

Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

VOLUME 11, NUMBER 2/3, DECEMBER 2006

Canada's 2003 renewed drug strategy — an evidence-based review

About three-quarters of the resources of Canada's Drug Strategy are directed towards enforcement-related efforts, despite a lack of scientific evidence to support this approach and little, if any, evaluation of the impacts of this investment. In this feature article, Kora DeBeck, Evan Wood, Julio Montaner and Thomas Kerr report on a study that examined expenditures and activities related to the Drug Strategy as renewed in 2003. The article reviews the effectiveness of the Strategy in light of current scientific evidence pertaining to the reduction of drug-related harm. The authors find that although the Drug Strategy promised to remain accountable and regularly report its progress, information pertaining to the evaluation of the Strategy remains limited. Further, Canada's Drug Strategy has not seized the opportunity to promote a national standard of care that reduces the most deadly harms associated with illicit drug use. The authors conclude that from a scientific perspective, Canada's Drug Strategy should make it a priority to ensure that federal funds are directed towards cost-effective, evidence-based prevention, treatment and harm reduction services, and that these services should be available to all Canadians.

Introduction

Illicit drug use is associated with an array of health and social harms. In particular, the risk of transmitting HIV and other blood-borne infections through the sharing of needles remains a prominent area of concern.^{1,2} In Canada, as of 2004, 269 000 people reported using needles

cont'd on page 5



Canadian
HIV/AIDS
Legal
Network

Réseau
juridique
canadien
VIH/sida



Production of the *HIV/AIDS Policy & Law Review* has been made possible, in part, by funding from the Public Health Agency of Canada. We gratefully acknowledge the financial contribution of the Joint United Nations Programme on HIV/AIDS and the American Bar Association (ABA) toward the publication of this issue.

AIDS 2006 Supplement

At the XVI International AIDS Conference, held in August 2006 in Toronto, Canada, there were more presentations on human rights issues than at any previous International AIDS Conference.

This issue of the *HIV/AIDS Policy & Law Review* includes a special section containing the most relevant presentations on legal, ethical, and human rights issues from the conference and its many satellite meetings. See page 61.



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
WFP
UNDP
UNFPA

UNODC
ILO
UNESCO
WHO
WORLD BANK

HIV/AIDS POLICY & LAW REVIEW

Published by the Canadian HIV/AIDS Legal Network
1240 Bay Street, Suite 600
Toronto, Ontario
Canada M5R 2A7
Tel: +1 (416) 595-1666
Fax: +1 (416) 595-0094
info@aidslaw.ca
www.aidslaw.ca

Providing analysis and summaries of current developments in HIV/AIDS-related policy and law, the *HIV/AIDS Policy & Law Review* promotes education and the exchange of information, ideas, and experiences from an international perspective.

The editors welcome the submission of articles, commentaries and news stories.

Managing Editor and Editor, Canadian Developments:
David Garmaise, dgarmaise@rogers.com

Editor, International Developments:
Richard Pearshouse rpearshouse@aidslaw.ca

Editor, HIV/AIDS in the Courts – Canada:
Glenn Betteridge, gbetteridge@aidslaw.ca

Editor, HIV/AIDS in the Courts – International:
Alana Klein, aklein@aidslaw.ca

Coordinator: Vajdon Sohaili
Translators: Roger Caron, Jean Dussault, Josée Dussault,
Johanne Forget
Typesetting: Liane Keightley, Taien Ng

For the list of members of the Editorial Board of the
HIV/AIDS Policy & Law Review, please visit www.aidslaw.ca/review.

© Canadian HIV/AIDS Legal Network, 2006. We encourage the dissemination of the information contained in the Review and will grant permission to reprint material, provided that proper credit is given. The editors kindly request a copy of any publication in which material from the Review is used.

Circulation: 3000
ISSN 1712-624X

Subscriptions

The *HIV/AIDS Policy & Law Review* is published three times per year. To subscribe, write to the address above.

Annual rate:
Within Canada: \$CA 75.00
International: \$US 125.00 (payment in US funds required)

Single or back issues:
Within Canada: \$CA 12.00
International: \$US 12.00 (payment in US funds required)

The Review has been published since 1994. Issues 1(1) to 5(2/3) were published under the title *Canadian HIV/AIDS Policy & Law Newsletter*. Issues 5(4) to 9(2) were published under the title *Canadian HIV/AIDS Policy & Law Review*.

Current and back issues of the Review are available at www.aidslaw.ca/review.

For membership information, write to the address above or visit www.aidslaw.ca/joinus.

Production of the *HIV/AIDS Policy & Law Review* has been made possible, in part, by funding from the Public Health Agency of Canada. We gratefully acknowledge the financial contribution of the Joint United Nations Programme on HIV/AIDS and the American Bar Association (ABA) toward the publication of this issue.

The opinions expressed in this publication are those of the authors/researchers and do not necessarily reflect the official views of the Public Health Agency of Canada, UNAIDS or the Canadian HIV/AIDS Legal Network.

The materials herein or in other publications or statements associated with the Canadian HIV/AIDS Legal Network represent the opinions of the authors, editors and/or the Legal Network, and should not be construed to be those of the American Bar Association (ABA) unless otherwise specified. Nothing contained herein is to be considered as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. This publication and any forms and agreements herein are intended for educational and informational purposes only.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

About the American Bar Association (ABA)

With more than 400 000 members, the American Bar Association (ABA) (www.abanet.org) provides law school accreditation, continuing legal education, information about the law, programs to assist lawyers and judges in their work, and initiatives to improve the legal system for the public. Its mission is to be the national representative of the legal profession, serving the public and the profession by promoting justice, professional excellence and respect for the law.

Comments?

We would like to hear your views and opinions. Letters to the editor, responses to specific articles, and comments on the format of the Review are welcome and encouraged.

CONTENTS

FEATURES

Canada's 2003 renewed drug strategy — an evidence-based review	1
Will they deliver treatment access?: WTO rules and Canada's law on generic medicine exports	13
The CDC's routine HIV testing recommendation: legally, not so routine	17

CANADIAN DEVELOPMENTS

Supervised injection facility granted time-limited extension	21
Federal prison guards call for power to test prisoners for HIV	23
Sex workers: report goes <i>Beyond Decriminalization</i>	24
Medical marijuana: CAS releases report, government cuts research funding	25
In brief	26
BCPWA files complaint against police disclosure of HIV status	
Toronto: Cracking down on crack pipes	
Conditional sentences to be abolished for some drug offences	
Health services, including needle exchange, key issue for Correctional Investigator	
CSC closes safer tattoo pilot sites	
Sex worker group receives human rights award	
Lifetime ban on blood donations from gay men to continue	
Some AIDS 2006 delegates claim refugee status	

INTERNATIONAL DEVELOPMENTS

Cameroon: UN group finds detention of gay men a violation of human rights	30
Russian Federation: NGO law creates difficulties for human rights organizations	32
U.S. Government Accountability Office criticizes PEPFAR	33
India: Pressure increases on government to decriminalize homosexuality	34
Developments in HIV/AIDS legislation	35
In brief	37
U.K.: HIV and human rights audit underway	
U.S.: Evidence of HIV transmission in prisons	
Europe & CEE: Prison needle exchange update	
California: Governor vetoes prison condom bill	
Jamaican activist receives human rights award	
India: Proposal for mandatory testing of marriage couples withdrawn	
France: Restrictions on residence visa for HIV-positive immigrants	

HIV/AIDS IN THE COURTS – CANADA

B.C. court gives go-ahead to non-profit needle exchange and drop-in	40
Another prisoner dies of HIV in a CSC institution — medical parole not considered until too late	41
Federal Court orders re-determination of HIV-positive Zimbabwean's refugee claim	42
HIV-positive gay Mexican's Convention refugee claim denied	44

cont'd

Criminal law and HIV transmission or exposure: 10 new cases	45
In brief	48
Supreme Court affirms that Ontario tribunal has power to consider <i>Human Rights Code</i>	
Police officer loses negligence suit against Correctional Services Canada	

HIV/AIDS IN THE COURTS – INTERNATIONAL

South Africa: Court orders government to provide antiretrovirals to prisoners	50
U.S.: Sexual history must be disclosed in lawsuit for negligent HIV transmission, California Supreme Court rules	52
Switzerland: HIV-positive woman ordered to disclose names of sexual partners	53
U.S.: Courts rule anti-prostitution policy restriction on AIDS funding violates right to free speech	54
U.S.: HIV-positive prospective employee can sue Foreign Service for discrimination	56
U.K. Court rejects prisoner's application for needle exchange	57
In brief	58
India: High Court of Andhra Pradesh upholds the right of HIV-positive person to employment in the police force	
Hong Kong: Appeal Court affirms that law criminalizing buggery infringes rights of gay men	
South Africa: Court overturns misconduct conviction of physician who denounced Minister's inaction on HIV	
South Africa: Herbal medicine proponent ordered to stop defaming treatment activists	

AIDS 2006: LAW, ETHICS AND HUMAN RIGHTS

Advancing rights for women: the role of litigation	62
Law reform and land rights for women in Tanzania	64
"Second on the needle": human rights of women who use drugs	66
Routine HIV testing: three perspectives	68
Opt-out routine testing: the case has not been made	68
HIV testing in the era of increased treatment access: a human rights perspective from Botswana	70
The routine offer of HIV counselling and testing: a human right	71
HIV and the decriminalization of sex work in New Zealand	73
Providing legal aid to members of vulnerable minorities in Ukraine	74
Reflections on 25 years of AIDS	75
Controlling HIV among injecting drug users: the current status of harm reduction	77
Using human rights law to advocate for syringe exchange programs in European prisons	80
Drug addiction treatment in Russia: no substitution therapy	82
Taking the fight to their realm: the role of patent oppositions in the struggle for access to medicines	84
Free trade negotiations can be harmful to your health	86
Vulnerable populations in Nepal face hostile environment	87
The Convention on the Rights of the Child in a world with HIV and AIDS	89
Removing requirement for self-disclosure of HIV status from Canada's Application for a Temporary Resident Visa	90
Community attitudes towards rationing ARVs: a qualitative study of justice and equity	92

Canada's 2003 renewed drug strategy — an evidence-based review

cont'd from page 1

to inject drugs.³ In the first six months of 2005, over 20 percent of all newly recorded HIV infections in Canada were associated with injection drug use; among newly infected women, injection drug use accounted for 38 percent of recorded infections.⁴ The health of people who inject drugs is also threatened by the risk of contracting hepatitis C, developing abscesses, endocarditis and other injection related infections, and overdosing.^{5, 6, 7, 8}

Drug-related harms also present a substantial economic burden for Canadians. In 2004, the medical costs of HIV infection among injection drug users in the city of Vancouver was estimated to be in excess of \$215 million.⁹ Nationally, direct health care costs attributable to illicit drug use were estimated to be over \$1.13 billion for 2002.¹⁰ In that same year, illicit drug use is believed to have contributed to over 215 000 sick days resulting in income loss of over \$21 million.¹¹

In the area of law enforcement, it is noteworthy that 23 percent of all criminal charges processed through Canadian courts in 2002 were attributed to illicit drugs. This was associated with a cost of \$330 million that year. Additionally, for 2002, policing costs and correctional service costs associated with illicit drugs were estimated to be \$1.43 billion and \$573 million respectively.¹² In spite of these efforts, in 2002 the Canadian Addiction Survey found that illicit drug consumption rates were higher than ever previously recorded. In 1994, 28.5 percent of Canadians

reported having consumed illicit drugs in their life; by 2004, that figure had jumped to 45 percent.¹³

In addition, drug law enforcement has contributed to incarceration rates in Canada that exceed those of most Western European Countries.¹⁴ Aboriginal communities have been particularly affected; rates of HIV infection among Aboriginal drug users have been shown to be elevated in comparison to non-Aboriginal persons.¹⁵ Recent studies have demonstrated that incarceration of injection drug users is independently associated with both syringe sharing¹⁶ and acquisition of HIV.¹⁷ In fact, estimates suggest that approximately 20 percent of HIV infections among injection drug users in Vancouver have been acquired in prison.¹⁸

Drug policy in Canada

Through the legal prohibition of psychoactive substances, Canada's Drug Strategy has attempted to address problems related to drug use by reducing the demand for and the supply of illicit drugs. An enforcement-based approach has dominated Canada's drug policies since the passing, in 1908, of the *Opium Act*, which made it illegal to import, manufacture or sell opium. Efforts to control and regulate psychoactive substances have subsequently relied on legislation — specifically, the *Opium and Drug Act*, the *Narcotic Control Act*, the *Food and Drug Act* and, currently, the *Controlled Drugs and Substances Act* — to ban the production, distribution and use of illicit drugs.

Canada's first federal drug strategy, introduced in 1987 under the title "National Drug Strategy," relied heavily on enforcement-based legislation, thus criminalizing people who use drugs and effectively resulting in the criminal justice system assuming a major role in dealing with illicit substance use. Of note, however, is the fact that the National Drug Strategy acknowledged substance use as primarily a health issue.

A substantial proportion of the funds previously directed towards demand reduction were reallocated to supply reduction.

In 1992, the National Drug Strategy became "Canada's Drug Strategy," and its five year budget was increased from \$210 to \$270 million. Of note, a substantial proportion of the funds previously directed towards demand reduction were reallocated to supply reduction efforts.¹⁹ Also, the National Strategy to Reduce Impaired Driving was merged with Canada's Drug Strategy, and a Drug Strategy Secretariat was introduced as a coordinating body.

In 1997, Canada's Drug Strategy was renewed with no increase in funding. In 2001 and 2002, concerns

regarding the direction and effectiveness of Canada's Drug Strategy were repeatedly stated throughout a number of high profile government reports including the 2001 Report of the Auditor General of Canada, the Report of the Senate Special Committee on Illegal Drugs (2002) and the Report of the Special [House of Commons] Committee on Non-Medical Use of Drugs (2002).

In 2001, the Auditor General reported that the federal government had failed to effectively lead and coordinate a national approach to addressing problematic substance use. The Auditor General found that the government lacked basic information pertaining to the progress of its activities, and did not even know what the provinces, territories and municipalities were spending on supply and demand reduction initiatives.²⁰ An analysis of recorded expenditures that were available revealed that 95 percent of federal funds related to illicit drugs were directed towards supply reduction efforts.²¹ The Auditor General also reported being unable to locate information on the extent of Canada's drug abuse problems.

Following the Auditor General's report, the Special Committee on the Non-Medical Use of Drugs echoed the concerns regarding the organization and structure of Canada's Drug Strategy. After an extensive review of Canada's Drug Strategy, the Special Committee recommended that "a renewed Strategy include clear, measurable goals and objectives as well as a process for evaluation and accountability."²²

The Report of the Senate Special Committee on Illegal Drugs, released the same year, presented similar critiques. The Senate Committee stated: "One of the obvious weak-

nesses of the [drug strategy] is its inability — inevitable in the absence of clear indicators — to provide a comprehensive evaluation of its success in meeting its objectives."²³ After considering many of the harmful effects of enforcement-based policies, the Senate Committee advised the Canadian government to move towards a regulatory approach for controlling cannabis. The report concluded that enforcing cannabis prohibition had been unsuccessful at reducing cannabis consumption or problematic use and that "the continued prohibition of cannabis jeopardizes the health and well-being of Canadians."²⁴

As a result, when Canada's Drug Strategy was renewed in 2003, special attention was given to developing leadership capacities; increasing research, monitoring and reporting capabilities; and supporting the modernization of drug legislation and policy.

The purpose of our analysis is to objectively review Canada's Drug Strategy as renewed in 2003. Specifically, we report on expenditures and activities related to the renewed Drug Strategy. Further, we evaluate these activities and expenditures in light of current scientific evidence pertaining to the reduction of drug-related harm.

Methodology

Information concerning the frameworks, activities, and expenditures associated with Canada's Drug Strategy were first obtained through a comprehensive review of the Government of Canada's website. Relevant search terms used included "drug strategy," "illicit drugs" and "drug policy." This was followed by a review of Health Canada's Drug

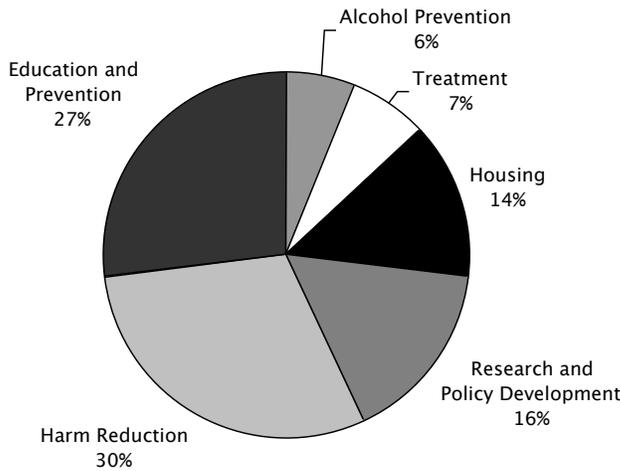
Strategy website (www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html) and relevant financial reports from the Treasury Board of Canada (www.tbs-sct.gc.ca/common/us-nous_e.asp). Then, individuals responsible for evaluating the performance of Canada Drug Strategy were contacted in writing and asked to provide relevant evaluation reports and information related to projected expenditures.

Additional information pertaining to actual Drug Strategy expenditures related to the Community Initiatives Fund was obtained through an Access to Information Request. A thorough review of all projects funded through Community Initiatives was then undertaken, and allocated project funds were categorized according to whether the project's main target was related to the prevention of alcohol-related harm, addiction treatment, education and prevention, housing, research and development, or harm reduction. Finally, expenditures pertaining to illicit drug treatment programs were calculated using the formula employed previously by the federal Auditor General. Specifically, the illicit drug portion of treatment and rehabilitation funding was estimated to be 45 percent of total treatment expenditures.²⁵

Canada's Drug Strategy (2003)

The stated central aim of Canada's Drug Strategy (2003) is to "ensure that Canadians can live in a society increasingly free of the harms associated with problematic substance use."²⁶ The Drug Strategy further states that with a balanced approach to reduce both the demand for and the supply of drugs through prevention, treatment, enforcement and harm reduction initiatives,

Figure 1 – Breakdown of Community Initiatives Fund for 2004-2005 by Category



Source: Records released under the Access to Information Act (Request #A-2006-00249/ma).

the Strategy will contribute to a “healthier, safer Canada.”²⁷ The Drug Strategy, as stated in its evaluation framework, aims to address past criticisms relating to: deficient federal leadership and coordination, lack of harmonization across and within levels of government around research, knowledge and evaluation frameworks, under-investment in demand reduction initiatives, and outdated legal and policy approaches.²⁸

Thus, Drug Strategy investments were concentrated in four specific areas. The first area pertained to initiatives to enhance the federal government’s leadership and coordination capabilities. A total of \$2.7 million was allocated to Health Canada for 2003-2004 to develop a Drug Strategy Secretariat, and \$1.3 million was delegated for a biennial conference intended to increase coordination and clarify national agendas, priorities and goals.²⁹

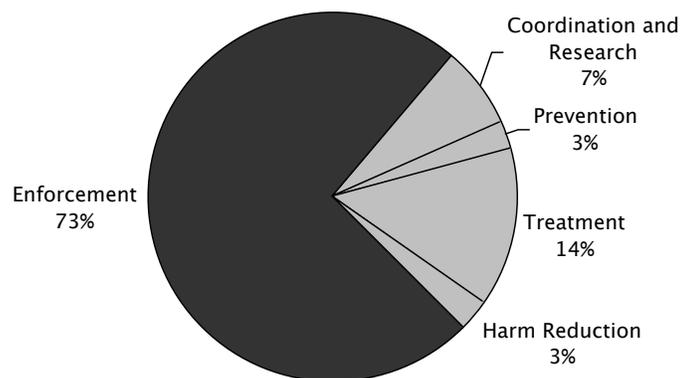
New monies were also directed towards research and monitoring substance abuse problems in Canada, specifically through the Canadian Centre on Substance Abuse. To sup-

port demand reduction initiatives, the renewed Strategy placed emphasis on developing partnerships and interventions that supported community-based education and prevention programs. This was largely accomplished through the Community Initiatives Fund, which distributed just under \$3 million in the 2004-2005 fiscal year to facilitate commu-

nity based approaches to substance abuse issues (see Figure 1 for a breakdown of Community Initiatives Fund expenditures by category).³⁰

Through the Drug Strategy, the government transferred \$13 million to the provinces in 2004-2005 for alcohol and drug treatment and rehabilitation programs.³¹ According to the Horizontal Logic Model in the Horizontal Results-Based Management and Accountability Framework for Canada’s Drug Strategy, in 2004-2005 a separate fund of around \$72 million was directed to First Nations alcohol and drug abuse programs, about \$3 million to Drug Treatment Courts, over \$5 million to Drug Awareness Services, including Drug Abuse Resistance Education (DARE) prevention programs, and upwards of \$18 million to alcohol and drug abuse services for federal inmates, of which \$8.8 million was for methadone maintenance treatment programs.³² Lastly, in 2004-2005, \$1.4 million was invested towards modernizing

Figure 2 – Illicit Drug Portion of Actual Federal Drug Strategy Expenditures for 2004-2005 by Category



Source: Harm reduction expenditures calculated from documents provided by the Government of Canada’s *Horizontal Results-Based Management and Accountability Framework for Canada’s Drug Strategy: Final Report*, 19 October 2004; and through records released under the Access to Information Act (Request #A-2006-00249/ma July 24, 2006). Remaining calculations derived from *Plans, Spending and Results for 2004/2005* (Treasury Board of Canada Secretariat).

legislation and policy, including making amendments to previous precursor control measures.³³

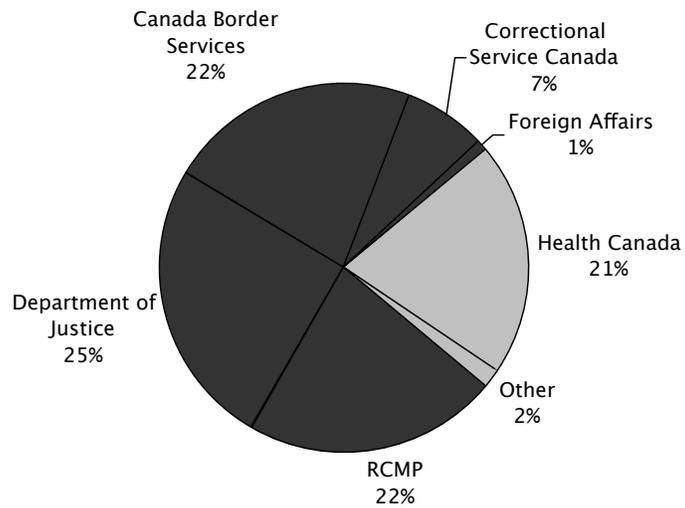
Treasury Board accounting documents indicate that of the \$368 million spent in 2004-2005 on addressing illicit drugs, 73 percent (\$271 million) was targeted towards enforcement initiatives (see Figure 2). These federally funded supply reduction measures include: border control programs (over \$80 million), RCMP drug-related investigations (approximately \$75 million), drug analysis services (approximately \$8 million) and federal prosecution services (approximately \$90 million).^{34, 35} The remaining 26 percent (\$97 million) was earmarked for coordinating and monitoring the renewed strategy, as well as generating research and knowledge surrounding substance use (seven percent, \$26 million); and, finally, prevention (2.6 percent, \$10 million), treatment (14 percent, \$51 million) and harm reduction related programs (2.6 percent, 10 million).³⁶

Further analysis of the distribution of the illicit drugs portion of Drug Strategy funds for 2004-2005 reveals that enforcement-related departments received a total of 77 percent (\$286.2 million) (see Figure 3.). Specifically, the RCMP received 22 percent (\$82 million), the Department of Justice 25 percent (\$92.4 million), the Canadian Border Services 22 percent (\$82 million), Correctional Services Canada seven percent (\$27 million) and Foreign Affairs one percent (\$2.9 million).³⁷

Discussion

Our review of the available evidence demonstrates that the funding structure of Canada's Drug Strategy (2003) continues to concentrate investments in enforcement related

Figure 3 – Illicit Drug Portion of Actual Federal Drug Strategy Expenditures for 2004-2005 by Department or Agency



Source: *Plans, Spending and Results for 2004/2005* (Treasury Board of Canada Secretariat).

activities. Although the proportion of funding allocated to enforcement-based initiatives has decreased from 95 percent in 2001 to 73 percent in 2005, Canada's Drug Strategy has been slow to respond to the growing body of scientific evidence indicating that many of the harms associated with psychoactive drugs are due to enforcement based policies and practices.^{38, 39, 40, 41, 42, 43, 44, 45, 46} For example, in terms of practices, intensified police enforcement strategies have been found to destabilize drugs markets and disperse concentrated drug scenes into surrounding areas, which separates drug users from health and prevention services, including needle exchanges and treatment programs.^{47, 48}

Furthermore, the effects of destabilized markets linked to intensified police enforcement include: heightened levels of violence, increased theft and property crime and, among some users, a shift from smoking to injecting illicit substances.⁴⁹ High-risk injecting

behaviour has also been repeatedly linked to enforcement practices.^{50, 51, 52, 53} When police pressure is intensified during supply reduction efforts, some drug users report being reluctant to access or carry clean injecting equipment.^{54, 55} When under pressure, injectors are more likely to skip important safety steps in the injection processes.⁵⁶ Specifically, injectors have been found to: be less likely to take the time to measure their dosage or to "taste" their drugs for purity before injecting,^{57, 58} are also less likely to clean the injection site prior to injecting,⁵⁹ and are more likely to damage their veins and cause other injection-related soft tissue damage.⁶⁰

However, while some evidence of health promoting police policies exists, as in Vancouver where police have implemented evidence-based overdose response policies⁶¹ and have been known to actively refer drug users to Vancouver's supervised injection site, it is unclear whether the current federal Drug Strategy is

supporting such innovative initiatives or police-public health partnerships.

