assault is about power. It is one individual disregarding the desires and choices of another, using or objectifying another person. HIV non-disclosure cases do not all fit within this framework. The Court has devised a test which treats all PHAs in the same manner, irrespective of their circumstances or their reason not to disclose. Mabior's actions cannot be differentiated from DC's on this legal test. Yet there is no logical basis on which to assert that DC was objectifying her partner, using him for her own sexual pleasures without any respect for his choices, or assaulting him.

Disclosure is not necessary for HIV prevention, nor is it always necessary in order to engage in respectful, responsible sex. Disclosure is also not always possible. Treating non-disclosure as aggravated sexual assault does little to empower those who are unable to decide the terms on which they have sex and little to promote greater equality in sexual relationships. Certainly, there are some cases where exposing a partner to HIV may merit criminal sanction, but the 'realistic possibility' test does not provide us with the tools to identify those cases or deal with them appropriately. In my years of working on this issue, I have seen some grave injustices. I expect that, as a result of *Mabior*, I will witness many more.

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