Likewise, the ongoing heavy investment in supply reduction efforts runs counter to the large body of evidence indicating that such approaches have been consistently ineffective in reducing illicit drug supply, as well as the price and purity of illicit drugs. By way of example, a 2001 World Customs Organization report found that even post-September 11th, security measures have had a “negligible” impact on the influx of illicit drugs into the U.S.;⁶² and a recent Canadian study demonstrated that the largest heroin seizure in Canadian history had no impact on the use, price and purity of heroin locally.⁶³ Furthermore, instead of guiding illicit drug users towards health and treatment services, enforcement-based practices routinely result in an increased number of drug users entering correctional facilities, despite evidence indicating that incarceration is associated with HIV infection among injection drug users.^{64, 65, 66} In fact, as noted above, a recent external evaluation of HIV transmission among injection drug users in Vancouver concluded that 20 percent of HIV infections among Vancouver users have been acquired in prison.⁶⁷

It is now widely understood that abstaining from drugs is not a realistic goal for many individuals.⁶⁸ The World Health Organization (WHO) affirms that, “[a]n exclusive focus on achieving a drug free state as an immediate goal for all patients may jeopardize the achievement of other important objectives such as HIV prevention.”⁶⁹ Indeed, many low-threshold treatment and harm reduction initiatives that provide services to those who cannot or

will not abstain from illicit drug use have historically been undermined by enforcement-based policies and practices.^{70, 71} Further, there are opportunity costs associated with such heavy investment in enforcement, as many low threshold programs remain under-funded and not available to high-risk drug injecting populations despite their established health benefits.^{72, 73}

The Auditor General, Senate Committee and Special Committee all identified a need for comprehensive public reporting on the performance of Canada's Drug Strategy. When the renewed Drug Strategy was put in place in 2003, it promised to use “measurable indicators of performance and to report every two years to Parliament and Canadians on the progress made by Canada's Drug Strategy.”⁷⁴ However, no reports or evaluations of the renewed Strategy have so far been made available and, overall, there is a lack of accounting for the effectiveness of invested resources.⁷⁵ For instance, the school-based prevention program, DARE, is one of the primary recipients of Drug Awareness Service funding.⁷⁶ In 2004-2005, DARE was implemented in over 1300 schools reaching over 50 000 students across Canada,⁷⁷ despite the fact that DARE has been shown to be ineffective.^{78, 79, 80, 81, 82}

In fact, a document published by Health Canada for Canada's Drug Strategy in 2001 reported that “studies published in peer reviewed journals, including a 5-year prospective study and a meta-analysis of D.A.R.E outcome evolutions, have been consistent in showing that the program does not prevent or delay drug use, nor does it affect future intentions to use drugs.”⁸³ This document, entitled “Preventing Substance

Use Problems Among Young People: A Compendium of Best Practices,” calls for curriculum development that exhibits interactive methods of instruction and conveys accurate and balanced information on substances — features which the DARE program has not been found to effectively incorporate.⁸⁴ From a scientific perspective, instead of continuing to fund DARE programs, Canada's Drug Strategy should be investing in more effective education prevention programming. However, in 2004-2005, Drug Strategy funds were used to re-certify 550 existing DARE officers and to recruit and train 150 additional officers.⁸⁵

Similarly, \$3.28 million in the 2004-2005 fiscal year were allocated to drug treatment courts⁸⁶ despite the lack of solid scientific evidence in support of this approach.⁸⁷ Furthermore, Canada's Drug Strategy continues to promote and fund drug treatment courts over chronically under-funded voluntary treatment programs that have established success rates.^{88, 89, 90}

Another critical shortcoming of Canada's Drug Strategy relates to the lack of decisive action to ensure that vital public health services exist across the country. Because health care in Canada is a provincial responsibility, the majority of prevention, treatment and harm reduction measures have been left to provincial authorities to attend. However, no federal body has been monitoring how or if provinces are providing these services.⁹¹ For example, in British Columbia, needle exchange programs are available in only 14 cities and communities.⁹² This situation continues despite rigorous evaluations reporting that needle exchange services effectively reduce the risks

of HIV and hepatitis C transmission among injection drug users.^{93, 94}

According to the WHO, “[t]he provision of access to sterile injection equipment for injecting drug users and the encouragement of its use are essential components of HIV/AIDS prevention programs, and should be seen as a part of overall comprehensive strategies to reduce the demand for illicit drugs.”⁹⁵ Canada’s Drug Strategy’s stated overarching goal is to reduce harms associated with substance use, yet the Strategy makes no provisions to ensure the availability of key services, such as needle exchange, on a country-wide basis.

The review of Drug Strategy expenditures to date also points to several important missed opportunities to encourage and effectively support the development of new, innovative public health services that could further contribute to the reduction of harms associated with substance use. Under Canada’s current Drug Strategy, innovative public health interventions, such as Vancouver’s supervised injection site (InSite) and the North American Opiate Medication Initiative (NAOMI), are limited to small pilot studies, and their operational requirements are vastly different from other drug-related programs.

For Vancouver’s injection site, these requirements included the condition that the local police department approve of the initiative, despite its status as a medical public health intervention. Interestingly, InSite and NAOMI are subjected to an extraordinarily high standard of evaluation, while projects such as the school-based prevention program DARE, run by the RCMP, continue to receive funds through Canada’s Drug Strategy despite a lack of evidence

supporting their efficacy. Conversely, the formal scientific evaluation of Vancouver’s injection site has objectively documented a significant range of positive public order and public health outcomes.^{96, 97, 98, 99, 100, 101}

Yet, even with established findings, including increased uptake into detoxification programs among those who use the facility¹⁰² and reductions in needle sharing,¹⁰³ and overall public order improvements in the surrounding area,¹⁰⁴ the federal government recently refused to extend the operation of the site for an additional three years beyond its initial pilot phase, claiming that there is a lack of understanding surrounding the impact of the facility.¹⁰⁵ (See “Supervised injection facility granted time-limited extension” in the Canadian Developments section of this issue.) It has also put a halt to the establishment of new injection sites. This decision by the federal government — and the federal Health Minister’s comments in September 2006 that “[r]ight now the only thing the research to date has proven conclusively is drug addicts need more help to get off drugs”¹⁰⁶ — demonstrates a limited understanding of the scientific evidence derived from the evaluation of the injection site.

Conclusions

Although Canada’s Drug Strategy was renewed in 2003 following criticisms regarding spending, activities, leadership and a lack of appropriate monitoring and evaluation, many of the problems of the past remain. Currently, through Canada’s Drug Strategy, the federal government continues to invest heavily in policies and practices that have repeatedly been shown in the scientific literature to be ineffective or harm-

ful. Specifically, while the stated goal of the Canada’s Drug Strategy is to reduce harm, evidence obtained through this analysis indicates that the overwhelming emphasis continues to be on conventional enforcement-based approaches which are costly and often exacerbate, rather than reduce, drug-related harms. Further, Canada’s Drug Strategy has not seized the opportunity to promote a national standard of care that reduces the most deadly harms associated with illicit drug use.

With regard to the distribution of funding, the findings of this analysis suggests that the current federal spending on harm reduction initiatives which target HIV/AIDS and other serious harms is insignificant compared to the funds devoted to treatment and, particularly, enforcement. This stands in stark contrast to recent comments made by various stakeholders suggesting that there has been an over-investment in harm reduction programming.¹⁰⁷

Our results also indicate that the Drug Strategy continues to suffer from a lack of appropriate evaluation. Despite promises of regular reporting, information pertaining to evaluation of the Drug Strategy is limited, making it difficult to assess the return on investments made. The exception is the areas in which the Drug Strategy has promoted innovation in harm reduction, such as the pilot study of Vancouver’s safer injection facility, which has produced a number of published scientific studies. However, it appears that while controversial interventions supported through the Drug Strategy are being held to an extraordinary standard of proof, interventions receiving the greatest proportion of funding remain under-evaluated. Canada’s Drug Strategy has so far

also failed to provide national standards of care for Canadians affected by substance use issues.

In summary, our results suggest there remain challenges associated with the federal Drug Strategy that pertain to spending, activities, leadership, and monitoring and evaluation. A greater concern relates to the continued allocations of funds to ineffective programs. Perhaps most importantly, if Canada wants to fulfill its mission of reducing the most severe harms associated with illicit drug use, steps must now be taken to implement a truly evidence-based national drug strategy.

— Kora DeBeck, Evan Wood,
Julio Montaner and Thomas Kerr

All four authors are with the British Columbia Centre for Excellence in HIV/AIDS. Kora DeBeck is also with the Graduate Public Policy Program at Simon Fraser University. Evan Wood and Thomas Kerr are also with the Faculty of Medicine at the University of British Columbia. Correspondence should be sent to Thomas Kerr at tkerr@cfenet.ubc.ca.

The authors would like to thank Gerald Thomas, Kenneth Tupper and Lindsey Richardson for their early advice on approaching this resource analysis.

Alcohol and Other Drugs: Prevalence of Use and Related Harms: Detailed Report. Canadian Centre on Substance Abuse, 2005.

⁶ European Monitoring Centre for Drugs and Drug Addiction, Annual Report: The State of the Drugs Problem in Europe, 2005. Available via <http://ar2005.emcdda.europa.eu/en/home-en.html>.

⁷ J.S. Millar, *HIV, Hepatitis C, and Injection Drug Use in British Columbia: Pay Now or Pay Later?* British Columbia Provincial Health Officer, June 1998.

⁸ J.V. Cain, *Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia.* Province of British Columbia: Office of the Chief Coroner, 1994.

⁹ L.M. Kuyper et al., "The cost of inaction on HIV transmission among injection drug users and the potential for effective interventions," *Journal of Urban Health* 81, 4 (2004): 655–660.

¹⁰ J. Rehm et al.

¹¹ Ibid.

¹² Ibid.

¹³ E Adlaf et al.

¹⁴ Correctional Service Canada, Speakers Binder, Section 7 Statistics. Available via www.csc-scc.gc.ca/text/pblct/guideorateur/sec7_e.shtml.

¹⁵ K.J. Craib et al., "Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver," *Canadian Medical Association Journal* 168, 1 (2003): 19–24.

¹⁶ E. Wood et al., "Recent incarceration independently associated with syringe sharing by injection drug users," *Public Health Reporter* 120, 2 (2005): 150–156

¹⁷ M. W. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV-1 epidemic," *AIDS* 17, 6 (2003): 887–893.

¹⁸ H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17, 6 (2003): 911–913.

¹⁹ Special Committee on Non-Medical Use of Drugs, *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy: Report of the Special Committee on Non-Medical Use of Drugs.* House of Commons, Government of Canada, December 2002.

²⁰ Office of the Auditor General of Canada, *Report of the Auditor General of Canada 2001, Chapter 11 Illicit Drugs: The Federal Government's Role*, 2001.

²¹ Ibid.

²² Special Committee on Non-Medical Use of Drugs.

²³ Senate Special Committee on Illegal Drugs, *Cannabis: Report of the Senate Special Committee on Illegal Drugs.* Abridged Version ed. University of Toronto, 2003.

²⁴ Ibid.

²⁵ Office of the Auditor General of Canada.

²⁶ Government of Canada, *Canada's Drug Strategy: What is it?* Cat. H 128-1/05-443-1, 2005.

²⁷ Ibid.

²⁸ Government of Canada, *Horizontal Risk-Based Audit Framework: Strategic Risk Management of Canada's Drug Strategy Renewed. Final Report.* Document provided by Office of Drug Strategy Secretariat, 2004. [On file with authors.]

²⁹ Government of Canada, *Horizontal Results-Based Management and Accountability Framework for Canada's*

Drug Strategy. Final Report. Document provided by Office of Drug Strategy Secretariat, 2004. [On file with authors.]

³⁰ Health Canada, *Records Released Under the Access to Information Act.* Request #A-2006-00249/ma. Access to Information and Privacy Division, 2006. [On file with authors.]

³¹ Ibid.

³² Government of Canada, *Horizontal Results-Based Management and Accountability Framework for Canada's Drug Strategy. Final Report.*

³³ Treasury Board of Canada Secretariat. *Canada's Drug Strategy: Plans, Spending and Results 2004/2005.* Government of Canada [database online]. Available from http://www.tbs-sct.gc.ca/proxy.lib.sfu.ca/rma/epi-ibdrp/hrbd/rhbd/cds-sca/2004-2005-bd_e.htm#s7.

³⁴ Government of Canada, *Horizontal Results-Based Management and Accountability Framework for Canada's Drug Strategy. Final Report.*

³⁵ Treasury Board of Canada Secretariat.

³⁶ Source for calculations: *Plans, Spending and Results for 2004-2005* (Treasury Board of Canada Secretariat), [available online]; *Horizontal Results-Based Management and Accountability Framework for Canada's Drug Strategy. Final Report* (Government of Canada) [available on file with authors]; and records provided by Health Canada released under the Access to Information Act request [also available on file with authors]. For this analysis, the illicit drug portion of treatment and rehabilitation funding was estimated to be 45 percent of total treatment expenditures; this was based on the Auditor General's 2001 assessment that the illicit drug portion of alcohol and drug treatment funding was 45 percent of total treatment expenditures.

³⁷ Ibid.

³⁸ E. Wood et al., "The impact of a police presence on access to needle exchange programs," *Journal of Acquired Immune Deficiency Syndrome* 34, 1 (2003): 116–118.

³⁹ D. Dixon and P. Coffin, "Zero tolerance policing of illegal drug markets," *Drug and Alcohol Review* 18: 477–486.

⁴⁰ J. Csete and J. Cohen, "Abusing the user: police misconduct, harm reduction and HIV/AIDS in Vancouver," *Human Rights Watch* 15, 2B (2003): 1–28.

⁴¹ H. Cooper et al., "Characterizing perceived police violence: implications for public health," *American Journal of Public Health* 94, 7 (2004): 1109–1118.

⁴² T. Kerr, W. Small and E. Wood, "The public health and social impacts of drug market enforcement: a review of the evidence," *International Journal of Drug Policy* 16, 4 (2005): 210–220.

⁴³ J. Fitzgerald, "Policing as public health menace in the policy struggles over public injecting," *International Journal of Drug Policy* 16, 4 (2005): 203–206.

⁴⁴ S. Friedman et al., "Relationship of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas," *AIDS* 20, 1 (2006): 93–99.

⁴⁵ H. Cooper, D. Wypij and N. Krieger, "Police drug crackdowns and hospitalization rates for illicit-injection-related infections in New York City," *International Journal of Drug Policy* 16, 3 (2005): 150–160.

⁴⁶ D. Dixon and L. Maher, "Anh Hai: policing, culture and social exclusion in a street heroin market," *Policing & Society* 12, 2 (2002): 93–110.

¹ Public Health Agency of Canada, *HIV and AIDS in Canada: Surveillance Report to June 30, 2005.* Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, 2005.

² J. Buxton, *Vancouver Drug Use Epidemiology.* Canadian Community Epidemiology Network on Drug Use, 2005.

³ J. Rehm et al., *The Costs of Substance Abuse in Canada 2002.* Canadian Centre on Substance Abuse, March 2006.

⁴ Public Health Agency of Canada.

⁵ E. Adlaf, P. Begin and E. Sawka, *2004 Canadian Addiction Survey (CAS): A National Survey of Canadians' Use of*

- ⁴⁷ E. Wood et al, "Displacement of Canada's largest public illicit drug market in response to a police crackdown," *Canadian Medical Association Journal* 170 (2004): 1551–1556.
- ⁴⁸ L. Maher and D. Dixon, "Policing and public health: law enforcement and harm minimization in a street-level drug market," *British Journal of Criminology* 39, 4 (1999): 488–512.
- ⁴⁹ Ibid.
- ⁵⁰ Ibid.
- ⁵¹ T. Kerr, W. Small and E. Wood.
- ⁵² W. Small et al, "Impacts of intensified police activity on injection drug users: evidence from an ethnographic investigation," *International Journal of Drug Policy* 17, 2 (2006): 85–95.
- ⁵³ C. Aitken et al, "The impact of a police crackdown on a street drug scene: evidence from the street," *International Journal of Drug Policy* 13 (2002): 189–198.
- ⁵⁴ L. Maher and D. Dixon.
- ⁵⁵ K. Blankenship and S. Koester, "Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users," *Journal of Law, Medicine and Ethics* 30, 4 (2002): 548–559.
- ⁵⁶ H. Cooper et al, "The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: a qualitative study," *Social Science & Medicine* 61, 3 (2005): 673–684.
- ⁵⁷ L. Maher and D. Dixon.
- ⁵⁸ W. Small et al.
- ⁵⁹ H. Cooper et al.
- ⁶⁰ L. Maher and D. Dixon.
- ⁶¹ D. Wiebe, Inspector 1162, *Vancouver Police Department Planning and Research Section Policy Report*, Vol. 0648. Vancouver Police Department, 2006.
- ⁶² World Customs Organization. Annual Report 2001. Available via www.wcoomd.org/ie/En/Contact/Contact.html.
- ⁶³ E. Wood et al, "Impact of supply-side policies for control of illicit drugs in the face of the AIDS and overdose epidemics: investigation of a massive heroin seizure," *Canadian Medical Association Journal* 168, 2 (2003): 165–169.
- ⁶⁴ W. Small et al.
- ⁶⁵ E. Wood, J. Montaner and T. Kerr, "HIV risks in incarcerated injection-drug users," *The Lancet* 366, 9500 (2005): 1834–1835.
- ⁶⁶ E. Wood et al, "Recent incarceration independently associated with syringe sharing by injection drug users." ⁶⁷ H. Hagan.
- ⁶⁸ Health Officers Council of British Columbia, *A Public Health Approach to Drug Control in Canada*. Discussion Paper, October 2005.
- ⁶⁹ World Health Organization, UNAIDS and UN Office of Drug Control, *WHO/UNODC/UNAIDS Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*, 2004.
- ⁷⁰ E. Wood et al, "The impact of a police presence on access to needle exchange programs."
- ⁷¹ W. Small et al.
- ⁷² World Health Organization, UNAIDS, and UN Office on Drugs and Crime, *Policy Brief: Reduction of HIV Transmission Through Drug-Dependence Treatment*, 2004.
- ⁷³ World Health Organization, UNAIDS, and UN Office on Drugs and Crime, *Policy Brief: Reduction of HIV Transmission Through Outreach*, 2004.
- ⁷⁴ Government of Canada, *Canada's Drug Strategy; Accountability and Reporting*. Cat. H128-1/05-443-4, 2005.
- ⁷⁵ Evaluation Analyst, Office of Drug Strategy Secretariat, Health Canada, personal correspondence [with K. DeBeck], 17 May 2006.
- ⁷⁶ Government of Canada, *Horizontal Results-Based Management and Accountability Framework for Canada's Drug Strategy. Final Report*.
- ⁷⁷ Treasury Board of Canada Secretariat.
- ⁷⁸ H. Becker, M. Agopian and S. Yeh, "Impact evaluation of drug abuse resistance education (DARE)," *Journal of Drug Education* 22, 4: 283–291.
- ⁷⁹ R. Clayton, A. Cattarello and B. Johnstone, "The effectiveness of drug abuse resistance education (Project DARE): 5-year follow-up results," *Preventive Medicine* 25, 3 (1996): 307–318.
- ⁸⁰ S. Ennett et al, "How effective is drug abuse resistance education? A meta-analysis of Project DARE outcome evaluations," *American Journal of Public Health* 84, 9 (1994): 1394–1401.
- ⁸¹ D. Rosenbaum et al, "Cops in the classroom: a longitudinal evaluation of drug abuse resistance education (DARE)," *Journal of Research in Crime and Delinquency* 31, 1 (1994): 3–31.
- ⁸² D. Rosenbaum and G. Hanson, "Assessing the effects of school-based drug education: a six-year multilevel analysis of Project D.A.R.E.," *Journal of Research in Crime and Delinquency* 35, 4 (1998): 381–412.
- ⁸³ G. Roberts et al, *Preventing Substance Use Problems Among Young People: A compendium of Best Practices*. Government of Canada, 2001.
- ⁸⁴ S. Ennett et al.
- ⁸⁵ Treasury Board of Canada Secretariat.
- ⁸⁶ Government of Canada, *Horizontal Results-Based Management and Accountability Framework for Canada's Drug Strategy. Final Report*.
- ⁸⁷ J. Anderson, "What to do about 'much ado' about drug courts?," *International Journal of Drug Policy* 12, 5–6 (2001): 469–475.
- ⁸⁸ E. Wood et al, "Inability to access addiction treatment and risk of HIV infection among injection drug users," *Journal of Acquired Immune Deficiency Syndrome* 36, 2 (2004): 750–754.
- ⁸⁹ D. MacPherson, *A Framework for Action — A Four-Pillar Approach to Drug Problems in Vancouver*, April Revised Edition ed. Drug Policy Program, 2001.
- ⁹⁰ J.S. Millar.
- ⁹¹ Programs Officer, Office of Demand Reduction, Health Canada, personal correspondence [with K. DeBeck], 22 June 2006.
- ⁹² Government of British Columbia, Ministry of Health, *HIV/AIDS and Problematic Substance Use: Needle Exchanges*, 21 July 2005. Available via www.healthservices.gov.bc.ca/hiv/needle.html.
- ⁹³ World Health Organization, UNAIDS and UN Office of Drug Control, *WHO/UNODC/UNAIDS Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*.
- ⁹⁴ World Health Organization, UNAIDS, and UN Drug Control Office, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, 2004.
- ⁹⁵ Ibid.
- ⁹⁶ M. Tyndall et al, "Attendance, drug use patterns, and referrals made from North America's first supervised injection facility," *Drug and Alcohol Dependence* 83, 3 (2006): 193–198.
- ⁹⁷ E. Wood et al, "Service uptake and characteristics of injection drug users utilizing North America's first medically supervised safer injecting facility," *American Journal of Public Health* 96, 5 (2006): 770–773.
- ⁹⁸ T. Kerr et al, "Drug-related overdoses within a medically supervised safer injection facility," *International Journal of Drug Policy*, in press, corrected proof (2006).
- ⁹⁹ E. Wood et al, "Safer injecting education for HIV prevention within a medically supervised safer injecting facility," *International Journal of Drug Policy* 16, 4 (2005): 281–284.
- ¹⁰⁰ T. Kerr et al, "Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study," *British Medical Journal* 332, 7535 (2006): 220.
- ¹⁰¹ E. Wood et al, "Do supervised injecting facilities attract higher-risk injection drug users?," *American Journal of Preventive Medicine* 29, 2 (2005): 126–130.
- ¹⁰² E. Wood et al, "Attendance at supervised injecting facilities and use of detoxification services," *New England Journal of Medicine* 354 (2006): 2512–2514.
- ¹⁰³ T. Kerr, et al, "Safer injection facility use and syringe sharing in injection drug users," *The Lancet* 366, 9482 (2005): 316–318.
- ¹⁰⁴ E. Wood et al, "Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users," *Canadian Medical Association Journal* 171 (2004): 731–734.
- ¹⁰⁵ Health Canada, "No new injection sites for addicts until questions answered says Minister Clement," news release, Ottawa, 1 September 2006.
- ¹⁰⁶ Ibid.
- ¹⁰⁷ B. Cleverley, "Tories say no decision on drug injection site until end of 2007," *CanWest News Service*, 2 September 2006. Available at www.canada.com/topics/news/politics/story.html?id=9a8e3301-ee1e-47ab-b52b-351d6537a474&k=12244.

Will they deliver treatment access?: WTO rules and Canada's law on generic medicine exports

More than two years since Canada enacted the *Jean Chrétien Pledge to Africa*, no generic medication produced under compulsory license has yet been exported from Canada. In this feature article, Richard Elliott describes attempts by two Canadian generic pharmaceutical companies to navigate the complicated and unwieldy processes established under the Act, and, noting the government's pledge to review the law and fix it to make it work, prescribes a number of ways in which the process should be streamlined.

Introduction

Many developing countries cannot afford patented brand-name medicines, but also lack the industrial capacity to manufacture their own less expensive generic products, which means they rely on imported medicines. Under the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS), countries belonging to the World Trade Organization (WTO) must grant exclusive patent rights on medicine, but also retain the right to grant compulsory licences that legally authorize the production of lower-cost, generic versions of patented drugs in exchange for royalties. Breaking the monopoly of patent-holders allows market competition, which brings down prices.

However, TRIPS also states that products made under compulsory licences must be "predominantly for the supply of the domestic market." This limits the quantity of generic medicines produced under a compulsory licence that can be exported from one WTO member country to any other country. Therefore, even if a developing country needing less expensive medicines

decided to import generics, this rule restricts other countries from supplying them. This undermines the ability of the importing country to use compulsory licensing effectively as a tool to get lower-cost treatment for patients.

Under great pressure from developing countries and treatment activists, on 30 August 2003 WTO members adopted an ostensible "solution" to this problem by relaxing this restriction to allow compulsory licences in one country to produce lower-cost generic drugs for export to developing countries in need.¹

In May 2004, Canada's Parliament unanimously enacted the *Jean Chrétien Pledge to Africa*, legislation that amended the *Patent Act* and the *Food and Drugs Act* to implement this WTO decision.² While Canadian civil society organizations belonging to the Global Treatment Access Group (GTAG) succeeded in obtaining significant improvements to what the government of the day had introduced, they warned that the remaining flaws could hinder the usefulness of the legislation. They also said that they would support efforts to use it, notwithstanding its limitations.³

Taking stock: what has happened with Canada's initiative?

An FDC ARV for HIV?

In May 2004, shortly after the law was passed, Médecins Sans Frontières (MSF) publicly committed to testing it by placing an order for medicines needed for its field projects.⁴ In August 2004, MSF identified to Health Canada and representatives of the Canadian generic pharmaceutical industry five drugs that were urgently needed to treat its patients.

Finally, in December 2004, Apotex Inc., a privately-held Canadian generic pharmaceutical company agreed to produce a three-in-one antiretroviral combination of zidovudine, lamivudine and nevirapine (AZT+3TC+NVP), drugs which represent one of the first-line treatment regimens for HIV recommended by the World Health Organization (WHO). At the time, those drugs were not available in the form of a fixed-dose combination (FDC), a product that would simplify treatment significantly and help with the global effort to scale up treatment.

Apotex developed an active prototype of the FDC by April 2005. However, this FDC was not on the list of products eligible for compulsory licensing for export in Schedule 1 of the *Patent Act*. The addition of a new product to the schedule requires a decision of the federal Cabinet, following the recommendation of both the Minister of Industry and the Minister of Health.

In September 2005, after further pressure, the Cabinet made the requisite order amending Schedule 1. In late 2005, Apotex submitted to Health Canada an application for approval, as required under the legislation (a step not required under the WTO 2003 decision), at which time MSF began discussions with potential importing country authorities. The Health Canada review process took seven months; the product received approval in July 2006.

In August 2006, shortly before the XVI International AIDS Conference, the WHO Prequalification Project, having reviewed the dossier submitted to Canadian drug regulators, also gave its stamp of approval, a precondition upon which many developing countries insist when making procurement decisions.

During the XVI International AIDS Conference, a representative of the Clinton Foundation HIV/AIDS Initiative indicated the Foundation would be willing to place an order for the Apotex FDC product as the basis for a compulsory licence application.⁵ Brokering a large-scale, multi-country order, in addition to the outstanding commitment by MSF to purchase an initial smaller quantity of the product, could provide significant pressure that could break the seeming logjam in this first effort to use Canada's legislation.

However, as of the time of writing, Apotex remained tied up in ongoing negotiations with the companies holding the relevant Canadian patents, even though in theory Canada's law requires only 30 days of such negotiations before the way is legally clear for an application to be filed for a compulsory licence. It remains unclear if or when a voluntary licence will be issued or if Apotex will proceed with a compulsory licence application.

Brokering a large-scale, multi-country order could provide significant pressure and break the logjam in attempts to use Canada's legislation.

Pandemic influenza: might the JCPA help?

There has been another effort to use the Canadian legislation, to respond to another emerging global health concern. It, too, remains an effort in progress. There is considerable concern about the possibility of a future global influenza pandemic, highlighted most recently by outbreaks of avian influenza and the fear that at some point a variant of this or another animal flu virus could be transmitted from human to human.

Leading public health authorities have warned there is a risk of a global pandemic of avian flu that could, in some scenarios, lead to the death and suffering of millions. Such a pandemic would likely take the greatest toll in regions where significant

numbers of people are already immunocompromised as a result of HIV, TB and other illnesses. The WHO has already released a report that recommends, among other things, stockpiling antiviral drugs,⁶ and the Canadian government has recognized the threat.⁷

Oseltamivir phosphate — marketed under the brand name Tamiflu — is an oral antiviral medicine used for both treatment and prophylaxis of influenza, including the H5N1 variant of avian flu that has provoked global concern, and is of considerable and growing interest given its possible beneficial use in the event of outbreaks. But very few developing countries have stockpiled oseltamivir in anything remotely close to the quantities recommended, which means they lack one of the tools for treatment or prevention of avian flu, should such a pandemic occur.

In December 2005, Canadian pharmaceutical company Biolyse Pharma announced it had developed an alternate process for producing oseltamivir, and that it wished to obtain a non-exclusive compulsory license to produce and export the medicine to developing countries at a reduced cost. However, the medicine was not included on Schedule 1 of the *Patent Act*, the list of pharmaceutical products eligible for compulsory licensing for export.

In February 2006, Biolyse submitted a formal request to the Ministers of Health and Industry to add oseltamivir phosphate (in both capsule and powder form) to the list of products eligible for compulsory licensing for export in Schedule 1 of the *Patent Act*.⁸ The multinational pharmaceutical company Hoffmann-La Roche, Inc. (Roche), which holds the relevant Canadian patents on oseltamivir,

has opposed the compulsory licensing of the product.

On 21 September 2006, the federal cabinet made the requisite order adding these two formulations of the drug to the list.⁹ Biolyse has stated that it now plans to ramp up its production capacity to produce up to one million doses a day once its facility is fully operational,¹⁰ on the assumption that it will line up purchase orders from eligible countries and then successfully proceed through the protracted process under the Canadian law for obtaining either a voluntary or compulsory licence allowing it to export to those purchasers.

Conclusion

As of this writing, more than two years since Canada passed its law, no generic medication produced under compulsory license has yet been exported from Canada. During the XVI International AIDS Conference in Toronto, under sustained public criticism of the failed initiative, Canada's new Minister of Health pledged to review the law and fix it to make it work. By law, Parliament must review the legislation by May 2007, providing an opportunity to replace the current unwieldy process with a more effective legal regime.

Beyond the unnecessarily burdensome features added by the Canadian government, the experience has illustrated a more fundamental problem, namely the mechanism agreed at the WTO in August 2003 — witness the fact that more than three years have passed since the WTO adopted its “solution” and not a single country has filed the required notification that it intends to use the mechanism to import lower-cost medicines.¹¹ MSF's experience to date, particularly as illustrated through its hands-on

experience with the Canadian legislation, has prompted the organization to comment that the WTO's August 2003 decision is “neither expeditious, nor a solution.”¹²

Canada needs to streamline the legal process so that developing countries and generic drug companies can and will use it.

In order to put in place a legislative regime that stands a greater chance of delivering on the “pledge” originally made in 2004, Canada's law-makers will need to be willing to step away from the flawed WTO mechanism and enact a series of changes that will simplify and streamline the process of compulsory licensing for export. The WTO decision embodied in Canada's law ignores the realities of both generic drug manufacturers and developing countries.

Developing countries need simple contract processes that will ensure sustainable supplies of essential medicines or other pharmaceutical products; these contracts must be flexible enough to adjust to changing needs. The WTO decision as enacted by Canada, however, forces generic companies through unnecessary red tape to get a licence to manufacture and export each patented drug, and even then allows for export only in a pre-negotiated quantity and to a single country.

What is needed is for Canada to streamline the legal process so that

developing countries and generic drug companies can and will use it. Generic manufacturers should be able to apply at the outset for a compulsory licence to manufacture and export any patented medicine, not just those on the limited list attached to the original legislation. With such a licence in hand, they should be able to negotiate multiple purchasing contracts with multiple developing countries — not just one-off agreements on a country-by-country, order-by-order basis for which a separate licence must then be obtained each time, as is currently the case.

There should be no arbitrary time limits on the length of the compulsory licence — currently, there is a two-year cap, limiting the economies of scale needed to make compulsory licensing viable for generic manufacturers and throwing into question for potential developing-country purchasers the long-term sustainability of supplies.

There should be no mandatory 30-day negotiation period between generic manufacturers and brand-name patent-holders — rather, getting the licence to produce for export to eligible developing countries should be automatic. (Generic producers would still be required to pay royalties to the patent holders, according to the sensible formula already contained in the existing law, which bases the royalty payable on any given contract on the level of development of the importing developing country.)

Such a process would give generic manufacturers and developing countries much more incentive to make use of the law and realize the goal of getting medicines to people who need them in developing countries. Canada has implemented the mechanism negotiated at the WTO in 2003.

So far, it hasn't worked. But WTO members agreed that their 2003 decision did not preclude using other "flexibilities" in the WTO's TRIPS Agreement, and they have also said that TRIPS should be interpreted and implemented so as to promote access to medicines.¹³ Under Article 30 of TRIPS, countries can create "limited exceptions" to patent rights in their own laws. Canada can legislate the simpler, streamlined mechanism described above as one such exception.

It remains to be seen whether the federal government — or perhaps Parliament as a whole, given that the opposition parties in the House of Commons jointly hold more seats than the minority governing party — has the political courage of the convictions all parties stated unanimously and solemnly when they originally enacted the legislation in 2004.

— Richard Elliott

Richard Elliott (relliott@aidslaw.ca) is Deputy Director of the Canadian HIV/AIDS Legal Network and a founding member of the Global Treatment Access Group (GTAG). More information about GTAG

and advocacy on Canada's legislation on compulsory licensing for export can be found at www.aidslaw.ca/gtag.

¹ WTO General Council, Decision on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health, WTO Doc. IP/C/W/40 (30 August 2003). Available via <http://docs.wto.org>.

² S.C. 2004, c. 23. The legislation was proclaimed into force one year later on 14 May 2005, and accompanying regulations came into force on 1 June 2005. See: "Food and drug regulations (1402 – drugs for developing countries," SOR/2005-141, *Canada Gazette (Part II)*, 139(11): 1112–24; "Medical devices regulations (developing countries)," SOR/2005-142, *Canada Gazette (Part II)*, 139(11): 1125–26; "Use of patented products for international humanitarian purposes regulations", SOR/2005-143, *Canada Gazette (Part II)*, 139(11): 1127–56, all at http://canadagazette.gc.ca/partII/2005/20050601/html/index_e.html. For more information about what the government has since labelled "Canada's Access to Medicines Regime," see http://camr-rcam.hc-sc.gc.ca/index_e.html.

³ For more detailed discussion, see: R. Elliott, "Pledges and pitfalls: Canada's legislation on compulsory licensing of pharmaceuticals for export," *International Journal of Intellectual Property Management* 1, 1/2 (2006): 94–112, available via www.aidslaw.ca/gtag; R. Elliott, "TRIPS from Doha to Cancún...to Ottawa: global developments in access to treatment and Canada's Bill C-56," *Canadian HIV/AIDS Policy & Law Review* 8, 3 (2003): 1, 7–18; R. Elliott, "Steps forward, backward and sideways: Canada's bill on exporting generic pharmaceuticals," *Canadian HIV/AIDS Policy & Law Review* 9, 3 (2004): 15–21; Canadian HIV/AIDS Legal Network and Interagency Coalition on AIDS and Development, *The Jean Chrétien Pledge to Africa Act and its Impact on Improving Access to HIV/AIDS Treatment in Developing Countries*, August 2006 (available via www.aidslaw.ca/gtag).

⁴ For a detailed analysis of MSF's effort to use the legislation to obtain this product, which is also one source of the information summarized here, see: MSF, *Neither Expeditious, Nor a Solution: The WTO August 30th Decision is Unworkable – An Illustration Through Canada's Jean Chrétien Pledge to Africa*, August 2006. At www.accessmed-msf.org/documents/WTOaugustreport.pdf.

⁵ Remarks of Anil Soni, Director of Pharmaceutical Services, Clinton Foundation HIV/AIDS Initiative at "Will it Deliver? WTO rules and Canada's law on compulsory licensing: the continuing challenge of scaling-up treatment access," satellite session, XVI International AIDS Conference, 15 August 2006, Toronto.

⁶ World Health Organization, *Responding to the Avian Influenza Pandemic Threat: Recommended Strategic Actions* (Geneva: WHO, 2005). WHO/CDS/CSR/GIP/2005.8. At: www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_8/en/index.html.

⁷ Information and news releases available on the Health Canada Website at www.hc-sc.gc.ca/dc-ma/avia/index_e.html.

⁸ Letter from Biolyse Pharmaceutical Corporation, 14 February 2006 (at www.biolyse.ca/news.asp?story=111). The Canadian HIV/AIDS Legal Network made the same request: letter from Canadian HIV/AIDS Legal Network, 14 February 2006 (at www.biolyse.ca/news.asp?story=114).

⁹ Order Amending Schedule I to the Patent Act (Oseltamivir Phosphate), P.C. 2006-996 (21 September 2006), SOR/2006-204, *Canada Gazette, Part II*, 4 October 2006. At <http://canadagazette.gc.ca/partII/2006/20061004/html/sor204-e.html>.

¹⁰ A. Deslonchamps, "Canada to let Biolyse make generic version of Tamiflu", Bloomberg, 27 September 2006. At: www.bloomberg.com/apps/news?pid=20601082&sid=a3iAW8wuUu84&refer=canada.

¹¹ See the dedicated webpage for such notifications at www.wto.org/english/tratop_e/trips_e/public_health_e.htm.

¹² MSF.

¹³ *Declaration on the TRIPS Agreement and Public Health*, WTO Ministerial Conference, Fourth Session, Doha (Qatar), 14 November 2001, WTO Doc. WT/MIN(01)/DEC/2, available via <http://docs-online.wto.org>, para. 4.

The CDC's routine HIV testing recommendation: legally, not so routine

Editor's Note: This issue of the Review marks the beginning of a new collaboration between the Canadian HIV/AIDS Legal Network and the American Bar Association (ABA), led by the ABA AIDS Coordinating Committee,ⁱ and including the ABA Sections of Individual Rights and Responsibilitiesⁱⁱ and International Law.ⁱⁱⁱ ABA members and other U.S.-based lawyers will contribute occasional articles reporting on and analyzing developments in the United States related to HIV/AIDS and the law. The ABA and the Legal Network will work together in interacting with the new editorial board and increasing the Review's visibility and readership in the U.S.

In this feature article, Ann Hilton Fisher, Catherine Hanssens and David I. Schulman (from the ABA) analyze the new guidelines on HIV testing from the U.S. Centers for Disease Control and Prevention (CDC) and find them wanting. The authors argue that the CDC's recommendation to do away with specific written informed consent for HIV tests is primarily based on a false assumption that the process of securing informed consent constitutes a barrier to HIV testing; and that, on the contrary, streamlined HIV testing, with rapid testing and counselling tailored to each individual's needs, has proven effective while retaining informed consent.

Introduction

Now that the U.S. Centers for Disease Control and Prevention (CDC) has recommended HIV testing for all Americans aged 13–64 presenting for health care who do not explicitly object,¹ the states must determine whether and how to revise state law provisions on pre-test counselling and proof of consent. When doing so, states should carefully consider an element overlooked by the CDC — the fundamental legal doctrine, and underlying purpose, of informed con-

sent. That doctrine holds that except in emergency situations, all patients at all times must consent to the medical care that is offered them.

Without consent, any touching is potentially unlawful. Though only several decades old, this doctrine is imbedded in the public's understanding of patient autonomy. A state's failure to preserve informed consent as central to diagnosis for HIV — a serious illness with serious medical and social consequences — could undermine this important doctrine for

a wide range of medical care beyond testing for HIV.

It is not clear why the CDC concluded that the absence of informed consent is sufficient predicate for HIV testing, particularly when there is no evidence that requiring informed consent is a barrier to testing. A general consent by definition covers only those procedures whose risks and benefits are generally well-known; the risks and benefits of HIV testing, like those of genetic testing, are complex.²

ⁱ The ABA AIDS Coordinating Committee (<http://www.abanet.org/AIDS/home.html>), under the auspices of the ABA Section of Individual Rights and Responsibilities, is comprised of liaisons appointed by various ABA entities and affiliated bar associations. Its mission is to develop and promote the Association's ongoing AIDS-related activities and to educate lawyers and the public about HIV/AIDS legal issues through public hearings, publications, national practitioner conferences and policy development, and to advocate for effective implementation of ABA policy on those issues.

ⁱⁱ Created in 1966, the ABA Section of Individual Rights and Responsibilities (<http://www.abanet.org/irr/home.html>) provides leadership within the ABA and the legal profession in protecting and advancing human rights, civil liberties and social justice. It fulfills this role by raising and addressing often complex and difficult civil rights and civil liberties issues in a changing and diverse society, and ensuring that protection of individual rights remains a focus of legal and policy decisions.

ⁱⁱⁱ The ABA Section of International Law (<http://www.abanet.org/intlaw/home.html>) serves as the gateway to international practice for more than 400 000 members of the legal profession. It long has been the home of leading experts in international law and a network for those who practice in international settings. It provides reliable and expert knowledge and perspectives on cutting-edge international legal issues to satisfy the information needs of its members, and is a leader in advocacy for international legal policy and the rule of law.



There are risks as well as benefits to the individuals tested, often depending on the timing and circumstances of the test itself. Informed consent may be abandoned under the narrow circumstances when public health exercises its emergency powers to take such draconian measures as quarantining those exposed to anthrax. But the CDC is not claiming its recommendation is based on those emergency powers.

As the American Medical Association (AMA) points out, “Informed consent is ... a process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention.”³ What constitutes sufficient information to ensure that consent is informed is contextual, determined by the nature and complexity of the condition at issue and the consequences of the diagnosis and subsequent care. The patient should have an opportunity to ask questions for a better understanding of the treatment or procedure to allow an informed decision to proceed or to refuse a particular course of medical intervention.⁴ This communication process is both an ethical and legal obligation spelled out in statutes and case law in all 50 states.

The CDC has long-recognized that the risks of HIV testing are not routine. Researchers have documented that the fear of stigma is a major barrier to testing.⁵ In response, the CDC has recommended that newly-tested HIV-positive persons be referred promptly to legal counselling on how to prevent discrimination by maintaining the confidentiality of these test results.⁶ Fortunately, established practice in HIV testing and care provides excellent models for obtaining

informed consent without undue burden, as we discuss below.

Faulty assumption

The CDC’s recommendation to forgo specific written informed consent for HIV tests in order to make testing routine rests primarily on a critical faulty assumption: that the process of securing informed consent presents a substantial barrier to busy health care professionals who would otherwise offer HIV testing to their patients. However, the experience in Illinois is illustrative of how health care providers committed to increasing HIV testing can do so efficiently and effectively while respecting their patients’ fundamental right to informed consent.

The vast majority of women accept HIV testing if it is recommended by their health-care provider.

In August 2005, the Illinois Department of Public Health initiated a pilot program to increase HIV testing of pregnant women. The Statewide Perinatal Rapid Testing Implementation in Illinois program (PRTII) sent workers into every Illinois birthing hospital to help labour and delivery room staff create systems for offering counselling and rapid HIV tests to women in active labour who did not have HIV tests already in their records.

These women were in medical crisis. Most had no previous prenatal care and thus no established relationship with the medical providers

charged with counselling them about HIV testing. It would be difficult to imagine a population presenting more “barriers” to informed consent. Yet one year after PRTII began, the percentage of women accepting HIV testing rose from 86.7 to 97.1. By the middle of 2006, that percentage rose to 98.3. Similar results have been obtained in similar programs in other states, such as California.

In fact, contrary to the CDC’s and others’ interpretation that the U.S. perinatal testing experience demonstrates that informed consent prior to HIV testing is dispensable, perinatal transmission of HIV has been all but eliminated in this country⁷ with informed consent in most states. Data from the Perinatal Guidelines Project further supports the experience of Illinois — i.e., that the vast majority of women accept HIV testing if it is recommended by their health-care provider⁸ — and also strongly suggest that “opt-out” approaches that eliminate proof of consent can result in substantial numbers of women not even knowing whether they had been tested.⁹

The lesson is obvious. Nearly all people offered HIV testing in a thoughtful, careful way — even people in the midst of a medical trauma — accept the offer. The few who do not accept it typically have good reason not to at that particular time; skilled counselling could ensure they return to test when the time is right for them. State legislatures can be assured that there is no basis to abandon the fundamental legal right of patients to informed consent in order to make HIV testing more “routine.”

Other concerns

The CDC’s conclusion that it has the authority to recommend the abandon-

ment of a fundamental legal doctrine rests on other faulty assumptions. It mischaracterizes state HIV testing laws as dated responses to a past time when stigma and the lack of effective treatment warranted special pre-test counselling, proof of consent, and assurances of confidentiality.¹⁰ Such laws, the reasoning continues, are interfering with HIV diagnosis and prevention.¹¹ Some public health officials, particularly in New York City, have even insisted that such laws are a primary cause of racial disparities in HIV testing.¹²

This reasoning relies to a surprising extent on serious mischaracterizations of AIDS' short history of research on why some people delay HIV testing and doctors do not offer it, and of informed consent in general, a doctrine that emerged *prior* to the enactment of state HIV testing statutes.¹³ Authors who assert that informed consent consumes an excess of doctors' time and discourages patient testing do not offer supporting evidence for these arguments because there is none.¹⁴

The CDC's recommendation also ignores the fact that streamlined HIV testing, with rapid testing and counselling tailored to each individual's needs, has proven effective while retaining informed consent. New York City (a jurisdiction with a detailed state HIV counselling and testing law) recently reported a 63 percent increase in HIV testing in the year since streamlined counselling and rapid testing was implemented.

Citing this report, the continuing reality of stigma in hard-hit communities, and the unique nature of HIV, New York State Health Commissioner Dr. Antonia Novello, a former U.S. Surgeon General, recently rejected the CDC's recom-

mendation as unwise. In an op-ed, Dr. Novello argued that increased HIV testing must not occur at the expense of adding one more problem to those who, unaware of their status, or in denial about their behaviour, or in a situation where language barriers impede their comprehension, or in a situation where they fear violence or deportation, might not be able to cope with the newly acquired diagnosis.¹⁵ The protection of confidentiality and dignity of New Yorkers, as well as the assurance of care and freedom of choice, must be respected.¹⁶

Legal and ethical principles dictate that informed consent remain an integral element of HIV testing.

Some who support the CDC's position argue that it eliminates the "AIDS exceptionalism" that has been inconsistent with "traditional" public health laws.¹⁷ The tragedy of this position is that it privileges an antiquated notion of patient autonomy and consent predating modern civil rights understandings. State HIV testing and confidentiality laws, adopted more recently than infectious disease control statutes governing most other health conditions, do more than merely reflect the past and continuing reality of HIV stigma and its practical consequences. They incorporate the evolving understanding of a patient's right to information and autonomy in making treatment decisions, a right undermined by proposals for a reversion to the outdated

"doctor knows best — you don't need to know" approach.¹⁸

Conclusion

The late Dr. Jonathan Mann, a seasoned public health practitioner and the first director of the World Health Organization's Special Program on AIDS, pioneered the principle that human rights are integral to advancing public health.¹⁹ The legacy of Dr. Mann, considered one of the most important figures in the 20th century fight against global disease and social injustice, still serves as a powerful refutation of the current fashion of pitting human rights *in opposition* to public health principles.²⁰

Legal and ethical principles dictate that informed consent remain an integral element of HIV testing.²¹ While the CDC's new guidelines may appear to serve physician convenience in the short term, they may also expand physician liability exposure²² while accommodating the eroded quality of care associated with the shift to managed care.²³ With most patients confronting multiple forms at every health care encounter, it is ironic that the one form relevant to protecting their autonomy is the one that health care providers purportedly find burdensome, particularly when there are multiple creative, effective ways to secure informed consent for HIV testing that involve little provider time.

— Ann Hilton Fisher, Catherine Hanssens
and David I. Schulman

Ann Hilton Fisher (ann@aidslegal.com) is Executive Director of the AIDS Legal Council of Chicago. Catherine Hanssens is Executive Director of the Center for HIV Law and Policy in New York. David L. Schulman is a Supervising Attorney

in the AIDS/HIV Discrimination Unit, Los Angeles City Attorney's Office. The authors wish to thank Michael Pates, Director, American Bar Association AIDS Coordination Project, for his editing and research assistance.

Editor's Note: See also "Routine HIV testing: three perspectives" in the AIDS 2006 Supplement in this issue.

update/EI%20Diario.pdf.

³ AMA, Office of the General Counsel, Division of Health Law, "Informed Consent," <http://www.ama-assn.org/ama/pub/category/4608.html>.

⁴ *Ibid.*

⁵ See, e.g., G.M. Herek, J.P. Capitanio and K.F. Widaman, "Stigma, social risk, and health policy: public attitudes toward HIV surveillance policies and the social construction of illness," *Health Psychology* 22, 3 (2004): 533–540. At http://psychology.ucdavis.edu/rainbow/html/health-psych2003_pre.PDF.

⁶ *Morbidity and Mortality Weekly Report (MMWR)* 50, RR-19 (2001). At www.cdc.gov/mmwr/PDF/RR/RR5019.pdf.

⁷ See, e.g., T.R. Frieden et al., "Applying public health principles to the HIV epidemic," *New England Journal of Medicine* 353 (2005): 2397–2402, p. 2399.

⁸ M.I. Fernandez et al., "Acceptance of HIV testing during prenatal care," *Public Health Reporter* 115 (2000): 460–468.

⁹ Centers for Disease Control and Prevention, "HIV testing of pregnant women — United States and Canada, 1998–2001," *MMWR* 51 (2002): 1013–1016.

¹⁰ See L.O. Gostin, "HIV screening in health care settings — public health and civil liberties in conflict?," *Journal of the American Medical Association*, 296 (2006): 2023–2025; New York Department of Health and Mental Hygiene, *Memorandum in Support of Proposed Legislation, "An Act to Amend the Public Health Law, in Relation to Improving the Care of Persons Living with HIV/AIDS."* At www.nyc.gov

[html/doh/downloads/pdf/ah/ah-memo-support.pdf](http://doh/downloads/pdf/ah/ah-memo-support.pdf).

¹¹ L.O. Gostin.

¹² New York Department of Health.

¹³ See B.L. Atwell, "The modern age of informed consent," *University of Richmond Law Review* 40, 591 (2006).

¹⁴ See, e.g., L.O. Gostin.

¹⁵ See New York State Health Commissioner.

¹⁶ *Ibid.*

¹⁷ See R. Bayer and A.L. Fairchild, "Changing the paradigm for HIV testing — the end of exceptionalism," *New England Journal of Medicine*, 355, 7 (2006): 647–649.

¹⁸ See, e.g., B.L. Atwell.

¹⁹ See, e.g., www.globalhealth.org/view_top.php?id=238.

²⁰ But see L.O. Gostin, Gostin characterizes the "civil rights paradigm that informed AIDS policy" as something distinct from "public health strategy," and argues that a continued focus on human rights seems unjustified in view of scientific and social developments over the last decade.

²¹ E. B. Cooper, "HIV disease in pregnancy: ethics, law and policy," *Obstetrics and Gynecology Clinics of North America* 24 (1997): 899–910.

²² See, e.g., AMA.

²³ P. Salgo, "The doctor will see you for exactly seven minutes," *New York Times*, op ed, 22 March 2006.

¹ B.M. Branson et al., "Revised recommendations for HIV testing of adults adolescents, and pregnant women in health-care settings," *MMWR Rec. Rep.* 55, RR-14 (2006): 1–17.

² New York State Health Commissioner Dr. Antonia Novello recently emphasized, in response to the CDC's release of its new testing guidelines, that general consent for a medical exam is not the same as the consent required prior to HIV testing, and that written consent provides important protections for high-risk groups such as women and youth. See www.hwadvocacy.com/

CANADIAN DEVELOPMENTS

This section provides brief reports of developments in legislation, policy, and advocacy related to HIV/AIDS in Canada. (Cases before the courts or human rights tribunals in Canada are covered in the section on HIV in the Courts – Canada.) The coverage is based on information provided by Canadian correspondents or obtained through scans of Canadian media. All of the articles for this section were written by David Garmaise, the editor of Canadian Developments, and Glenn Betteridge, Senior Policy Analyst at the Canadian HIV/AIDS Legal Network. Address correspondence to David Garmaise at dgarmaise@rogers.com. Glenn Betteridge can be reached at gbetteridge@aidslaw.ca.

Supervised injection facility granted time-limited extension

The long-term fate of Insite, Vancouver's supervised injection facility, remains in doubt. The federal government granted a 16-month renewal of Insite's exemption under Section 56 of the *Controlled Drugs and Substances Act*, but refused to grant the three-year exemption Insite was seeking. The government said that more information is needed on whether Insite has been successful, despite a slew of scientific studies that have demonstrated Insite's value in terms of both health and public safety.¹

Insite opened its doors in September 2003, following an intensive campaign by activists. The British Columbia government provided start-up funding and continues to provide operating funding through the

Vancouver Coastal Health Authority. On 1 September 2006, only 12 days before Insite's Section 56 exemption under was set to expire, the federal government announced a new exemption to 31 December 2007.²

In announcing the new exemption, Health Minister Tony Clement said that before a decision could be made on a three-year exemption, additional studies would have to be conducted on how supervised injection sites

affect crime prevention and treatment. He added:

Do safe injection sites contribute to lowering drug use and fighting addiction? Right now the only thing the research to date has proven conclusively is drug addicts need more help to get off drugs.... Given the need for more facts, I am unable to approve the current request to extend the Vancouver site for another three-and-a-half years.³

Clement said that additional studies will be conducted into how supervised injection facilities affect crime, prevention and treatment. Clement also said that the federal government would accelerate the launch of a new national Drug Strategy (NDS) and that Health Canada will not entertain any applications for the establishment of additional injection sites in other parts of Canada until the NDS is in place and the review of Insite is complete.⁴

During the last election campaign, Conservative Party leader Stephen Harper promised to shut Insite down. The government decision to allow Insite to continue (if only temporarily) followed tremendous pressure from activists, community groups, drug users themselves, academics, editorialists and certain politicians — and a significant amount of media coverage generated by the campaign to keep Insite going.

In July 2006, nine national AIDS NGOs sent a letter to Minister Clement asking him to allow Insite to continue its life-saving work. The letter pointed to the impressive body of peer-reviewed research demonstrating that Insite had reduced risk behaviours for HIV and hepatitis C transmission, reduced drug injection in public places, prevented overdose

deaths, steered people who use drugs into treatment, and had not led to an increase in drug use.⁵

The letter asked the Minister to use the International AIDS Conference in Toronto in August 2006 (AIDS 2006) to “recognize the remarkable achievements of Insite” and to make an announcement ensuring its continuation.⁶

The federal government’s indecision “flies in the face of internationally recognized, peer-reviewed evidence.”

When it appeared that no announcement was forthcoming at AIDS 2006, on August 15 the Legal Network held a news conference at AIDS 2006 to call on the federal government to make a decision based on evidence and not ideology, and to keep Insite alive.⁷ To highlight the urgency of the situation, the Legal Network was joined by an expert panel of speakers including Dr. Julio Montaner, Director of the British Columbia Centre for Excellence in HIV/AIDS and president-elect of the International AIDS Society, Diane Tobin of the Vancouver Area Network of Drug Users, and Gillian Maxwell of Insite for Community Safety.

When Minister Clement announced that the government would only grant Insite a 16-month exemption, four national NGOs issued a statement saying that the

federal government’s indecision “flies in the face of internationally recognized, peer-reviewed evidence.”⁸

Statistics compiled by the Insite over a two-year period ending 31 March 2006 show there was an average of 607 visits a day to the clinic, and that 453 addicts overdosed at the clinic — but with no deaths because of the trained staff. There were also 4083 counselling referrals during the two-year period, including about 1600 referrals to addiction counselling.⁹

Comment

The fact that Minister Clement is seeking more information on whether Insite contributes to lower drug use and fighting addiction is troubling. There is already evidence that Insite has facilitated entry into drug treatment programs. But, more significantly, Insite’s primary purpose was never to get people off drugs. Rather it was designed to reduce the harms from injection drug use by reducing public disorder, overdoses, deaths, emergency room visits and needle sharing. Insite was seen as one element in a four-pillar strategy to address drug use (prevention, enforcement, harm reduction and treatment). By requiring Insite to “break the cycle of dependency,”¹⁰ the Conservative government seems to be setting Insite up for failure.

— David Garmaise

¹ “B.C. injection site to continue operating, for now,” *CBC News* (online), 5 September 2006.

² Health Canada, “No new injection sites for addicts until questions answered says Minister Clement,” news release, Ottawa, 1 September 2006. At www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_85_e.html.

³ *Ibid.*

⁴ *Ibid.*

⁵ The NGOs were the Canadian HIV/AIDS Legal Network, the Canadian AIDS Society, the Canadian AIDS Treatment Information Exchange, the Canadian Aboriginal AIDS Network, the Canadian Working Group on HIV and Rehabilitation, the Canadian Treatment Action Council, the Canadian HIV Trials Network, the Canadian HIV/AIDS Information Centre (Canadian Public Health Association) and the Interagency Coalition on AIDS and Development. A copy of the letter is available via www.aidslaw.ca/drugpolicy. For examples of the results of peer-driven research on Insite, see G.

Betteridge, "Two recently published articles report on the positive impact of Insite on drug use among people who inject drugs," *HIV/AIDS Policy & Law Review* 11, 1 (2006): 19–20; D. Garmaise, "Safe injection facility attracts high-risk injection drug users, study finds," *HIV/AIDS Policy & Law Review* 10, 3 (2005): 18; G. Betteridge, "First evaluation of Vancouver safe injection facility," *HIV/AIDS Policy & Law Review* 10, 2 (2005): 20.

⁶ *Ibid.*

⁷ See Canadian HIV/AIDS Legal Network, "Harper needs

hard dose of reality," news release, Toronto, 15 August 2006.

⁸ Canadian HIV/AIDS Legal Network, Canadian AIDS Treatment Information Exchange, Canadian Aboriginal AIDS Network, and Canadian Working Group on HIV and Rehabilitation, "Health Minister's indecision on Insite ignores scientific evidence," news release, Toronto, 2 September 2006.

⁹ "B.C. injection site."

¹⁰ Health Canada.

Federal prison guards call for power to test prisoners for HIV

The union representing federal prison guards is lobbying the government to amend the *Corrections and Conditional Release Act (CCRA)*¹ to permit prison staff to apply for orders to test prisoners for HIV and the hepatitis B and C viruses. This article summarizes the union's proposal and the Legal Network's response.

Proposed amendment to the CCRA

In January of 2006, it was reported that the Union of Canadian Correctional Officers (UCCO) was lobbying Public Safety Minister Stockwell Day for legislation to permit the forced testing of prisoners in Correctional Service Canada (CSC) institutions for infectious diseases such as HIV and hepatitis.² The proposal seeks to amend the CCRA to permit the forced testing of prisoners in two distinct situations: (1) in the event of an occupational exposure of a staff member to the bodily substance of a prisoner; and (2) preemptively, where there is a significant risk that a staff member might come in contact with the bodily substances of a particular prisoner.

The proposal would permit a CSC staff member to apply to a justice of the peace or provincial court judge for a warrant authorizing the taking of a sample of blood from a prisoner.³ Before the justice or judge can issue a warrant, he or she must have reasonable grounds to believe that a number of conditions have been met.⁴ The proposal identifies procedures to be followed and legal duties arising in the execution of a warrant, and contains provisions which prohibit the use of the blood sample and results of its analysis for purposes other than that for which they were obtained.⁵

Legal Network's response⁶

In its submissions to Minister Day, the Legal Network took the position that

legislation authorizing the forced testing of people for HIV (i.e., without a person's informed consent) does not represent an appropriately balanced policy response to the issue of prison guards' potential or actual occupational exposures to HIV. Forced testing legislation remains a flawed approach that does not adequately respect and protect human rights. Moreover, the section of the proposal that permits forced testing in the absence of an occupational exposure is without precedent in Canadian law.

In particular, the Legal Network argued that the forced testing of prisoners under the proposal is an unjustifiable infringement of prisoners' constitutional rights to privacy and to be secure against an unreasonable search and seizure. The proposal also

raises serious concerns about the privacy of prisoner's medical information, once known, and the potential for discriminatory treatment of prisoners known to staff to be living with HIV or hepatitis B or C. Moreover, in light of CSC's existing protocol for responding to exposure to blood and bodily fluids, forced testing is unnecessary.⁷ There is no evidence that the existing protocol is ineffective or

does not adequately protect the occupational health and safety of CSC staff. Nor is there any evidence that the proposal, if it became law, would result in increased workplace safety for CSC staff. The Legal Network concluded that the Government of Canada should not introduce or support forced testing legislation applicable to federal prisoners.

– Glenn Betteridge

¹ S.C., 1992, c.20.

² K Harris, "Jailers seek safeguards," *Ottawa Sun*, 30 April 2006, p. A4; J Pursaga, "Convicts attack with nasty bodily fluids," *Winnipeg Sun*, 7 May 2006, p. A3.

³ UCCO proposal, s. 57.01(2). On file with the author.

⁴ *Ibid.*, s. 57.03(1).

⁵ *Ibid.*, ss. 57.08(3), 57.09, 57.10.

⁶ Canadian HIV/AIDS Legal Network, *Legislation to Authorize Forced Testing of Federal Prisoners for HIV: An Unjustified Violation of Human Rights*, October 2006. Available via www.aidslaw.ca/prisons.

⁷ CSC, *Managing Exposure to Blood and/or Body Fluids*, Commissioner's Directive 821-1 (24 March 2004).

Sex workers: report goes *Beyond Decriminalization*

A new report examines the legislative and regulatory reforms that would be required to protect sex workers in the event that the adult sex industry is decriminalized.¹

The 229-page report from Pivot Legal Society in Vancouver, entitled *Beyond Decriminalization: Sex Work, Human Rights and a New Framework for Law Reform*, examines how employment and labour standards can be used to provide rights and protections for workers in the sex industry. The report also examines other areas of the law where reforms would be required, including municipal, employment, social welfare, tax, company, human rights, immigration and family.

The report presents the results of two years of research and in-depth discussions with 84 sex workers from various parts of the sex industry in Vancouver, Calgary and Edmonton.

Pivot's 2004 report, *Voices for Dignity*, called for the complete decriminalization of adult prostitution in order to reduce harm to sex workers and protect their human rights.² That report showed how current prostitution laws marginalize sex workers and produce high levels of violence, exploitation and discrimination.

Beyond Decriminalization presents a series of recommendations for what the report calls a sex workers "call to action." The recommendations include the following:

- Sex workers should be provided with full access to the rights and protections found in the

Employment Standards Act;

- The law must protect sex workers' right to maintain control over their contracts for the provision of sexual services.
- Sex workers should have the right to unionize.
- Sex workers should be involved in a meaningful way in municipal governance issues, such as business licensing and city zoning.
- Sex workers should have fair and equal access to workers' compensation, employment insurance and other employment benefits.
- Sex workers should be free to choose from a range of business structures.

- A parent's involvement in sex work should not automatically create grounds for the apprehension of a child or loss of custody.
- Migrant sex workers should be afforded the rights and protections found in the *Canadian Charter of Rights and Freedoms*.

The report argues that because they have a unique insight and expertise

regarding their industry, sex workers must be given a prominent role in the process of law, policy and social reform.

Pivot says that *Beyond Decriminalization* is the beginning of an important social dialogue about the role that the law will play in governing the sex industry in Canada.

– David Garmaise

¹ Pivot Legal Society, *Beyond Decriminalization: Sex Work, Human Rights and a New Framework for Law Reform*, 2006. Available via www.pivotlegal.org/Publications/reports.htm.

² Pivot Legal Society, *Voices for Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws*, 2004. Available via www.pivotlegal.org/Publications/reports.htm. See also, G. Betteridge, "Reports call for end to harms caused by Criminal Code prohibitions surrounding prostitution," *Canadian HIV/AIDS Policy & Law Review* 9,2 (2004): 22–23.

Medical marijuana: CAS releases report, government cuts research funding

In June 2006, the Canadian AIDS Society (CAS) released a comprehensive report with recommendations to overcome barriers to the use of cannabis for medical purposes faced by people living with HIV/AIDS in Canada.¹ On 25 September 2006, as part of package of spending cuts, the federal government announced plans to eliminate its marijuana medical research program.²

CAS report

The CAS report was the product of extensive consultation with people living with HIV/AIDS as well as interviews with stakeholders, including national organizations representing people living with HIV/AIDS, government and researchers. The report takes as the starting point for its legal and policy analysis the Charter section 7 right to "security of the person" and the federal program established under the *Marihuana Medical Access Regulations* (MMAR).³

The MMAR were intended to provide people in need with a means

to legally produce and possess marijuana for medical purposes. Among those consulted for the report, between 14 to 37 percent of people used cannabis for symptomatic management of appetite loss, wasting, nausea, vomiting, pain, anxiety, depression and stress. However, the vast majority of users (74 percent) reported that they were not legally authorized to do so under the federal program.

The report highlights a number of problems with the MMAR. Currently the options for legally obtaining marijuana under the

MMAR are limited — a person authorized to possess marijuana can grow it for him or herself, designate another person as a grower, or obtain it from the government source. The report also points to a lack of awareness and misinformation about the MMAR, problems with the application and renewal processes, and the reluctance of physicians to complete applications for patients.

The report's recommendations call for increased generation and dissemination of accurate and up-to-date information regarding medical marijuana. The report calls on scientists,

the Canadian Institutes for Health Research (CIHR) and Health Canada to undertake and facilitate research into medical marijuana with a view to obtaining approval of the drug and ultimately enabling physician prescription of marijuana.

Funding cut

The federal government announced a \$4 million cut to the CIHR medical marijuana research program, effec-

tively terminating funding for any new research under the program, and for the Expert Advisory Committee on Marijuana for Medical Purposes, which was responsible for the ongoing review of scientific evidence to inform the MMAR. Numerous organizations have spoken out against the cut.⁴

– Glenn Betteridge

¹ CAS, *Cannabis as Therapy for People Living with HIV*

AIDS: "Our Right, Our Choice," June 2006. Available via www.cdnaids.ca.

² Department of Finance, "Canada's New Government cuts wasteful programs, refocuses spending on priorities, achieves major debt reduction as promised," Background: Effective Spending, Ottawa, 26 September 2005. At www.fin.gc.ca/news06/06-047e.html.

³ See CAS, *Cannabis as Therapy*, pp. 17–24, for the legal basis of medical marijuana in Canada.

⁴ See e.g., CAS, "Cuts to medical marijuana research affect the health of one million Canadians," 27 September 2006; Registered Nurses Association of Ontario, "Open letter to Prime Minister Harper: Ontario's nurses condemn cuts to social programs," 28 September 2006; "What are they smoking?," *National Post*, 14 October 2006, p. A16.

In brief

BCPWA files complaint against police disclosure of HIV status

Since the last issue of the *Review*, police in a number of Canadian cities have issued public media advisories disclosing the HIV status of people suspected of having sexual intercourse without disclosing their HIV status to partners. On 21 March 2006, the Vancouver Police Department issued such an advisory concerning a 28-year-old HIV-positive male charged with two counts of aggravated sexual assault. The advisory included two photos of the male and alleged that he denied his HIV-positive status to two men with whom he had sex.

While the facts of the case and content of the police-issued media advisory are familiar, the community response was not. In a letter to

Vancouver Mayor Sam Sullivan dated 15 June 2006, Derek Bell, Secretary of the Board of the British Columbia Persons With AIDS Society (BCPWA) complained of the police disclosure. He wrote: "On behalf of the ... BCPWA I respectfully submit that no consideration of public safety sufficient to outweigh Mr. [X's] reasonable expectation of privacy as regards the confidential nature of his HIV-positive status obtained in this instance."¹

The letter pointed out the seriousness of the disclosure "because HIV stigma and consequent discrimination are still very real and destructive features of Canadian society." BCPWA called on Mayor Sullivan to put in place a policy to limit police disclosure of HIV status to situations where there is ongoing risk to the public.

– Glenn Betteridge

Toronto: Cracking down on crack pipes

On 13 February 2006, the *Globe and Mail* reported that members of the Toronto Police Service (TPS) had confiscated and destroyed personal possessions, including crack pipes, of people who use illegal drugs.² The activities were linked to the TPS's TAVIS initiative (budget: \$5 million), under which three 18-officer teams intensively patrol Toronto's most high-risk neighbourhoods.

In response to the report, Joanne Csete, Executive Director of the Canadian HIV/AIDS Legal Network, wrote a letter of complaint to TPS Chief William Blair.³ Csete wrote: "We are concerned by any reports suggesting that this new initiative will become another excuse to crack down on people who use drugs, many of whom are already among

society's most marginalized and vulnerable."

The letter questioned the authority of the TPS officers to destroy personal property and expressed concern that seizure of personal items such as crack pipes undermine public health, given the increased risk of HIV transmission associated with sharing crack pipes. The letter called for Chief Blair to investigate the matter and to take a leadership role in ensuring that policing activities are consistent with the harm reduction measures adopted in the Toronto Drug Strategy.⁴

The only response from the TPS was an acknowledgement indicating that the complaint had been forwarded to the unit commander for attention.

– Glenn Betteridge

Conditional sentences to be abolished for some drug offences

During the 2006 federal election, the Conservative Party's platform included a promise to introduce mandatory minimum sentences for certain serious crimes and to abolish conditional sentences (i.e., a non-custodial sentence) for some crimes.⁵

On 4 June 2006, the Conservative Government introduced Bill C-9, *An Act to Amend the Criminal Code (conditional sentence of imprisonment)*. The Bill removes the possibility of a conditional sentence where a person is found guilty of an offence "prosecuted by way of indictment for which the maximum term of imprisonment is ten years or more." Generally, indictable offences are more serious criminal offences, contrasted with summary conviction offences.

The Bill would not apply to simple possession of illicit drugs, but would apply to people convicted of trafficking and possession for the purpose of trafficking.

The Canadian HIV/AIDS Legal Network has argued that mandatory incarceration for certain drug offences is bad public policy.⁶ Increasing incarceration rates among drug users may exacerbate the HIV epidemic in Canada and may be a violation of the human rights of people who suffer from drug addiction. The Legal Network also noted that mandatory minimum sentences for drug offences have been in place in the United States for some time and there is no evidence that they have reduced drug-related crime or problematic drug use.

After several days of hearing before the Standing Committee on Justice and Human Rights, the Bill, with minor amendments, is to be sent back to the House of Commons for third reading. It will likely receive approval of the House.

– Glenn Betteridge

Health services, including needle exchange, key issue for Correctional Investigator

In his 2005-2006 Annual Report to the federal Minister of Public Safety, the Correctional Investigator identifies six key issues, one of which is health services, including mental health and needle exchange.⁷

The Correctional Investigator is the legislatively-mandated, independent ombudsperson responsible for investigating complaints of fed-

eral prisoners in Canada. For the Correctional Investigator, the failure of the Correctional Service Canada (CSC) to have its health services accredited by an independent internationally-recognized agency raises questions about whether such services meet "professionally accepted standards" as is required under the *Corrections and Conditional Release Act*.⁸ His assessment of mental health services is categorical — CSC is failing to provide essential mental health care and reasonable access to non-essential mental health care.

The Annual Report cites the report of the 1994 Expert Committee on AIDS in Prisons, commenting that the only outstanding recommendation in the report regarding education, treatment and harm reduction relates to the absence of needle exchange programs. Accordingly, the Correctional Investigator "recommend[s] that the Correctional Service immediately implement a prison-based needle exchange to ensure that inmates and society at large are best protected from infectious disease."⁹

Correctional Service Canada, in its response, signals that it is not seriously considering introducing prison needle exchange. Rather, its priority is on supply reduction: "CSC's immediate focus is to curtail the supply, use and impact of drugs in institutions while recognizing that additional efforts and resources will be required over time in the area of prevention, treatment, enforcement and harm reduction."¹⁰

The Correctional Investigator had previously recommended that CSC introduce needle exchange.¹¹

– Glenn Betteridge

CSC closes safer tattoo pilot sites

As reported previously, Correctional Services Canada (CSC) put in place in six prisons a safer tattooing pilot program.¹² The program was scheduled to start in April of 2005 and last until 31 March 2006. None of the sites started on time. All sites were closed down effective 30 September 2006. Earlier in the year, it had been reported that the Canadian Government was considering closing the pilot projects.¹³ CSC is expected to release a report evaluating the pilots.

– Glenn Betteridge

Sex worker group receives human rights award

Stella, a Montréal-based support and information group organized by and for sex workers has won the 2006 Canadian Award for Action on HIV/AIDS and Human Rights.

The awards were established in 2002 by the Canadian HIV/AIDS Legal Network and Human Rights Watch to highlight outstanding contributions that decrease vulnerability to HIV/AIDS and protect the rights and dignity of those infected and affected.

Stella serves women, transvestites and transsexuals, and maintains an ongoing presence in sex work venues, including streets, escort agencies, massage parlours and strip bars. The award recognized Stella's courageous work of over a decade defending sex workers' human rights and advocating against the criminalization of their lives and livelihood.

For further information, see www.aidslaw.ca/awards.

Lifetime ban on blood donations from gay men to continue

The [Montreal] Gazette reported in March 2006 that both the Canadian Blood Services and Héma-Québec say that they have no plans to rescind the lifetime ban on blood donations from any man who has had sex with another man since 1977.¹⁴

This is in spite of arguments that the ban is excessive because of better testing and screening procedures; and in spite of the fact that the three major blood collection agencies in the U.S. — the American Red Cross, American Association of Blood Banks, and American Blood Centres — recommended in March 2006 that the ban be reduced to a year after a man has had sex with another man.

The U.S. Food and Drug Administration, which sets policy in this area, is to formally reconsider its position this year.

David Page, of the Canadian Hemophiliac Society, whose members depend on regular blood transfusions, noted that hemophiliacs and their spouses are also not permitted to donate blood. Page said that historically the gay community is more at risk of blood-borne transmission of infection. He also said that the incidence of sexually transmitted diseases and HIV infection among gay men has increased in the past few years.

Page added that even if the ban is reduced to 12 months, "the vast majority of gay men would be deferred anyway."

In Canada, any new policy would have to come from Health Canada, which regulates blood and plasma collection in Canada and approves donor-screening criteria.

– David Garmaise

Some AIDS 2006 delegates claim refugee status

Up to 150 delegates who attended the XVI International AIDS Conference in Toronto in August 2006 (AIDS 2006) have stayed behind and have filed refugee claims. Most of the claimants are HIV-positive and are from some of the countries hardest hit by AIDS.¹⁵

Francisco Rico-Martinez, of the FCJ Refugee Centre in Toronto, said that many of the claimants face discrimination and are treated as outcasts in their native countries.¹⁶

"There's no entitlement to stay in Canada based on the fact that you have HIV-AIDS, even if the consequences of turning you away mean ... you will die from lack of medical attention," said Janet Dench, executive director of the Canadian Council for Refugees. "You have to show that you're being persecuted because of your HIV status."¹⁷

Many of the claimants are staying at Toronto hostels awaiting hearing dates before an immigration board. Melissa Anderson, of the Immigration and Refugee Board, said that it will take about a year to rule on the cases. She said that about 48 percent of all claimants are accepted as refugees. Of the 24 000 people who attended AIDS 2006, about 14 000 were from outside North America.¹⁸

– David Garmaise

¹ Copy of letter on file with author.

² T. Appleby, "New police strategy designed to blanket high-violence areas," *Globe and Mail*, 13 February 2006.

³ Available via www.aidslaw.ca/drugpolicy.

⁴ For more information, see G. Betteridge, "Toronto City Council adopts drug strategy," *HIV/AIDS Policy & Law Review* 11, 1 (2006): 21–22.

⁵ Conservative Party of Canada, *Stand up for Canada: Conservative Party of Canada Election Platform 2006*. Available via www.conservative.ca/.

⁶ Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses*, April 2006; *Misleading and Misguided: Mandatory Incarceration for Certain Drug Offences*, 26 September 2006. Both documents are available via www.aidslaw.ca/drugpolicy.

⁷ Office of the Correctional Investigator, *Annual Report of*

the Office of the Correctional Investigator 2005-2006, 2006. At www.oci-bec.gc.ca/reports/AR200506_e.asp#HealthServices.

⁸ S.C., 1992, c.20.

⁹ Office of the Correctional Investigator, p. 9.

¹⁰ *Ibid.*, p. 39.

¹¹ Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2003-2004*, 2004.

¹² G. Betteridge, "Safer tattooing piloted in six federal prisons," *HIV/AIDS Policy & Law Review* 10, 2 (2005): 15.

¹³ See, e.g., K. Harris, "Feds could wipe out jail tattoo par-

lours," *Calgary Sun*, 26 June 2006, p. 7; J. Tibbetts, "Tories might scrap prison tattoo parlours," *National Post*, 11 July 2006, p. A7.

¹⁴ I. Block, "Hema-Quebec won't reconsider blood ban: homosexual men can't donate," *The [Montreal] Gazette*, 21 March 2006, p. A7.

¹⁵ T. Godfrey, "AIDS stay-behinds: up to 150 delegates to last month's T.O. conference have filed refugee claims," *Toronto Sun*, 1 September 2006, p. 2.

¹⁶ *Ibid.*

¹⁷ M. Jacobs, "Trying to sort out the real refugees," *Edmonton Sun*, 7 September 2006, p. C11.

¹⁸ T. Godfrey.

INTERNATIONAL DEVELOPMENTS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. (Cases before the courts or human rights tribunals are covered in the section on HIV in the Courts – International.) We welcome information about new developments for future issues of the *Review*. Readers are invited to bring cases to the attention of Richard Pearshouse, editor of this section at rpearshouse@aidslaw.ca.

Cameroon: UN group finds detention of gay men a violation of human rights

In an opinion issued on 11 October 2006, the United Nations Working Group on Arbitrary Detention declared that the detention of 11 men in Cameroon on the basis of their presumed sexual orientation constituted an arbitrary deprivation of liberty and a violation of the principle of equal protection of the law. The Working Group called on the Cameroonian government to “examine the possibility of amending the legislation” criminalizing homosexual sex.¹

In late May 2005, police arrested a number of people at a nightclub believed to be frequented by gays and lesbians in Yaoundé, the capital of Cameroon. Of those arrested, 11 men were detained on suspicion of offences criminalizing homosexual sex, and an investigation commenced.

In Cameroon, sexual relations between members of the same sex are an offence punishable by up to five years in prison.²

In March 2006, more than seven months after their arrest, two of the detained were released for a lack of evidence. When the trial eventually

began on 17 March 2006, the prosecution was ill-prepared and presented no witnesses. The judge postponed the trial until 21 April 2006. Again, the prosecution produced no witnesses or evidence of the charges. The remaining nine men were then acquitted for lack of evidence.

However, despite this judgment, the Prosecutor's Office refused to order their release. The nine men were tried before a different tribunal. In a decision dated 12 June 2006, this tribunal ordered the release of two of the men and found the remaining seven guilty. The seven were condemned to 10 months prison. They were released shortly after the judgment as they had already spent over 12 months in pre-trial detention.

The guilty verdicts were criticized by civil society groups, because a conviction under the Penal Code requires being apprehended or witnessed in the very act of the crime or shortly afterwards.³ In this case, the men were arrested while drinking in a bar.

One of the detained men, Mr. Alim Mongoche, died in the week following his release as a direct result of the conditions endured in prison.

In its communication to the government of Cameroon, the Working Group stated that

the existence of laws which criminalize private homosexual relationships between consenting adults, as well as the application of penalties against these persons, violates the protection of private life and non-discrimination established by the International Covenant on Civil and Political Rights. Consequently, the Working Group considers that the criminaliza-

tion of homosexuality established in the penal legislation of Cameroon is incompatible with articles 17 and 26 of the International Covenant on Civil and Political Rights.⁴

The case was also raised before the African Commission on Human and People's Rights in May 2006.⁵

The criminalization of private homosexual conduct violates the right to privacy and non-discrimination in the International Covenant on Civil and Political Rights (ICCPR), according to a 1994 decision by the United Nations Human Rights Committee.⁶ Cameroon acceded to the ICCPR in 1984.

The case is representative of widespread discrimination, abuse and marginalization of gays and lesbians in Cameroon, where political and religious leaders often associate homosexuality with corrupt Western values. Observers note that in the last year some 30 young people, mainly girls, have been expelled from their academic institutions on suspicion of same sex behaviour.⁷ Cameroonian tabloids have engaged in a campaign to "out" businessmen, politicians, musicians and sports stars.⁸ More than 50 individuals have been named by three newspapers. The lists have been condemned by one of those named, the communications minister Pierre Moukoko

Mbonjo, who said that "[w]hether heterosexual or homosexual, sexual intercourse takes place in an intimate environment between two persons."⁹

— Richard Pearshouse and Alana Klein

Alana Klein (aklein@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

¹ UN Working Group on Arbitrary Detention, Opinion No.22/2006, 31 August 2006 at para. 24.

² *Cameroon Penal Code*, Art. 347, provides "Whoever has sexual relations with a person of the same sex shall be punished with imprisonment for from six months to five years and a fine of from 20,000 to 200,000 francs [CAN\$ 42–420]."

³ International Gay and Lesbian Human Rights Commission, "Cameroon: Justice subverted as seven men convicted on sodomy charges," news release, New York, 13 June 2006.

⁴ UN Working Group at para. 20.

⁵ International Gay and Lesbian Human Rights Commission.

⁶ *Toonen v. Australia* (1994) UN Doc CCPR/C/50/D/488/1992.

⁷ International Gay and Lesbian Human Rights Commission.

⁸ "Des journaux camerounais font chasse aux homosexuels," *Le Monde*, 6 February 2006; A. Meldrum, "50 public figures named in gay witchhunt by Cameroon's papers," *The Guardian*, 6 February 2006.

⁹ A. Meldrum.

Russian Federation: NGO law creates difficulties for human rights organizations

On 10 January 2006, amendments were adopted to the law of the Russian Federation on NGOs.¹ The amendments establish a new procedure for re-registration of both domestic and foreign NGOs working in the Russian Federation.

The amended law came into force on 18 April 2006. Foreign NGOs had a six-month period (which expired on 18 October 2006) to renew their registrations. (Domestic NGOs were required to register at a later date.) In the re-registration process, the law required foreign NGOs to submit information, including passport numbers and home addresses of founding members of the parent organization and all founding documents, to the Russian Federal Registration Service. According to the Chief State Registrar, those foreign NGOs that had not yet been entered into the register by the deadline cease "to have legal validity on the territory of the Russian Federation" and will be compelled "to suspend their principal activity aimed at fulfilling their objectives and tasks."²

Critics said that the law gives officials a free hand to harass charities and human rights groups it does not approve of.³ Under the amended law, each NGO must submit a detailed work plan for 2007 which could allow officials to follow and monitor their activities. NGOs will also

have to file quarterly financial reports on their activity. Domestic NGOs must inform the Federal Registration Service about all funding received from international and foreign donors, and must account for their expenditures.

According to the Chief State Registrar, 80 foreign NGOs have already been entered onto the register, another 72 are being examined, and the review of a further 25 organizations has been delayed for lack of sufficient documentation.⁴ Before the re-registration process began, estimates of the number of foreign NGOs working in Russia ranged from 200 to 500.⁵ According to some reports, many international human rights organizations did not receive a notification of re-registration or were not able to submit their documents in time. The foreign NGOs that have experienced problems with the re-registration process are primarily those with close contacts with Russian human rights organizations.⁶

– Leah Utyasheva

Leah Utyasheva (lutyasheva@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

¹ Federal law of the Russian Federation, January 10, 2006 # 18-FZ "On amending some legislative acts of the Russian Federation" amending Federal law of the Russian Federation, May 19, 1995 # 82-FZ "On non governmental organizations."

² News conference on procedure to re-register foreign non-profit organizations in Russia, *Interfax*, 16 October 2006. Available via www.fednews.ru.

³ A. Kortunov, "Russia's civil society at the crossroads: foreign donors face new challenges," *Russia Profile*, 18 October 2006.

⁴ I. Romanov, "Victims of the register: Justice Ministry starts pursuing NGOs 'working illicitly on the side,'" *Nezavisimaya Gazeta*, 19 October 2006.

⁵ J. Kilner, *Registration confusion for foreign NGOs in Russia*, Reuters, 18 October 2006. Available via <http://ru.today.reuters.com/news/default.aspx>.

⁶ I. Romanov.

U.S. Government Accountability Office criticizes PEPFAR

On April 4th 2006, the U.S. Government Accountability Office (GAO) released a report criticizing the administration of HIV/AIDS prevention funds from the President's Emergency Plans for AIDS Relief (PEPFAR). The report concluded that the U.S.-mandated requirement of abstinence promotion was hindering international HIV prevention efforts by limiting funding to other types of HIV-prevention programs.¹

Created in 2003, PEPFAR is a five-year, US\$15 billion aid program that provides funding for HIV/AIDS, tuberculosis and malaria to 15 "focus" countries. Administered by the Office of the U.S. Global Aids Coordinator (OGAC), PEPFAR funds are subject to the constraints of the "ABC" HIV prevention model (Abstain, Be Faithful, or use Condoms). By law, 33 percent of PEPFAR funds spent on prevention must be allocated to programs promoting abstinence and faithfulness. OGAC therefore requires that each recipient country follow this guideline.

The GAO report indicated that for many of the PEPFAR country teams, the ABC restrictions created challenges in their ability to respond to local "local epidemiology and cultural and social norms."² Some countries received exemptions, which allowed them to spend less on promoting abstinence and faithfulness. But because 33 percent of all PEPFAR prevention funding must be spent on programs promoting abstinence and faithfulness, this meant that the non-exempted countries were effectively required to spend more than the requisite 33 percent of their PEPFAR funds on such programs.

This has led to reduced spending on prevention of mother-to-child HIV transmission programs in nine

countries, as well as limited funding for care programs and prevention messaging to high-risk groups, such as people who inject drugs or commercial sex workers.³

Furthermore, according to the GAO report, ambiguities in OGAC's policies left two-thirds of the country teams uncertain how to integrate the ABC model. Various country teams were concerned about "crossing the line between providing information about condoms and promoting or marketing condoms" and thereby straying from promoting abstinence and faithfulness.⁴

The GAO report recommended that OGAC collect information from country teams to assess the impact of the abstinence-until-marriage funding restrictions on HIV prevention programs. It said that the collected information should be used by Congress to assess "the extent to which the spending requirement supports ... endorsement of both the ABC model and the strong abstinence-until marriage programs."⁵ The report also recommended that the one-third spending requirement be applied only to a portion of PEPFAR's funds.⁶

In response to the report, a statement by OGAC and the U.S. State Department reiterated their position that "ABC is the most effective, evi-

dence-based approach to sexual transmission of HIV infection," in which abstinence and faithfulness is balanced with HIV prevention through other means such as prevention of mother-to-child transmission programs.⁷ Studies from Zimbabwe and Kenya showing reduced HIV prevalence rates were cited as evidence that the ABC strategy is successful in HIV prevention and changing sexual behaviour.⁸

However, human rights and HIV/AIDS groups viewed the GAO report as illustrative of the shortfalls of the Bush administration's ABC policy.⁹ These groups maintained:

- that the emphasis placed on abstinence leaves condom use promotion a distant third in HIV prevention;
- that, in some circumstances, abstinence was being promoted through emphasizing the failure rates of condoms;
- that PEPFAR funds may not be used to provide information to youths fourteen and younger; and
- that the insistence in the PEPFAR guidelines that condom distribution should be limited to narrowly defined risk groups, such as commercial sex workers, creates stigma and discrimination against individuals who are highly vul-

nerable, and undermines the potential of such people to play a significant role in preventing HIV transmission.

U.S.-funded HIV prevention efforts are further hampered by the requirement that all recipients of U.S. HIV/AIDS funds pledge their opposition to commercial sex work and sex trafficking.¹⁰ This has led to U.S. funding being recently removed or suspended from several HIV prevention programs, such as those of the Brazilian National AIDS Commission (who refused to suspend their work with a sex workers' organization).¹¹

In January 2006, the U.S. pulled out of a contract to fund a joint BBC-Tanzanian HIV prevention campaign because the BBC World Service Trust refused to sign a pledge opposing

commercial sex work. The BBC felt that signing the pledge would limit its ability to do effective and non-judgmental prevention work.¹²

— Cheryl Robinson

Cheryl Robinson is a second year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro bono Students Canada.

¹ United States Government Accountability Office, *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief* [GAO-06-395], April 2006. Available via www.gao.gov/.

² *Ibid.*, p. 6

³ *Ibid.*, pp. 36–7.

⁴ *Ibid.* at p. 30.

⁵ *Ibid.* at p. 46.

⁶ *Ibid.*, p. 49.

⁷ "Response to the Government Accountability Office Report, Global Health: Spending Requirement Presents Challenges to HIV/AIDS Relief," 7 April 2006. Available via www.state.gov/.

⁸ *Ibid.*; see also S. Gregson et al., "HIV decline associated with behaviour change in eastern Zimbabwe." *Science* 311, 5761 (2006): 664–666.

⁹ See, for example, Global Aids Alliance, "US Government report shows Bush AIDS policy is unworkable," news release, Washington, 4 April 2006 (available via www.globalaidsalliance.org/); Advocates for Youth, *Improving U.S. Global HIV Prevention for Youth: A Critique of the Office of Global AIDS Coordinator's ABC Guidance*, August 2006.

¹⁰ The source of the anti-prostitution policy requirement is the *U.S. Leadership against HIV/AIDS, Tuberculosis and Malaria Act of 2003* which authorized the creation of PEPFAR. For previous coverage of this issue, see R. Schleifer, "United States: Challenges filed to anti-prostitution pledge requirement." *HIV/AIDS Policy and Law Review* 10, 3 (2005): 21–22.

¹¹ M. Reel, "Where Prostitutes Also Fight Aids," *Washington Post*, 1 March 2006.

¹² "BBC quits HIV-prevention campaign over USAID policy requiring pledge against commercial sex work," Kaiser Daily HIV/AIDS Reports, 24 January 2006.

India: Pressure increases on government to decriminalize homosexuality

Civil society groups, backed by a number of prominent Indians, have urged their government to drop a provision in the Indian penal code criminalizing homosexuality.¹

Section 377 of the *Penal Code* makes "carnal intercourse against the order of nature with man, woman or animal" punishable by 10 years imprisonment.² The provision dates from 1861 and British colonial legislation.

Although the provision is seldom used to prosecute consenting adults engaging in sex with members of the

same sex, according to a letter of protest sent by the groups,

the provision has been used to systematically persecute, blackmail, arrest and terrorize sexual minorities. It has spawned public intolerance and abuse, forcing tens of millions of gay and bisexual men and women to live

in fear and secrecy, at tragic cost to themselves and their families.³

The protest letter also considers it to be "especially disgraceful that section 377 has on several recent occasions been used by homophobic officials to suppress the work of legitimate HIV-prevention groups, leaving gay

and bisexual men in India even more defenceless against HIV infection.”⁴

Amongst those supporting the protest letter are author Vikram Seth and Nobel Prize winning economist Amartya Sen. Sen argues in his statement of support that “what has to be borne in mind is that whenever any behaviour is identified as a penalizable crime, it gives the police and law enforcement officers huge power to harass and victimize some people.”⁵

The National Aids Control Organization (NACO) has also supported the decriminalization of sex between members of the same sex, arguing that the ban is driving a high risk group underground and thereby holding back efforts to limit infections.⁶ The Additional Secretary and Director General of NACO, Sujatha Rao, said that meetings had been held with the home ministry discussing the abolition of the provision. According to Rao, HIV infection can only be successfully tackled among this high risk group if members of this group could come out in the open without having

to fear harassment. She described the provision as a “great restraint.”⁷

In a related development, in July 2006, a statement was filed by NACO with the Delhi High Court supporting the Naz Foundation, a New Delhi AIDS service organization, in demanding that section 377 be overturned because it violates the constitutional rights of sexual minorities.⁸ The case was initially rejected by the Delhi High Court on the grounds that the Naz Foundation did not suffer as a result of the law and therefore had no grounds to sue.⁹ However, the Supreme Court of India decided in February 2006 to send the case back to Delhi court to be reviewed on its merits.¹⁰

In May 2006, India was reported to have surpassed South Africa as the country with the highest number of individuals living with HIV in the world.¹¹ According to UNAIDS, 5.7 million Indians were living with HIV/AIDS, as of May 2006.¹²

– Liisa Seim

Liisa Seim is an exchange student at the University of Toronto Faculty of Law, and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ “Open letter against sec 377”, 16 September 2006. At www.openletter377.com.

² Section 377 of the *Indian Penal Code 1861*.

³ Open letter at para. i.

⁴ *Ibid.* at para. ii.

⁵ *Ibid.*

⁶ M. Williams, “Great and good call on India to scrap anti-gay law,” *Scotland on Sunday*, 17 September 2006.

⁷ “Govt working to repeal law against homosexuality,” *Rediff India Abroad*, 26 September 2006. At www.rediff.com/news/2006/sep/26gay.htm.

⁸ High Court of Delhi, Writ Petition (Civil) no.7455 of 2001, “Reply affidavit on behalf of respondent 4 and 5,” 17 July 2006.

⁹ R. Wockner, “Indian Supreme Court orders reconsideration of sodomy case,” *San Francisco Bay Times*, 16 February 2006.

¹⁰ Supreme Court of India, Civil appeal no 952 of 2006 (Arising out of S.L.P. (C) Nos. 7217–7218 of 2005).

¹¹ UNAIDS, *2006 report on the global AIDS epidemic*, May 2006.

¹² *Ibid.*

Developments in HIV/AIDS legislation

Vietnam

In June 2006, Vietnam adopted a new Law on Prevention and Control of HIV/AIDS to replace the Ordinance on Prevention and Control of HIV/AIDS (1996). The law is exceptional as an HIV/AIDS law in that it explicitly legalizes harm reduction interventions.¹

Although Vietnam’s National AIDS Strategy included harm reduction as a priority, the implementation of such programs has been made difficult by the lack of a legislative basis. The management of opioid addiction by opioid substitution treatment — a crucial HIV prevention intervention

in countries where the HIV epidemic is driven by injection of illegal drugs — was especially controversial.

According to the new law, “harm reduction interventions in prevention of HIV transmission include ... communication and mobilization, promotion of the use of condom and

clean needle and syringes, treatment of opioid addiction by substitution and other harm reduction measures to support safe behaviors to prevent HIV infection and transmission.”² The law will come into force on 1 January 2007.

Kazakhstan

On 7 June 2006, the law of the Republic of Kazakhstan “On prevention of the AIDS disease” was amended.³ The amendments included state guarantees on accessibility and high quality anonymous HIV testing; psychosocial, legal and medical assistance for people living with HIV/AIDS; and accessibility of information on HIV prevention.⁴ According to the amended law, discrimination on the basis of HIV/AIDS status is unlawful.

However, the law also provides that citizens of Kazakhstan, foreign nationals and stateless persons must undergo compulsory HIV testing at the request of public health services, prosecutors, police or courts “if there are sufficient reasons to think that these persons are HIV-infected.”⁵ Foreign nationals and stateless persons who refuse to undergo HIV testing or submit to “preventive observation” if living with HIV/AIDS, are to be deported.⁶

Tajikistan

In December 2005, Tajikistan adopted a new law titled “Counteraction to human immunodeficiency virus and Acquired immunodeficiency syndrome.”⁷ Under the law, the state guarantees the protection of all human rights of people living with HIV/AIDS and their relatives as well as medical and psychosocial services

free of charge. People living with HIV/AIDS enjoy, among other rights, the right to monetary compensation for damages connected to disclosure of their HIV status.⁸

HIV testing is generally voluntary and anonymous. However, the legislation provides for compulsory HIV testing for refugees and foreign nationals; and HIV testing is compulsory for specific categories further defined by the government regulations, based on epidemiological considerations.⁹

Foreign nationals with HIV are to be deported.¹⁰ This provision is in violation of domestic and international human rights law,¹¹ but sadly exists in a number of countries.¹²

China

In March of 2006, it was reported that a deputy to the Tenth National People’s Congress introduced a legislative proposal to make the intentional spread of HIV a crime.¹³ The offence would apply to those who deliberately spread HIV by means of biting, scratching and injecting others, sexual intercourse, syringe sharing, blood transfusion and organ transplant. The proposal includes sentences ranging from a minimum of 10 years imprisonment to the death penalty. The report said that currently only Article 360 of the Criminal Law of China, which applies to the knowing transmission of a sexually transmitted disease and carries a maximum penalty of five years and a fine, is applicable in such cases.

Uganda

In September of 2006, it was reported that the Ugandan parliament will soon consider a bill criminaliz-

ing persons who knowingly infect minors with HIV.¹⁴ The bill proposes to introduce the felony charge of “aggravated defilement,” which would carry a mandatory death penalty. Defilement refers to an act of sex with person 18 years or younger, with or without consent. Under current law, according to the report, people found guilty of rape and defilement can be sentenced to death or a lesser sentence; to date no one has received a death sentence. Various human rights and HIV/AIDS groups, including Actionaid International Uganda, have spoken out against the proposed law and have called upon the international community to do so as well.

– Leah Utyasheva, Richard Pearshouse and Glenn Betteridge

Glenn Betteridge (gbetteridge@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

¹ *Law on Prevention and Control of HIV/AIDS*, 21 June 2006 [Vietnam], art. 21.

² *Ibid.*, art. 2.15.

³ *Law on Prevention of the AIDS disease*, No. 172-III 3PK, October 5, 1994, last amended on June 7, 2006 [Republic of Kazakhstan].

⁴ *Ibid.*, art. 2-4 and 2-5.

⁵ The law does not specify what "sufficient reasons" are.

⁶ *Law on Prevention of the AIDS disease*, art. 6.

⁷ *Law on Counteraction to human immunodeficiency virus and Acquired immunodeficiency syndrome*, December 28, 2005 [Republic of Tajikistan].

⁸ *Ibid.*, art. 12.

⁹ *Ibid.*, art. 9.

¹⁰ *Ibid.*, art. 9.

¹¹ For example, art. 17 of the *Constitution of the Republic of Tajikistan*, November 6, 1994, guarantees equality of rights to everybody. Art. 26 of the *International Covenant on Civil and Political Rights*, which the Republic of Tajikistan ratified on 4 January 1999, prohibits discrimination.

¹² See, e.g., *Federal law on prevention of spread of the*

disease, caused by the human immunodeficiency virus (HIV-infection) in the Russian Federation, March 30, 1995 [Russian Federation], art. 11.

¹³ "Make intentional spread of AIDS a crime: lawmaker," *Kaiser Daily HIV/AIDS Report*, 14 March 2006.

¹⁴ E.K. Matsamura, "Uganda drafts bill to execute HIV infectors," *Inter Press Service News Agency*, 13 September 2006.

In brief

U.K.: HIV and human rights audit underway

The U.K. AIDS and Human Rights Project, in partnership with the All-Party Parliamentary Group on AIDS (APPGA), is currently conducting an audit of HIV-related rights in the U.K.

The aim of the audit is to bridge international obligations and national practice by evaluating the extent of the legal implementation of international human rights law with reference to the International Guidelines on HIV/AIDS and Human Rights and other HIV-specific human rights standards. The project will provide a comprehensive and accurate account of the impact of governmental policies on HIV-related rights and will be used as an advocacy tool to stimulate legal and policy reform.

The APPGA will produce a report based on the evidence submitted by NGOs and individuals, and will also issue a background report to be prepared by the UK AIDS and Human Rights Project. Parliamentary hearings will take place early 2007, with

the aim of publishing a final report, including further recommendations for the U.K. government, in the Spring of 2007.

The audit will provide a comprehensive follow-up to the APPGA's parliamentary inquiry into the U.K.'s implementation of the International Guidelines on HIV/AIDS and Human Rights in 2001. At the time of the inquiry, the U.K. Human Rights Act was not in force; so, the audit will examine the impact of the Human Rights Act on HIV-related rights. The project is also timely as some governmental policies adopted over the past few years have had a significant impact on HIV-related rights in the U.K.

– *Delphine Valette*

Delphine Valette (delphine.valette@aidrightsproject.org.uk) is Director of the U.K. AIDS and Human Rights Project (www.aidrightsproject.org.uk).

U.S.: Evidence of HIV transmission in prisons

According to a report published by the U.S. Centers for Disease Control and Prevention (CDC), a number of cases of HIV transmission occurred

among males in Georgia state prisons during the period 1992 to 2005.¹ Eighty-eight prisoners were known to have had an HIV-negative test result on entry into prison and a subsequent confirmed HIV-positive test result in prison. In 1988, Georgia corrections introduced mandatory testing for all newly admitted prisoners and voluntary testing on demand or where clinically indicated. Four factors were significantly associated with HIV transmission: male-male sex in prison; receipt of a tattoo in prison; low body mass upon entry into prison; and black race.

The editors of the report comment that HIV prevention education in state prisons should address male-male sex and suggests that providing condoms to sexually active prisoners is an integral part of HIV prevention interventions inside prison. Despite no difference in risk behaviours among racial groups, significant seroconversion among blacks may be attributable to the fact that 86 percent of infected males entering the prison system were black, combined with the potential existence of black-only sex or tattooing networks. The authors call on corrections officials, in partnership with public health officials, to assess existing HIV prevention programs.

Another CDC report revealed that a prisoner developed acute retroviral syndrome, indicative of HIV seroconversion, after he had unprotected sexual intercourse with two HIV-infected prisoners. The authors, who are public health and infectious disease physicians, “urge correctional facilities to address the issue of unprotected sex among inmates and the associated transmission of sexually transmitted diseases” and highlight condom distribution as a means to do so.²

– Glenn Betteridge

Europe & CEE: Prison needle exchange update

Recently, needle exchange programs have been implemented in prisons in two countries, and plans to do the same in two additional countries have been reported.

One prison in Luxembourg has been distributing sterile needles since August 2005.³ To participate in the program, prisoners must get approval from the prison physician. If approved, prisoners are provided with a kit containing two syringes (and other items for safer injecting), which may be legally possessed by the prisoner and exchanged at health care.

In 2006, Armenia began needle exchange in prison using funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, with three of nine harm reduction programs in Armenian penal institutions exchanging needles.⁴

The Scottish Prison Service and Portugal are considering implementing prison needle exchange in 2007 and 2008, respectively.⁵ In a related development, the Canadian HIV/AIDS

Legal Network has released a new version of its comprehensive report on the issue, updated to April 2006.⁶

– Glenn Betteridge

California: Governor vetoes prison condom bill

In October 2006, California Governor Arnold Schwarzenegger vetoed a bill that would have allowed non-profit organizations or public health care agencies to distribute condoms and dental dams in Californian prisons. Bill 1677, proposed by Assembly member Paul Koretz (Democrat) and passed by the California State Assembly in June 2005, was held up by the California State Senate Appropriations Committee in August 2005.⁷ The Senate finally approved the bill in August 2006. The decision to veto the bill came despite advocacy efforts in support of the bill from prominent groups such as AIDS Healthcare Foundation and Human Rights Watch.⁸

The veto leaves California’s estimated 162 000 prison inmates without adequate measures to protect themselves from HIV/AIDS. Prisons in Mississippi and Vermont, and jails in New York, Philadelphia, Washington, D.C., San Francisco and Los Angeles permit the distribution of condoms.⁹ Consistent with the principle that inmates should have the same access to health care and treatment as people outside prisons, the World Health Organization has recommended that condoms be made available to inmates throughout the span of their detention.¹⁰

– Richard Pearshouse

Jamaican activist receives human rights award

Gareth Williams, a leading AIDS activist and voice for the rights of sexual minorities in Jamaica and the English-speaking Caribbean, has won the 2006 International Award for Action on HIV/AIDS and Human Rights.

The awards were established in 2002 by the Canadian HIV/AIDS Legal Network and Human Rights Watch to highlight outstanding contributions that decrease vulnerability to HIV/AIDS and protect the rights and dignity of those infected and affected.

As the lead activist and main fundraiser for the Jamaica Forum for Lesbians, All-Sexuals and Gays (J-FLAG), Williams spearheads an emergency support program that provides material care and support for victims of homophobic violence, including assistance with taking their cases through the justice system. Williams also played a key role in encouraging community members to share their stories with researchers for the 2004 Human Rights Watch report, *Hated to Death: Homophobia, Violence, and Jamaica’s HIV/AIDS Epidemic*.¹¹

For further information, see www.aidslaw.ca/awards.

India: Proposal for mandatory testing of marriage couples withdrawn

In March 2006, the Indian state of Goa announced plans to make HIV tests mandatory for couples register-

ing to be married.¹² The proposed amendment to the *Goa Public Health Act* would have required all couples registering to be married to undergo HIV testing and if either or both individuals test positive, the couple would then decide whether or not to proceed with the marriage.

According to the Goa Chief Minister, Pratapsingh Rane, underlying the proposal for HIV tests was a concern that an increase in HIV infection was hurting the tourism industry.¹³

UNAIDS country director for India Denis Broun urged the government of Goa not to make the testing mandatory because it would be counterproductive in efforts to limit spread of the virus.¹⁴ The Lawyers Collective, the leading organization working on HIV/AIDS and human rights issues in India, suggested that mandatory HIV tests before marriage would give people a false impression of safety from being subsequently infected and that it would be synonymous with a certificate of a woman's virginity.¹⁵

After intense public debate, the government backed down and now proposes to make the HIV testing before marriage voluntary. "We are planning to enact a law wherein it will be voluntary for the couple to go for the HIV/AIDS tests before marriage," the Chief Minister said.¹⁶

— Liisa Seim

France: Restrictions on residence visa for HIV-positive immigrants

Following amendments to French immigration law adopted in 1998,

non-French citizens with serious illnesses may remain in France with a residence visa if they don't have access to medical treatment in their home country.¹⁷ The residence visa for people with serious illnesses qualifies the holder for social security services and medical treatment, and grants the holder the right to work.

The residence visa is granted by the local administrative representative [*préfet*] or, in the case of Paris, by the head of the Paris police, on the advice of a specialized medical officer. NGOs have observed that in recent years, the law is being applied more and more restrictively. While approximately 75 percent of applications for a residence visa for serious illnesses were approved in 2003, this had dropped to 50 percent in 2004.¹⁸

Legislative plans to restrict even further the residence visa for people with serious illnesses, as part of a conservative immigration bill proposed by France's Interior Minister Nicolas Sarkozy, appear to have been dropped.¹⁹ Other proposals contained in the proposed bill, including restrictions on residence visas for family members of children with serious illnesses, still concern health and human rights organizations.²⁰ According to France's National AIDS Council, "Access to health care for all patients, regardless of their administrative status, and the right to stay to obtain health care, form essential elements of an effective fight against the HIV epidemic."²¹

There are approximately 20 000 HIV-positive non-French citizens living in France, mainly from Africa.²² The majority learn of their HIV status after arriving in France.

— Richard Pearshouse

¹ CDC, "HIV transmission among male inmates in a state prison system — Georgia, 1992-2005," *Morbidity and Mortality Weekly Report* 55, 15 (2006): 421-426.

² A. Macher, D. Kibble and D. Wheeler, "HIV transmission in correctional facility," *Emerging Infectious Diseases* 12, 4 (2006): 669-671.

³ M. Melis, "As prison needle exchange programmes are scaled up, Luxembourg joins in," *Connections* 19 (2006): 1-2.

⁴ Personal communication with Daniel Wolfe, International Harm Reduction Development Program, Open Society Institute, 1 February 2006.

⁵ "Inmates may get drug-taking kits," *BBC News*, 20 September 2006; "Portugal approves supervised drug injection sites, aims to establish prison needle-exchange programs by 2008," *Kaiser HIV/AIDS Daily Report*, 28 August 2006.

⁶ R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, Second Edition, Canadian HIV/AIDS Legal Network, 2006. Available via www.aidslaw.ca.

⁷ California Bill AB 1677 (Koretz) is available online at <http://info.sen.ca.gov>. For previous coverage of this issue, see T. Franklin, "California: Senate fails to pass bill to allow condom distribution in state prisons," *HIV/AIDS Policy and Law Review* 10, 3 (2005): 31-32.

⁸ Human Rights Watch, *Letter to the Governor's Office in Support of Assembly Bill 1677*, 25 August 2006. At www.hrw.org.

⁹ *Ibid.*

¹⁰ World Health Organization, *WHO guidelines on HIV infection and AIDS in prisons*, 1993, p. 5.

¹¹ Available at <http://hrw.org/reports/2004/jamaica1104>.

¹² "Want to marry?... do the HIV test first", *Goa Herald*, 17 March 2006.

¹³ "HIV test before marriage to be made voluntary in Goa," *Medindia*, 17 September 2006.

¹⁴ J. Johnson, "UN urges Goa to end plans for HIV tests on couples," *Financial Times*, 27 March 2006.

¹⁵ *Ibid.*

¹⁶ "Goa to make pre-marriage HIV tests voluntary," *DNA India*, 16 September 2006.

¹⁷ Article 12 bis no. 11 (inserted 11 May 1998) of Ordinance of 2 November 1945.

¹⁸ Observatoire du droit à la santé des étrangers, "Pour le droit au séjour des malades étrangers," news release, Paris, France, 11 May 2005.

¹⁹ Act Up Paris, "Projet de loi sur l'immigration et l'intégration: le gouvernement fait l'impasse sur le droit à la santé," news release, Paris, France, 30 March 2006.

²⁰ Observatoire du droit à la santé des étrangers, "Un projet de loi dangereux pour la santé des étrangers malades," news release, Paris, France, 24 April 2006.

²¹ Conseil national du sida, "Communiqué de presse sur les restrictions en matière d'immigration et la lutte contre le VIH," news release, Paris, France, 1 May 2006.

²² "No papers, no aid — plight of HIV-positive migrants in France," *PlusNews*, 9 October 2006.

HIV/AIDS IN THE COURTS – CANADA

This section presents a summary of Canadian court cases relating to HIV/AIDS or of significance to people with HIV/AIDS. It reports on criminal and civil cases. The coverage aims to be as complete as possible, and is based on searches of Canadian electronic legal databases and on reports in Canadian media. Readers are invited to bring cases to the attention of Glenn Betteridge, editor of this section, at gbetteridge@aidslaw.ca.

B.C. court gives go-ahead to non-profit needle exchange and drop-in

In a 15 February 2006 decision, the Supreme Court of British Columbia effectively ordered the City of Surrey to licence the Surrey HIV/AIDS Centre Society as a medical office. As a result, the Society did not have to submit to city council a community impact statement and study in order to obtain a new licence to operate.¹

The Society delivers a number of programs, including a 24-hour drop-in centre, a 36-bed emergency shelter, a hot meal program, youth street services, support services to people living with HIV/AIDS, medical services to uninsured people, and a needle exchange. The Society applied for a building permit to carry out renovations to its new premises. The City

took the position that, given its activities, the Society had to first obtain a “community service” business licence. Such a licence requires that a community impact statement and related study be submitted to City Council for consideration, whereas a “medical office” licence does not.

The issue addressed by the Court was whether the Society needed to

obtain a “community service” rather than a “medical office” licence under the relevant bylaw.² The Court’s decision turned on its interpretation of the bylaw, and the definition of the word “medicine.” The Court stated that:

... it is difficult to see how the activities proposed by the Society at the new premises did not fall within those

of a medical office. HIV/AIDS support services must fall within the treatment and prevention of disease, as would the provision of clean needles to drug addicts, presumably to prevent the spread of disease.³

The city argued that the Society, as a non-profit organization, was necessarily providing community services. Based on the definition of “community service,” the Court decided that not all not-profit societies had to hold a community service business licence. Moreover, the Court found that it was unreasonable in the circumstances for the city to refuse to issue the licence. The Court declared that the “Society’s proposed use is that of a medical office, and it is entitled to a business licence for medical use.”⁴

Comment

The Court’s broad interpretation of medical services permitted the Society to circumvent the lengthy and costly process of preparing a community impact statement and report for consideration by city council.

Many agencies across Canada that deliver HIV/AIDS, harm reduction, shelter and drop-in services consistently report experiences of community opposition, often times coming from residents and businesses who do not want such services operating in “their” neighbourhoods.⁵ The conflict often finds expression at the municipal level within the licensing and zoning processes where community opposition finds support among elected officials. The Court’s reasons may be of assistance to other

service agencies in their struggle to find premises from which to provide medical services, including needle exchange and drop-in services, to people living with or vulnerable to HIV/AIDS, thereby helping to realize the right to health for such people.

– Glenn Betteridge

¹ *Surrey HIV AIDS Centre Society v. City of Surrey and Murray Dinwoodie* (February 15, 2006), Vancouver L052209.

² City of Surrey, *Business Licence Bylaw 1999*, No 13680.

³ *Surrey HIV AIDS Centre Society* at paras. 19, 20.

⁴ *Ibid.* at para 29.

⁵ Discussion with A Klein, Senior Policy Analyst, Canadian HIV/AIDS Legal Network, based on her research regarding barriers to needle exchange programs in Canada.

Another prisoner dies of HIV in a CSC institution — medical parole not considered until too late

In a 20 July 2006 report, a Québec Coroner criticized Correctional Service Canada’s (CSC) handling of a prisoner who died of HIV-related complication while imprisoned.¹ The Coroner recommended that CSC change the way it handles cases of medical parole.

Éric Boyer, 36, died in Archambault Institution on 18 March 2006. As mandated by Québec law, a provincial Coroner held an inquest into his death. Boyer had been under palliative care in the Institution since September 2005. The Coroner found

that steps were not taken to prepare his case for an application for medical parole until four days before his death. The Institution relied on a policy under which it did not prepare cases until prisoners were at 20 on the Karnofsky Score, used to measure

patient performance on activities of daily living. (One hundred indicates no evidence of disease, 20 indicates very sick requiring active support treatment, 10 indicates moribund.)

The Coroner reviewed the exceptional parole criteria under the

Corrections and Conditional Release Act (CCRA) and associated policy. The policy states that “[t]he institutional Parole Officer/Primary Worker will consider all release options for offenders who are terminally ill or otherwise meet any of the criteria identified in section 121 of the CCRA at the earliest possible time,”²² and that “[i]f an inmate is terminally or seriously chronically ill, the Service shall consult with the National Parole Board to determine eligibility for parole.”²³ The Coroner concluded that Boyer’s file should have been submitted to the Board in September 2005, the point at which his prognosis was irreversible.

The Coroner made two recommendations:

- that Archambault Institution not wait until a prisoner reaches 20

on the Karnofsky Scale before submitting the file to the Board; and

- that CSC put in place a criteria and expedited process for presenting terminally ill prisoners’ files to the Board.

Comment

Boyer was not the first prisoner to die of HIV- or hepatitis C-related complications in a CSC institution without any real opportunity for parole. At least two other Coroners inquiring into the deaths of HIV-positive prisoners have remarked upon or recommended that CSC review its process for medical parole.⁴ CSC’s failure to put in place and follow an effective process for parole applications by legally eligible, terminally ill prisoners is unacceptable and unrea-

sonable — which begs the questions of whether CSC’s conduct in Boyer’s case was legally negligent.

– Glenn Betteridge

¹ Report of Coroner’s Investigation, (20 July 2006) A-302537, Office of the Coroner, Québec. On file with author.

² CSC Commissioner’s Directive 712-1, s. 102.

³ CSC Commissioner’s Directive 800, s. 42.

⁴ R. Lines, “Death exposes treatment of prisoners living with HIV/AIDS,” *Canadian HIV/AIDS Policy & Law Newsletter* 3, 4/4, 1 (1998): 29–20; J. G. Betteridge, “Inquest into the death of a prisoner co-infected with HIV and hepatitis C: how many more will there be?” *Canadian HIV/AIDS Policy & Law Review* 6, 1/2 (2001): 65–69.

Federal Court orders re-determination of HIV-positive Zimbabwean’s refugee claim

On April 5, 2006, the Federal Court ordered the Immigration and Refugee Board (IRB) to re-hear an HIV-positive Zimbabwean man’s applications under the *Immigration and Refugee Protection Act (IRPA)* for Convention refugee status and status as a person in need of protection. The issues before the Court centred on the IRB’s assessment and application of the evidence regarding the applicant’s access to health care in his home country, and the IRB’s refusal to hear a constitutional challenge to the IRPA.

The applicant, his wife and their children came to Canada from Zimbabwe in 2001 on work and education visas. The applicant tested HIV-positive

following an employment medical examination and subsequently applied for refugee status on the basis of his HIV diagnosis. The applicant

received, and responded well to, HIV antiretroviral therapy. In 2005, the IRB denied the applicant’s claims for refugee status.

Convention refugee status

Under section 96 of the IRPA, “Convention refugees” are people who are unable or unwilling to return to their countries of nationality “by reason of a well-founded fear of persecution for reasons of ... membership in a particular social group.” The IRB accepted the applicant’s membership in an eligible social group — i.e., those fearing persecution because of HIV-positive status. However, it dismissed as speculative the evidence regarding the inaccessibility of medical care, severely truncated life-expectancy and level of social stigmatization that he would face in Zimbabwe.

The Court concluded that the IRB’s decision was not patently unreasonable — the standard for judicial review in such cases — given that the IRB had before it “a large amount of conflicting documentary evidence about the social and health care conditions in Zimbabwe for persons suffering from HIV/AIDS.”¹

Status as a person in need of protection

Section 97(1)(b) of the IRPA recognizes “a person in need of protection as a person in Canada whose removal to their country of nationality ... would subject them personally .. to a risk to their life.” However, such protection is only available if “the risk is not caused by the inability of that country to provide adequate health or medical care” — the so-called health care exclusion.²

The applicant argued that his life would be at risk owing to the unavailability of HIV-treatment in Zimbabwe. In an attempt to circumvent the health care exclusion, the applicant also argued that the government was *unwilling* to provide health

care (as opposed to being *unable* to do so). Based on the evidence, the IRB found that there would be no risk to the applicant’s life because of lack of medical treatment.

The Court stated that the section 97(1)(b) analysis involved two steps. First, the IRB should decide whether there is a risk to life. Second, if there is such a risk, the IRB must determine if the health care exclusion is applicable. The Court found that the IRB made an error when it “expressly declined to qualitatively assess the treatment programs that would be available” to the applicant, instead finding that “some level of health care would not be denied” him. In doing so, the IRB “wrongly conflated the two parts of the test.”³

The Court rejected the distinction between “unable” and “unwilling.” The Court found that the health care exclusion will exclude from refugee protection persons who could not access health care because they do not have the resources to pay for it. The Court stated that “[e]ven in countries with the most deficient health care systems, there will usually be access to quality medical care for persons with the means to pay for it.”⁴

The Court clarified that section 97 protects persons where “access to life-saving treatment would be denied to a person for prosecutorial reasons not otherwise caught by section 96 of the IRPA.”⁵ The Court accepted the IRB’s determination that the applicant would not face persecution or discrimination in accessing treatment.

Constitutional challenge

The Court decided that the IRB had erred by refusing to consider the constitutional challenge, the nature of which was not detailed in the judg-

ment. The Court noted that a similar constitutional challenge to the health care exclusion is currently pending before the Federal Court of Appeal.⁶

The Court set aside the IRB’s decision and remitted the case for a re-determination by a differently constituted panel of the IRB.

– Jennifer Chan

Jennifer Chan is a second year student at the University of Victoria Faculty of Law, and was a summer intern with the Canadian HIV/AIDS Legal Network.

¹ *Travers v Canada (Minister of Citizenship and Immigration)*, [2006] F.C.J. No 667 (QL) at para. 14.

² *Immigration and Refugee Protection Act*, S.C., 2001, c 27 ss. 97(1)(b)(iv).

³ *Travers v Canada* at para. 18.

⁴ *Ibid.* at para. 25.

⁵ *Ibid.* at para. 27.

⁶ *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, [2005] F.C.J. No 1470 (Federal Court) (QL).

HIV-positive gay Mexican's Convention refugee claim denied

In May 2006, the Federal Court of Canada upheld an Immigration and Refugee Board (IRB) decision refusing to grant refugee status to an HIV-positive gay man from Mexico.¹ The Court did not find patently unreasonable the IRB's conclusion that the applicant would not experience a lack of state protection against persecution and discrimination based on sexual orientation and HIV status.

In December 2001, the HIV-positive gay man arrived in Canada and within one year filed an application for Convention refugee status under the *Immigration and Refugee Protection Act* (IRPA). Under section 96 of the IRPA, "Convention refugees" are people who are unable or unwilling to return to their countries of nationality "by reason of a well-founded fear of persecution for reasons of ... membership in a particular social group."

The IRB accepted the applicant's fears of persecution and discrimination in Mexico regarding his homosexuality and HIV-positive status. However, the IRB denied the application on the basis that the man had failed to establish that the Mexican state could not protect him from such persecution and discrimination.²

Before the Court, the applicant argued that the IRB had inadequately considered his fears of persecution, had erred in refusing to admit post-hearing evidence, had erred in presuming state protection, and had failed to consider his right to freedom of expression as a basis for refugee

status. The Court found that the IRB had heard evidence which pointed to "government efforts to fix the situation and the efforts of NGOs trying to improve the treatment of homosexuals."³

The Court concluded that, as the body responsible for weighing the evidence, the IRB had not acted in a patently unreasonable manner — the standard for judicial review in such cases — in reaching the decision that state protection was available to the applicant. The Court also determined that additional post-hearing evidence presented by the applicant was not definitive and, therefore, the IRB was within its rights to refuse to consider it.

The Federal Court also dismissed the argument that the IRB had failed to consider the applicant's right to freedom of expression as a basis for Convention refugee status. The applicant had claimed that he was an AIDS activist in Canada, an activity that he would not safely be able to continue in Mexico. The Court remarked that the applicant did not raise this issue in his claim for

Convention refugee status, nor was there evidence before the IRB that his alleged activism would place him at risk in Mexico.⁴

– Jennifer Chan

¹ *Contreras v. Canada (Minister of Citizenship and Immigration)*, [2006] F.C.J. No 763 (QL).

² See S. Bahk, "Federal Court overturns negative Pre-Removal Risk Assessment of HIV-positive failed refugee claimant," *HIV/AIDS Policy & Law Review* 10, 2 (2005): 39 for a previous unsuccessful refugee claim based on HIV status and sexual orientation discrimination in Mexico.

³ *Contreras v. Canada* at para. 12.

⁴ *Ibid.*, para. 17.

Criminal law and HIV transmission or exposure: 10 new cases

Six month conditional sentence for mother who hid HIV status for son's birth

In what may be the first case of its kind in Canada, a mother who failed to inform her medical team of her HIV-positive status during childbirth was sentenced in April 2006 to a six-month conditional sentence and three years probation.¹ She had pled guilty to a charge of failing to provide the necessities of life after additional charges of criminal negligence causing bodily harm and aggravated assault were dropped by the Crown.

The mother had been diagnosed with HIV before the birth of her first child in 2003. Having received counselling from hospital staff, she took HIV antiretroviral therapy throughout her pregnancy and during the birth, delivered the child via caesarean section, and did not breast-feed the newborn — actions which can reduce the chance of mother-to-child HIV transmission to as low as two percent. Her first child did not contract the virus.

During her second pregnancy in 2004, she stopped taking antiretroviral medications and instead of returning to the hospital that had overseen her first pregnancy, she went to a different hospital to deliver the child. Denying that she had HIV, the mother did not receive pre-delivery antiretroviral medications, the baby was delivered vaginally, the newborn infant did not receive antiretroviral medications, and the mother breast-fed the infant for three days until

blood tests revealed her HIV-positive status. The baby tested HIV-positive two months later.

In response to this case, Richard Elliott, Deputy Director of the Canadian HIV/AIDS Legal Network, stated that it is not helpful to criminalize women in these cases: “The vast majority of women have concern for their child and want to do what’s best for them. There is risk that this [conviction] will drive women most in need underground because they may see it as being coerced.”²

Side effects from preventative anti-retroviral treatment lead to assault causing bodily harm conviction

In March 2006, a man of unknown HIV status was convicted of assault causing bodily harm.³ While attempting to escape arrest on the suspicion of possessing crack cocaine, the man wrestled with the arresting officer on the ground. The officer suffered scrapes to his arms and hands, and a bruise on his face; as well, the man bit the officer on the forearm. The officer admitted that his injuries were of a minor nature and that, under normal circumstances, he would have expected an immediate return to duties. However, the officer suffered additional discomfort while undergoing a 35-day course of antiretroviral treatment aimed at preventing possible infection with HIV. Side effects suffered by the officer included sleeplessness, vomiting, diarrhoea and

weakness leading to incapacitation and the loss of twenty pounds.

Under the Criminal Code, “bodily harm” means “any hurt or injury to a person that interferes with the health or comfort of the person and that is more than merely transient or trifling in nature.”⁴ The judge suggested that the officer’s injuries alone would fall short of proof beyond a reasonable doubt of the bodily harm required to elevate simple assault to assault causing bodily harm. However, the judge concluded that the side effects associated with the antiretroviral treatment met the bodily harm requirement and were triggered by the bite.

Comment

The transmission of HIV through a bite, though biologically possible remains “epidemiologically insignificant.”⁵ Only five cases HIV transmission attributable to bites have been reported worldwide since 1987.⁶

HIV-positive man who used syringe in robbery sentenced to six years

In February 2006, an HIV-positive man was sentenced to six years imprisonment after pleading guilty to one count of robbery.⁷ The man was arrested shortly after robbing a Vancouver coffee shop. He had held out a blood-filled syringe and told the store clerk that he was HIV-positive. In sentencing, the judge cited aggravating factors such as the accused’s knowledge that he was HIV- and hepatitis C-positive, his long criminal

history and his inability to complete a drug treatment program. A comparable five-year sentence given to an HIV-positive man who used a syringe during robbery was reported in a previous issue of the *Review*.⁸

Man accused of failing to disclose HIV-positive status found not guilty

An HIV-positive man was found not guilty of aggravated assault after a judge found the complainant's testimony to be argumentative, imprecise and riddled with contradictions.⁹ The complainant had changed his testimony regarding the percentage of times a condom had been used during sex, and had provided false information regarding his date of birth on medical records.

Significantly, the judge dismissed the defence's argument that the undetectable level of virus existing in the blood of the accused diminished the chances of HIV-transmission and thus did not meet the requirement for conviction of a significant risk of serious bodily harm. The judge called the argument "fragile" because it revealed the level of virus present on the day of the blood test and not the level to which the complainant may have been exposed throughout the course of their sexual relationship.

Woman who claimed she had AIDS jailed for 21 days after spitting on police officer

In February 2006, a 19-year old Ontario woman was found guilty of assaulting a police officer. After having been arrested for public intoxica-

tion, the young woman was being led to a cell, at which point she spat in the face of a female police officer, laughed and stated that she had AIDS. The trial judge stated that the sentence would have been much harsher had the accused not already spent 59 days in pre-trial and pre-sentence custody. The actual HIV-status of the accused remains unreported.

Comment

The low level of HIV present in the saliva of HIV-infected persons coupled with the fact that saliva itself inhibits HIV-1 infectivity makes HIV-transmission through spitting extremely unlikely.¹⁰ Of the half million cases of AIDS reported to the U.S. Centers for Disease Control and Prevention by 1997, not one had been attributable to exposure to saliva.¹¹ A previous case involving an HIV-positive prisoner who received an additional year of imprisonment for spitting in the face of a correctional officer was reported in the *Review*.¹²

Ten years imprisonment for HIV-positive man who struck and bit homeowner during break-and-enter

In July 2006, a 45-year old HIV-positive man was sentenced to 10 years imprisonment after pleading guilty to charges of aggravated assault, assault with a weapon, break-and-enter and breach of probation.¹³ During the robbery, the accused struck a 63-year old homeowner on the head with a vase, bit him several times on the wrist and head and stuck his finger in the man's eye. In handing down the lengthy sentence the judge cited a long criminal record which included

convictions for break-and-enter, robbery and aggravated assault.

HIV-positive man sentenced to 15 years imprisonment for aggravated sexual assault

In March 2006, a B.C. Supreme Court Justice sentenced an HIV-positive man to 15 years imprisonment for five counts of aggravated sexual assault, one count of sexual assault and one count of attempted aggravated sexual assault.¹⁴ The man engaged in unprotected sex with seven women without disclosing his HIV-positive status, three of whom have since tested positive for HIV.¹⁵ In handing down what may be the stiffest sentence for such an offence, the judge noted that the effects of the man's actions had been "catastrophic and dreadful" for the young women affected.¹⁶

Court of Appeal replaces jail term for aggravated sexual assault with conditional sentence

In February 2006, as a result of a plea bargain, an HIV-positive Winnipeg man pled guilty to a charge of aggravated sexual assault.¹⁷ Three years earlier, he had met a woman at a house party, became intoxicated and engaged in unprotected consensual sex. He stated to police that it had not occurred to him at the time to disclose his HIV-positive status or to use a condom, indicating that "everything happened so quickly."¹⁸ The woman, who is intellectually impaired, remains HIV-negative.

Defence and Crown Counsel jointly recommended a conditional

sentence of two years less a day to be served within the community, followed by three years probation. The sentencing judge rejected the joint recommendation, indicating that it did not fall within a range that is fit for the offence, and imposed a sentence of two and a half years imprisonment. The judge stated, “[i]n light of the heightened responsibility required of someone carrying the diseases the accused knew he was carrying, his indifference and recklessness are staggering.”¹⁹

In June 2006, the Manitoba Court of Appeal set aside the two-and-a-half-year imprisonment term and imposed a two-year conditional sentence followed by three years probation.²⁰ The majority of the judges of the Court of Appeal determined that the sentencing judge had not provided “cogent and convincing” reasons for rejecting the joint recommendation.²¹ The Court of Appeal imposed conditions including house arrest, an absolute curfew, abstaining from alcohol, not contacting the complainant and completing substance abuse assessments as directed by a supervisor.

Ontario Court of Appeal allows aggravated sexual assault charge to stand on *inferred* HIV-positive status

In March 2006, the Ontario Court of Appeal unanimously allowed a charge of aggravated sexual assault to proceed to trial.²² The accused was charged with aggravated sexual assault of his then five-year-old daughter, based on the theory that he exposed her to the risk of HIV. The issue before the Court of Appeal was whether or not there was some evi-

dence that the “conduct that led to the transmission of the gonorrhoea bacteria also endangered the complainant’s life by exposing her to HIV.”²³ The accused argued that the prosecution had not produced any evidence during the course of the preliminary inquiry upon which a court could infer that the complainant’s life was actually endangered through exposure to HIV — the “aggravating” factor in the sexual assault. The Court found that there was sufficient evidence to merit a consideration of an aggravated sexual assault charge at trial.

In the circumstances, a charge of aggravated sexual assault requires that the accused knew of, or was wilfully blind to, his HIV-positive status. The accused had never been tested for HIV. The Court of Appeal determined that evidence indicating the accused “deliberately refused to be tested” after his sexual partner had told him he that she was HIV-positive could lead a trial court to make the “common sense inference that the appellant knew he was HIV-positive.”²⁴ Alternatively, the Court found that there may be sufficient evidence for a trial court to consider whether the accused was wilfully blind to the fact of being HIV-positive. The Court pointed to the fact that the accused man’s common law spouse tested positive for HIV five years into a monogamous relationship with him, and testified that she “engaged in no other conduct from which it was likely she contracted HIV.”²⁵ The Court found that “on this admittedly fragile basis, a trier of fact could conclude that the appellant infected [his common law spouse] or that he was infected by her prior to their beginning to use condoms.”²⁶

On appeal, the Court was called upon to determine whether there

was evidence that the accused put the daughter’s life at risk owing to HIV — in other words, whether there was a risk of HIV transmission as a result of the assault. At the preliminary inquiry, the Crown brought forward evidence that the accused and his five year-old daughter were both diagnosed with the same strain of gonorrhoea, allegedly as a result of unprotected sexual intercourse involving partial penetration. Expert evidence about the transmission of HIV was not adduced at the preliminary inquiry. Nonetheless, the Court drew the common sense inference that the degree of contact that resulted in the transmission of gonorrhoea to the daughter could have also resulted in her exposure to HIV. At trial, in order to secure a conviction, the prosecution has to prove all of the elements of the offence of aggravated sexual assault beyond a reasonable doubt.

The man was acquitted at trial of the aggravated sexual assault charge since there was no proof of his HIV status at the time of the assault.²⁷ He was found guilty of sexual assault causing bodily harm and sexual interference. He is awaiting sentencing.

Man sentenced to 10 years for assault on seven-year-old girl

In August 2006, a 38 year-old HIV-positive Ontario man was found guilty of six charges including aggravated sexual assault and possession and production of pornographic material in relation to a seven-year-old girl.²⁸ He was sentenced to 10 years in prison and declared a long-term offender.

– Jennifer Chan

¹ *R. v. J.L.*, [2006] O.J. No. 3742 (Ontario Court of Justice) (QL); L. Priest, "Mother convicted of hiding HIV status for son's birth," *The Globe and Mail*, 7 August 2006.

² D. Healey, "Mom hid HIV for son's birth," *Hamilton Spectator*, 8 August 2006.

³ *R. v. Luu*, [2006] O.J. No. 1083 (Ontario Court of Justice) (QL).

⁴ *Ibid.*, citing *R. v. Dupperon* (1984), 16 C.C.C. (3d) 453 (Saskatchewan Court of Appeal).

⁵ K.M. Richman and L.S. Rickman, "The potential for transmission of human immunodeficiency virus through human bites," *Journal of Acquired Immune Deficiency Syndromes* 6, 4 (1993): 402–406.

⁶ C.F. Bartholomew and A.M. Jones, "Human bites: a rare risk factor for HIV transmission," *AIDS* 20, 4 (2006): 631–632.

⁷ *R. v. Leahy*, [2006] B.C.J. 1049 (B.C. Provincial Court) (QL).

⁸ T. Franklin, "HIV-positive man who used syringe in robberies sentenced to prison for five years," *HIV/AIDS Policy*

& Law Review 11, 1 (2006): 42.

⁹ D. Lajoie, "Judge tosses HIV assault case: allegation that ex-lover hid his medical status called unreliable," *The Windsor Star*, 10 March 2006.

¹⁰ U.S. Centers for Disease Control and Prevention, "Transmission of HIV possibly associated with exposure of mucous membrane to contaminated blood," *Morbidity and Mortality Weekly Report* 46, 27 (1997): 620–623.

¹¹ *Ibid.*

¹² "One year sentence for spitting," *Canadian HIV/AIDS Policy & Law Review* 7, 1 (2002): 52.

¹³ J. Pritchett, "HIV-infected man bit victim in assault," *Kingston Whig-Standard*, 31 July 2006.

¹⁴ G. Bellett, "Man with HIV jailed 15 years for unsafe sex: seven victims: 'catastrophic and dreadful' crime, judge says," *National Post*, 3 March 2006.

¹⁵ T. Franklin, "HIV-positive man convicted of aggravated sexual assault," *HIV/AIDS Policy & Law Review* 11, 1 (2006): 41.

¹⁶ G. Bellett.

¹⁷ *R. v. Lamirande*, [2006] M.J. No. 33 (Man. Provincial Court) (QL), para. 34.

¹⁸ *Ibid.* at para. 6.

¹⁹ *Ibid.* at para. 14.

²⁰ *R. v. Lamirande*, [2006] M.J. 223 (Man. Court of Appeal) (QL), para. 1.

²¹ *Ibid.* at para. 26.

²² *R. v. S(F)*, 2006 CarswellOnt 1539 (Ont. Court of Appeal) (WestlaweCARSWELL).

²³ *Ibid.* at para. 29.

²⁴ *Ibid.* at para. 19.

²⁵ *Ibid.*, para. 18.

²⁶ *Ibid.* at para. 18.

²⁷ S. Pazzano, "'Despicable' dad; HIV-positive man guilty of sex with daughter, 5," *Toronto Sun*, 14 October 2006.

²⁸ Canadian Press, "HIV-positive man sentenced to jail," *Sudbury Star*, 31 August 2006.

In brief

Supreme Court affirms that Ontario tribunal has power to consider Human Rights Code

In a significant decision for human rights advocates in Ontario, the Supreme Court decided on 21 April 2006 that the Ontario Social Benefits Tribunal (the Tribunal) must consider the *Ontario Human Rights Code* (the Code) when deciding cases.¹

The applicants, both of whom were addicted to alcohol, had applied for and been refused disability benefits under the Ontario act under which social assistance is provided to people with disabilities.² They appealed to the Tribunal the decision to refuse them benefits.

At the Tribunal, they argued that section 5(2) of the Act should be disregarded by the Tribunal because it infringed the right not to be discriminated against on the grounds of disability, as found in the Code. Section 5(2) of the Act states that a person is not eligible for income support where the person's disability is based solely on addiction to drugs, alcohol or another substance. The Tribunal found that it did not have the power to consider the Code in reaching its decision.

The Court looked at the Code and the acts that established the Tribunal, and at the disability benefits scheme. It found that the Tribunal had no power to refuse to consider the Code when it was relied upon by a party in

an appeal. The Court sent the case back to the Tribunal so that it can rule on whether, in light of the Code, section 5(2) of the act can be applied to refuse the applicants disability benefits.

It is worth noting that, in a 2000 decision, the Ontario Court of Appeal decided that substance abusers are handicapped and entitled to the protection of the Code.³

The Supreme Court's decision may also be relevant to other tribunals and human rights law in Canada, depending on the wording used in the relevant laws.

– Glenn Betteridge

Police officer loses negligence suit against Correctional Services Canada

In March 2006, an Ontario Superior Court of Justice dismissed on procedural grounds a police officer's claim that Correctional Services Canada (CSC) staff was negligent in withdrawing a suspension warrant issued against an HIV-positive man who bit him after being released.⁴

The police officer filed suit eleven months after being bitten, arguing that but for the negligence of the CSC, he would not have come into contact with the man and therefore would not have suffered the bite injury. He had sought \$75,000 general damages and \$25,000 punitive damages. Fearing infection with HIV, the police officer underwent blood tests for one year. The officer did not contract HIV.

Under the federal *Crown Liability and Proceedings Act*, no civil suit alleging the negligence of a public authority can be instituted after six

months have passed from the date of the injury.⁵ In cases where an element of the claim of negligence cannot reasonably be known by the plaintiff within the limitation period, such as the extent of the injury suffered, an exception is allowed. This exception is known as the “discoverability rule” and allows the limitation period to begin from the date on which the missing information was known, or ought to have been known, by the plaintiff. The Court found that the police officer could not benefit from the discoverability rule. Soon after being bitten, the officer was aware of the fact that the man who bit him had HIV and knew that the suspension warrant had been withdrawn and the details of the facts involved in the decision to withdraw it. The case was dismissed.

In additional comments, the Court noted that even if the police officer had filed his claim on time, he would not have won the case. After considering the “tremendous amount of time”⁶ CSC staff spent attempting to assist the officer's assailant and the

factual circumstances of the case, the Court concluded that withdrawing the assailant's arrest warrant was a reasonable act of discretion.⁷ Furthermore, it was not foreseeable that the police officer would be bitten.⁸ The police officer indicated his intent to appeal.⁹

– Jennifer Chan

¹ *Tranchemontagne v. Ontario (Director, Disability Support Program)*, 2006 SCC 14 .

² *Ontario Disability Support Program Act, 1997*, S.O., 1997, c. 25, Schedule B.

³ *Entrop v. Imperial Oil* (2000), 50 O.R. (3d) 18.

⁴ *Tsoutsoulas v. Canada (Attorney General)*, [2006] O.J. 1020 (Q.L).

⁵ R.S.C., 1985, C-50, s. 32.

⁶ *Tsoutsoulas v. Canada* at para. 23.

⁷ *Ibid.*, para. 37.

⁸ *Ibid.*, para. 34.

⁹ N. Pona, “Bitten cop loses lawsuit; lived in fear of HIV,” *Toronto Sun*, 16 March 2006.

HIV/AIDS IN THE COURTS - INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the Review. Coverage of U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Alana Klein, editor of this section, at aklein@aidslaw.ca.

South Africa: Court orders government to provide antiretrovirals to prisoners

On 28 August 2006, the High Court of South Africa denied the government's attempt to suspend an earlier Court order to provide antiretroviral (ARV) treatment to eligible HIV-positive prisoners in Westville Correctional Centre (WCC).¹ In reaching its decision, the Court considered, among other factors, the irreparable harm and neglect that would be suffered by the prisoners should the access to ARV treatment be delayed. The judgment is the latest development in an eleven-month struggle by WCC prisoners living with HIV, the Treatment Action Campaign (TAC) and the AIDS Law Project (ALP) to compel the government to provide ARVs to WCC prisoners.²

Original application and Court order

In the original application to the Court, filed on 12 April 2006, 15 prisoners living with HIV in WCC

and TAC requested that the Court compel the government to provide the prisoners and all similarly situated prisoners in WCC with access to ARVs. The prisoners had significantly compromised immune systems

and thus were eligible to be assessed for ARV treatment under the South African national HIV treatment program and guidelines. In its original decision of 22 June 2006, the Court determined that the government had

not fulfilled its constitutional and other legal obligations to the prisoners in WCC.³ As a result, it ordered the government to:

- remove restrictions that prevented HIV-positive prisoners in WCC from accessing ARVs;
- provide ARVs in accordance with the national plan and guidelines; and
- report-back within two weeks to ALP and the Court on its plan to implement the above.

The government sought the Court's permission to appeal the order which, in the normal course of legal proceedings, would suspend the order. However, ALP successfully argued the order should not be suspended. In its decision, the Court highlighted the urgency of ARV treatment for the prisoners, citing the government's own statistic of the deaths in WCC of nine prisoners per month of HIV/AIDS-related illnesses since the beginning of 2005.⁴ The government then sought permission to appeal the Court's decision not to suspend the order.

Leave to appeal suspension of order refused

In deciding that leave to appeal should not be granted, the Court applied the test set out in previous cases, which required that proof of irreparable harm and prejudice to the government be balanced against that experienced by the prisoners. In order to determine this, the medical situation of the applicants and other WCC inmates was examined. The government claimed that there was no need for the 22 June 2006 order as the prisoners were all properly looked after and provided with adequate medical treatment, including ARVs.

Affidavits filed by TAC reported the death of one of the original applicant prisoners in the period since the initial judgment, citing his death as proof of inadequate medical care. The Court noted that despite clear indications of the prisoner's need for ARV treatment assessment, this did not occur until legal proceedings were instituted against the government, at which point his ARV treatment was ineffective. Furthermore, the Court noted that in addition to the prisoner-applicants, there were a number of other prisoners, at least 48 more, who were very sick with HIV/AIDS, but were not receiving appropriate medical treatment, including assessment for ARV therapy.

The Court concluded that since no claim was presented of unavailable resources or other insuperable practical difficulties, provision of ARV treatment would simply present an "organisational inconvenience" for the government. In contrast, the prisoners' health would suffer irreparable harm should the interim execution order be suspended. Citing the long history of neglect set out in both the earlier judgments and the TAC affidavits, the Court determined that it was necessary for the government to comply with the order. Therefore, the leave to appeal was denied and the Court amended the original order to extend the deadline for the government to report to the ALP and the court on its plan to fulfill the order.

Government's report, ALP's response⁵

On 8 September 2006, the government filed a brief sworn statement containing its plan. In sum, the government asserted that its plan is the government of South Africa's plan for providing ARVs to all those who require

publicly funded HIV/AIDS treatment. Further, the government asserted that all WCC prisoners with CD4 counts of less than 200 have been receiving care in accordance with the national plan. Specifically, it stated that 72 of the 114 prisoners were taking ARV therapy. The government also detailed steps that WCC was taking to become an accredited facility for the purposes of undertaking ARV assessment, prescription and dispensing.

In a detailed response, ALP, while recognizing progress on the part of the government, disputed numerous of the government's assertions including, significantly, that all those in urgent need of ARV treatment had been assessed for same. For this and other reasons, ALP contended that the WCC plan was unreasonable and therefore failed to pass constitutional muster. The government responded in detail, maintaining its position that it has always complied with its constitutional obligations to WCC prisoners, and that it has fully complied with the Court's order.

– Cheryl Robinson

Cheryl Robinson is a second year student at the University of Toronto Faculty of Law and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ *EN et al. v. Government of the Republic of South Africa et al.* (28 August 2006), 4576/2006 (Durban and Coast Local Division).

² ALP, a specialized legal clinic, acted as the lawyer for the prisoners and TAC. All decisions and numerous other documents in the case are available via ALP's website: www.alp.org.za.

³ *EN et al. v. Government of the Republic of South Africa et al.* (22 June 2006), 4576/2006 (Durban and Coast Local Division).

⁴ *EN et al. v. Government of the Republic of South Africa et al.* (25 July 2006), 4576/2006 (Durban and Coast Local Division).

⁵ The three sworn statements referred to in this section are available via www.alp.org.za.

U.S.: Sexual history must be disclosed in lawsuit for negligent HIV transmission, California Supreme Court rules

In July 2006, the Supreme Court of California ruled that a man being sued for allegedly transmitting HIV to his partner was required to disclose information about his sexual history.¹ The court also decided that in order to sue for negligent transmission of HIV, a plaintiff need not prove that the defendant actually knew he was HIV-positive at the time of sexual relations. Rather, it would be enough for the plaintiff to show that the defendant had *reason to know* he was living with HIV at the time of the alleged transmission.

A woman (Bridget) sued her partner (John) for intentionally and negligently transmitting HIV to her. Shortly after they began their relationship in 1998, John told Bridget he was monogamous and did not have any sexually transmitted infections, and insisted that they stop using condoms. The couple married in July 2000 and Bridget tested positive for HIV in October 2000. John tested HIV-positive soon after. John later revealed to Bridget that before their marriage he had had sex with men. Each partner claimed the other had become infected first.

The trial judge had ruled that as part of the pre-trial discovery process, Bridget was entitled to know, among other things, the name, address and telephone number of every man that John had had sex with in the previous ten years. John appealed. The Court of Appeal ruled that John had to disclose only the total number and dates of every sexual encounter with a man in the years prior to their relationship. John appealed again.

John argued before the Supreme Court of California that that in order to sue him successfully for negligently or intentionally transmitting HIV to her,

Bridget would have to show that he actually knew he had HIV. Therefore, during the pre-trial discovery process, Bridget should only be able to inquire into whether John had had a positive HIV test or a medical diagnosis.

Majority opinion

Justice Baxter, writing for the majority, held that in order to be civilly liable for negligent transmission of HIV, it would be sufficient if the defendant had “reason to know” he was living with the virus when he had unprotected sex with the plaintiff. Reason to know exists “when there is sufficient information to cause a reasonable actor to infer that he or she is infected with the virus or that infection is so highly probable that his or her conduct would be predicated on that assumption.” He expressed concern that if people were required to have actual knowledge they might choose not to be tested for HIV in order to avoid legal liability.

Finally, he held that state constitutional privacy rights did not bar discovery in this case because John’s privacy interests did not outweigh the state’s compelling interest in “facilitating the ascertainment of truth in

connection with legal proceedings” and preventing the spread of AIDS.

Dissenting opinions

Justices Werdegar and Moreno wrote separate dissenting opinions. Both agreed that the test for liability should be based on actual knowledge of HIV status, and that extending liability for HIV transmission to people without actual knowledge might hinder the fight against AIDS.

Part of the legislature’s response to HIV/AIDS was to encourage testing by protecting the confidentiality of HIV test results in civil proceedings through California’s Health and Safety Code. Forcing people to disclose in civil proceedings information about their sexual partners would necessarily lead to questions about their partners’ HIV status.

At the same time, Justice Moreno found the majority’s view that people would want to avoid diagnosis and treatment in order to avoid liability in the future “difficult to believe.”

For her part, Justice Werdegar called the divergence of views on public health, privacy and other policy considerations “all conjecture as far as this court knows,” and con-

cluded that they were better left to a legislature that has already extensively addressed the issue.

Both dissenting judges also expressed concerns about the intrusiveness of discovery and the risk it may be used for harassment by HIV-positive people seeking lucrative settlements or to embarrass a former sexual partner by exposing that person's sexual history. Justice Moreno concluded that the majority's decision had "opened a Pandora's box."

Comment

The case reveals a number of concerns about imposing civil liability for exposure and transmission of HIV.² First, the "ought to have known" standard risks stigmatizing people who are members of at-risk populations, because is difficult to

draw a clear line between someone who "ought to know" he or she is living with HIV and a person who is a member of an at-risk population. The potential for reinforcing stereotypes is reflected in the plaintiff's discovery request in this case: she limited her discovery request to John's sexual history with men.

In addition, the role that the law plays in structuring incentives to seek testing and treatment needs to be better understood. Both the majority and the dissenting judges believed that their judgments would encourage people to seek testing.

Finally, the fact that the majority failed to recognize that HIV carries special stigma that is relevant to HIV-related policymaking is worrying. Justice Baxter supported his view that HIV is no different from other sexu-

ally transmitted diseases with a 1984 law review article quoting a popular magazine that labelled genital herpes as the "new scarlet letter."

While civil liability may be an appropriate response to HIV transmission in some circumstances, care should be taken to ensure that it does not unnecessarily and unjustifiably interfere with human rights and undermine other important public policy objectives.

– Alana Klein

¹ *John B. v. The Superior Court of California and Bridget B.*, 137 P.3d 153, 3 July 2006).

² Similar policy considerations have been explored in the criminal context. See UNAIDS, *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*. June 2002, pp. 23–27.

Switzerland: HIV-positive woman ordered to disclose names of sexual partners

An HIV-positive woman was sentenced in March 2006 by Zurich County Court to a 12-month suspended prison sentence after having had unprotected sex with three men. She was also ordered to disclose to authorities a list of her sexual partners' names and to keep the list updated with names of future partners with whom she had unprotected or protected sex.¹

The 42-year-old mother of two came to the Zurich court's attention when a man being investigated for rape identified her as being one of his victims. Prior to the rape, she had had consensual sex with the attacker and two other men, all of whom had been

informed of her HIV-positive status.²

The court relied on article 231 of the Swiss penal code,³ which is intended to prevent the spread of infectious disease. The provision, which dates back to 1942, makes it a crime to "intentionally propagat[e] ...

a dangerous and transmissible human disease." As per the Swiss High Court's previous interpretation of the law, an HIV-positive person can be prosecuted for having unprotected sex even if the partner is informed of the infection before hand and both

partners agree to have unprotected sex. According to the Zurich County Court, the purpose of the provision, to prevent spread of infectious disease, was the only important consideration. That the woman's sexual partners had agreed to have unprotected sex knowing that she had HIV, and that none of them had actually contracted the virus, were considered irrelevant.⁴

Comment

The case raises a number of human rights and policy concerns. First, the requirement to disclose to authorities the names of sex partners in the past and going forward raises serious privacy concerns, both for the woman and those persons whose names she has been ordered to report.⁵ Swiss human rights groups have reacted strongly to these privacy incursions,

and have questioned the purpose of making the list, noting that the actual effects it will have on preventing HIV from spreading are difficult to imagine.⁶

In addition, as the organization AIDS Assistance Switzerland argued, “[c]riminalising the passing on of HIV can even be counterproductive and can lead to people ignoring their HIV infection ... [and to] not testing themselves out of fear that they would face repression.”⁷ Thomas Lyssy, spokesperson for AIDS Assistance Switzerland also opposed making the HIV-infected person solely responsible for keeping the virus from spreading. Instead, he argued, both partners should be equally responsible for using protection.⁸

– *Liisa Seim*

Liisa Seim is an exchange student at the University of Toronto Faculty of Law, and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ “Strafbarkeit der Übertragung,” *Swiss Aids News*, June 2006.

² B. Panevski, “Swiss judge orders HIV positive woman to disclose partners’ names,” *British Medical Journal*, 332, 7545 (2006): 809–a.

³ *Strafgesetzbuch* (StGB)

⁴ B. Panevski, para. 2.

⁵ “Strafbarkeit,” para. 1.

⁶ *Ibid.*

⁷ B. Panevski at para. 2.

⁸ T. Renz, “HIV-positive Frau muss Sexualpartner melden,” *Basler Zeitung*, 24 March 2003.

U.S.: Courts rule anti-prostitution policy restriction on AIDS funding violates right to free speech

Two U.S. District Courts ruled that a U.S. government policy making government HIV/AIDS funding contingent upon signing a pledge to oppose prostitution violates the First Amendment.

Courts in the District of Columbia¹ and in the Southern District of New York² recently heard cases concerning a policy of the U.S. Agency for International Development (USAID)

that requires that government funds only be given to groups that explicitly oppose prostitution and sex trafficking.

This policy has met wide opposition because it is seen as preventing

aid groups from effectively working with prostitutes to stem the spread of HIV/AIDS, even when they use their own private funds to do so. The USAID provision specifically

requires all recipients of government funding to “abstain from all speech that could be understood by the government as supporting the decriminalization of prostitution,”³ regardless of the source of the money used to engage in such speech.

The plaintiffs in the cases were U.S. NGOs — the Alliance for Open Society International (AOSI) and Pathfinder International, acting jointly, and DKT International (DKT) — that work on international HIV prevention. While none of the plaintiff organizations “support” prostitution, they argued that they must maintain their ability to engage directly with at-risk populations using proven methods of intervention. DKT, for example, refused to sign the required agreement because it runs condom distribution programs for sex workers in Vietnam and it says that signing the pledge would stigmatize and alienate its clients.

In May 2006, the court issued summary judgment in the DKT case to the effect that USAID’s policy requirement is unconstitutional because it violates the First Amendment.

Earlier the same month, the court issued a preliminary injunction against USAID on the basis that AOSI and Pathfinder may suffer irreparable harm if they are forced to continue to conform to the

policy requirement pending a ruling in the case. As a result, AOSI and Pathfinder cannot be compelled to conform to USAID’s funding pledge until a decision is reached in the case. A decision on the merits of that case remains pending. In granting the preliminary injunction, however, the court determined that the anti-prostitution pledge is “likely to violate the first amendment.”⁴

The central issue in these cases was freedom of speech, as protected by the First Amendment of the U.S. Constitution. In both cases, the plaintiff groups argued that USAID violated their right to free speech by using its spending power to interfere with their groups’ use of private funds. USAID argued that it did nothing to limit freedom of speech because the plaintiffs were free to adopt any policy they wished, but that the government could not be compelled to fund activities contrary to its policy objectives. The court, however, found that the government failed to narrowly tailor its restriction and that it could have achieved its policy goal of opposing prostitution globally in a manner less restrictive than a total ban on private speech. It is well established that there are limits on the government’s spending power and that it cannot use the provision of subsidies to expressly suppress “disfavored viewpoints.”⁵

Further, while the U.S. Supreme Court has ruled that the government may selectively fund one viewpoint over another, this power has only been found to extend to the use of federal funds, not private funds.

The U.S. Department of Justice recently filed an appeal of the court’s decision in the DKT case.

– Ellen Silver

Ellen Silver is a student at the Faculty of Law, University of Toronto and is volunteering with the Legal Network through Pro Bono Students Canada.

¹ *DKT Intern., Inc. v. U.S. Agency for Intern. Development* 435 F.Supp.2d 5 (2006).

² *Alliance for Open Society Intern., Inc. v. U.S. Agency for Intern. Development* 430 F.Supp.2d 222.

³ *Ibid.* at 270.

⁴ *Ibid.* at 278.

⁵ *Ibid.* at 271, quoting *National Endowment for the Arts v. Finley*, 524 U.S. 569 at 587 (U.S. Supreme Court, 1998).

U.S.: HIV-positive prospective employee can sue Foreign Service for discrimination

On 27 June 2006, the U.S. Federal Court of Appeals overturned a lower court ruling and permitted an HIV-positive man to sue the Secretary of State for alleged discrimination in hiring.¹ He was denied a position as a foreign service officer, which required travel and work at overseas posts, because of his HIV status.

Lorenzo Taylor was extended a conditional offer of employment with the Foreign Service. However, the State Department refused to hire him when it found out that he was living with HIV and had a pulmonary condition.

The State Department has a policy of, as a general rule, assigning HIV-positive individuals, regardless of their health, only to postings where there exists a physician experienced in the treatment of HIV and labs comparable to U.S. standards. Under the policy, people living with HIV were considered not to possess “worldwide availability.”

However, existing staff living with HIV are treated differently from candidates: candidates are refused employment, whereas existing staff will continue to be employed and given assignments as their health permits.

Taylor sued the State Department under the *Rehabilitation Act*, alleging discrimination on the basis of HIV status. The Secretary of State brought a motion for summary judgment — arguing the case should be dismissed before a trial because there was no genuine issue regarding the facts, and the law on the matter was clear and in favour of the Secretary of State.

The lower court granted the motion concluding that reasonable worldwide availability was an essential function of a foreign service

officer and that, because of his HIV status, Taylor was not capable of fulfilling this function without posing a direct threat to himself. The lower court also held that the significant risk to Taylor’s health could not be reduced by any reasonable accommodation short of undue hardship on the part of the State Department.

The Court of Appeal determined that the Secretary of State was not entitled to summary judgment. There was a genuine issue regarding the extent to which foreign service officers must be available to serve overseas. Moreover, there was contested evidence regarding whether Taylor’s HIV could be accommodated without undue hardship on the part of the Secretary of State. Finally, the evidence regarding his pulmonary condition was not settled. The Court of Appeal sent the case back to the lower court to proceed to trial of the issues.

Comment

People living with HIV may aspire to employment which requires work in diverse countries with different health care systems and levels of care for HIV.

The fundamental, inter-related human rights issues raised by this case are threefold: (1) whether people living with HIV can be refused such employment solely on the basis of their underlying HIV status; (2) to

what extent must employers take into account a prospective HIV-positive employees’ present health and medical prognosis and offer accommodations; and (3) within reason, does an HIV-positive prospective employee get to determine the acceptable level of risk involved in a work setting?

The resolution of these issues may have legal significance beyond the U.S., despite the fact that Taylor based his legal suit on a U.S. act. Concepts akin to “essential job duties,” “reasonable accommodation,” “direct threat” and “undue hardship” underpin anti-discrimination law as it applies to HIV and employment in a number of countries (e.g., Canada, Australia).

One issue that did not come up in this case is the impact of HIV-related immigration and border entry restrictions on job duties. If travel to countries with such restrictions is found to be an essential duty of a job, it may be legal for an employer to refuse to hire, or to fire, a person solely on the basis of her HIV status.

– Glenn Betteridge

Glenn Betteridge (gbetteridge@aidslaw.ca) is a Senior Policy Analyst with the Canadian HIV/AIDS Legal Network.

¹ *Taylor v. Rice*, 451 Federal Reporter 3d 898 (District of Columbia Circuit 2006).

U.K. Court rejects prisoner's application for needle exchange

The U.K. Court of Appeal has ruled against prisoner John Shelley's challenge to the Prison Service refusal to provide needle exchange in prison.¹

Shelley was first denied permission to seek judicial review of the prison policy in April 2005.² As he had in his original application for judicial review, Shelley claimed in his appeal that inmates who use drugs in prisons are at risk of contracting blood-borne viruses such as HIV and hepatitis B and C if they do not have access to sterile needles for each injection, and that the disinfecting tablets that the prison were providing were not as effective as sterile injection equipment.

He claimed that the failure to provide needle exchange violated articles 2, 3 and 8 of the *European Convention on Human Rights* (the European Convention) which deal, respectively, with the right to life, the prohibition of human or degrading treatment, and the right to privacy.³

The Court of Appeal affirmed that under the European Convention, the prison service must provide an adequate health care system. However, like the administrative court below, it held that there was no violation of the European Convention and that it was not unreasonable for U.K. authori-

ties to provide disinfection tablets instead of a needle exchange scheme to protect the health of people living in prison.

Lady Justice Hallett found that the benefits of needle exchange were not yet clearly established for the prison system in England and Wales. She stated that there was “no satisfactory evidence as to the difference in the decreased risk to life inherent in a needle exchange scheme as opposed to a disinfection scheme,”⁴ despite having cited one study that found disinfection to be less effective at preventing disease than providing new and sterile syringes.

Lady Justice Hallett also found that needle exchange “may lead to increased drugs use and more syringes in prison.”⁵ The studies presented at trial showing that needle exchange programs did not lead to increased drug use were, in her view, not necessarily generalizable to the larger prisons in England and Wales.

The court stated, however, that the balance of the evidence might tip in favour of needle exchange programs in the future. It held that authorities

need to keep the situation under constant review; and that a failure to do so could itself be challenged in court.

Shelley has brought the case to the European Court of Human Rights, which has invited submissions from the U.K. government.

– Alana Klein

¹ *The Queen on the Application of John Shelley v. Secretary of State for the Home Department* [2005] EWCA Civ 1810.

² See D. Valette, “UK: Legal action on needle exchange programs in prisons dismissed.” *HIV/AIDS Policy and Law Review* 10, 2 (2005): 51.

³ For a more thorough discussion of the applicant's arguments, see *ibid.*

⁴ *Ibid.* at para. 33.

⁵ *Shelley* at para. 42.

In brief

India: High Court of Andhra Pradesh upholds the right of HIV-positive person to employment in the police force

Recently, a Division Bench of the High Court of Andhra Pradesh upheld the right of an HIV-positive person to appointment in the Police Department. The right to employment of a person living with HIV/AIDS has been enforced in a number of cases since the Bombay High Court issued its landmark decision on the employment rights of people living with HIV/AIDS in *MX v. ZY* in 1997.¹

The petitioner, a reserve police constable, had applied for the post of Sub-Inspector of Police. Though the petitioner passed both the physical and written tests and was provisionally selected for the job, he was later denied appointment on the ground that he had tested HIV-positive. The Police Department relied on Order 70(3) of the Andhra Pradesh Revised Police Manual, which prohibits the appointment of otherwise eligible HIV-positive candidates as Sub-Inspector of Police.

On being denied appointment, the petitioner first approached the Andhra Pradesh Administrative Tribunal but failed to get any relief. He then challenged the tribunal's decision and Order 70(3) of the Police Manual before the Andhra Pradesh High Court. In support of the case, the petitioner adduced medical evidence that an HIV-infected person is healthy, functional and productive during the asymptomatic period

which may range from three to 18 years before the onset of AIDS.

Hence, the petitioner argued, denial of employment to a person only on the ground of being HIV-positive infringes his right to life and livelihood.

The High Court of Andhra Pradesh declared Order 70(3) to be against the constitutional mandate of equality and non-discrimination in public employment. The Court directed the respondents to appoint the petitioner to the post of Sub-Inspector subject to the satisfaction of required standards.

The High Court of Andhra Pradesh's judgment in this case is important because it recognizes the employment rights of people testing HIV-positive in jobs where high physical fitness is a pre-condition for employment.

– Asha Mohan

Asha Mohan is an advocacy officer with the Lawyers' Collective HIV/AIDS Unit (www.lawyerscollective.org/lc_hivaids) in New Delhi, India.

Hong Kong: Appeal Court affirms that law criminalizing buggery infringes rights of gay men

On 20 September 2006, the Hong Kong Court of Appeal affirmed the decision of the Court of First Instance declaring unconstitutional the buggery provision of the *Hong Kong Crimes Ordinance* as it applies to gay men.²

Section 118C of the Crimes Ordinance made it illegal for a man to commit buggery with a man under

the age of 21 years, and illegal for a man under the age of 21 to commit buggery with another man. Under the Crimes Ordinance, the age of consent for heterosexual vaginal intercourse is 16 years of age, and women under the age of 21 years are not subject to criminal penalty for engaging in buggery with either a man or a woman.

The Court of Appeal largely adopted the reasons of the Court of First Instance in finding that section 118C infringed the equality and privacy rights of gay men as protected under the *Hong Kong Basic Law* and *Bill of Rights*. Accordingly, the Court of Appeal affirmed the lower court's order that section 118C was unconstitutional and of no force and effect, and ordered the government to pay the costs of the gay man who had challenged the law.

– Glenn Betteridge

South Africa: Court overturns misconduct conviction of physician who denounced Minister's inaction on HIV

On 24 March 2006, a South African court of appeal ruled that a physician is not guilty of misconduct for openly condemning the Health Minister's failure to provide the drug AZT to HIV-positive pregnant women.³

In 1999, a charge was filed against Dr Costa Gazidis after he told a newspaper reporter that he was gathering information in order to have Health Minister Dr Nkosazana Zuma charged

with manslaughter for refusing to provide AZT to pregnant women to prevent mother-to-child transmission of HIV. Dr. Gazi was an employee of the Department of Health at the time. He was convicted of misconduct under the Public Service Act,⁴ which prohibits public officers from making comments to the prejudice of any government department.⁵

The Court of Appeal overturned Dr Gazi's conviction on narrow grounds, without addressing constitutional questions relating to freedom of expression. The court found that the Minister's refusal to fund AZT for financial reasons generated significant public controversy, irrespective of Dr Gazi's comments. As a result, any prejudice to the Ministry that resulted from the physicians remarks already existed as a result of widespread public criticism.

– Ellen Silver

South Africa: Herbal medicine proponent ordered to stop defaming treatment activists

On 3 March 2006, the High Court of South Africa issued a preliminary order against Dr Matthias Rath, his foundation and a traditional heal-

ers organization.⁶ They are interdicted from publishing any statement alleging that the Treatment Action Campaign (TAC) is a front for or funded by the pharmaceutical companies or industry; and that TAC targets poor communities as a market for the pharmaceutical industry.

The order was made pending the trial in the case. TAC, a civil society HIV treatment activist organization, filed the lawsuit as a result of public statements by Rath and his foundation, which sell herbal treatments for HIV infection and claim antiretroviral medications are extremely toxic. Rath publicly stated that TAC, among other things, in promoting such medications is acting in league with the pharmaceutical industry; forces the government to spread disease and death among South Africans; and destabilizes democracy in South Africa.

The Court focused on the allegation that TAC was a "front" for drug companies. Applying the legal test for defamation, it found that the statements had no factual basis and injured TAC and its members by lowering them in the estimation of members of society generally. Applying the legal test for granting an order before trial, the Court found that TAC would suffer irreparable harm if the defamatory statements continued to

be published pending the outcome of the trial. Finally, the Court dismissed Rath's argument that an order would limit his constitutionally protected freedom of speech.

– Glenn Betteridge

¹ *MX v. ZY* [1997] A.I.R. 1997.

² *Leung v Secretary for Justice* (20 September 2006), CACV 317/2005; affirming *Leung v Secretary for Justice*, [2005] HKEK 1334, as reported by G. Betteridge, "Hong Kong: Courts says laws criminalizing sexual activity infringe rights of gay men," *HIV/AIDS Policy & Law Review* 10, 3 (2005): 39–41.

³ *Costa Gazidis v. The Minister of Public Administration* (24 March 2006) Case No. A2050/04 (High Court of South Africa, Transvaal Provincial Division).

⁴ A. Ketter, "South Africa: Court upholds disciplinary measures against outspoken physician," *HIV/AIDS Policy & Law Review* 10, 1 (2005): 63.

⁵ *Public Service Act (Proclamation No. 103 of 1994)*, s. 20(f) (South Africa).

⁶ *Treatment Action Campaign v Matthias Rath et al.* (3 March 2006), 2807/2005 (Cape of Good Hope Provincial Division). The decision and other materials in the law suit are available via www.tac.org.za.



UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
WFP
UNDP
UNFPA

UNODC
ILO
UNESCO
WHO
WORLD BANK

AIDS 2006:

LAW, ETHICS, AND HUMAN RIGHTS

In this special section of the *HIV/AIDS Policy & Law Review*, made possible by funding received from the Joint United Nations Programme on HIV/AIDS (UNAIDS), we reproduce the most relevant presentations on legal, ethical, and human rights issues related to HIV/AIDS given at the XVI International AIDS Conference in Toronto, Canada, in August 2006, and at the many satellite meetings. We did the same for the conferences held in Geneva in 1998, in Durban in 2000, in Barcelona in 2002 and in Bangkok in 2004.¹ With funding from UNAIDS, this issue will be mailed to over 500 people and organizations with an interest in HIV/AIDS and human rights, particularly in developing countries, in addition to the *Review's* regular distribution list. This issue will also be distributed via the UNAIDS Information Centre to thousands of additional recipients. The goal is to increase access to materials on human rights, legal and ethical issues related to HIV/AIDS for individuals and organizations worldwide; to facilitate networking among individuals and groups active in the area; and to promote policy and legal responses to HIV/AIDS that respect human rights.

The AIDS 2006 conference featured more presentations on human rights issues than any previous International AIDS Conference.

¹ "Geneva98: Law, Ethics, and Human Rights," *Canadian HIV/AIDS Policy & Law Newsletter* 4, 2/3 (1999): 78–117; "Durban 2000: Law, Ethics and Human Rights," *Canadian HIV/AIDS Policy & Law Review* 5, 4 (2000): 54–117; "Barcelona 2002: Law, Ethics, and Human Rights," *Canadian HIV/AIDS Policy & Law Review* 7, 2/3 (2002): 77–122; "Bangkok 2004: Law, Ethics and Human Rights," *HIV/AIDS Policy & Law Review* 9, 3 (2004): 67–113. All four supplements are available via www.aidslaw.ca/review.

Advancing rights for women: the role of litigation

Litigation is becoming an increasingly attractive advocacy tool for human rights movements around the world. It has served as an effective strategy not only for reforming or enforcing laws that deny or protect basic human rights, but also for raising awareness of and mobilizing support for human rights issues. In this article, which is based on a presentation at a symposium session at the conference, Luisa Cabal focuses on a specific area within the realm of women's health and rights — the rights of HIV-positive women and girls and, in particular, violations they experience vis-à-vis access to health care — and discusses the potential for litigation to help raise awareness and advance efforts to protect and promote human rights in this area.

Violations against women and girls living with HIV/AIDS in the health-care context have been documented in countries around the world, but have not yet been addressed in a comprehensive way through litigation, despite increasing resort to the courts on broader issues relating to HIV/AIDS and the rights of HIV-positive individuals.

To date, most HIV-related litigation has focused primarily on three thematic areas: discrimination against HIV-positive individuals, access to treatment and health services, and prevention and care in prisons.¹ Litigation in this field has yet to focus on gender issues, despite growing recognition that women are not only disproportionately affected and infected by the disease, but are also affected in different ways.² In a UNAIDS survey of HIV-related litigation, only one of 32 highlighted cases specifically involved the rights of HIV-positive women.³

Most cases involving access to treatment do not address the specific needs or experiences of HIV-positive women, despite recognition in international policy documents that, under seemingly neutral laws and policies,

women may be the last group to have access to drugs.⁴ In litigation on HIV-related discrimination, most cases have generally concerned the employment context, such as employers' refusal to employ or dismissal of people with HIV, illegal military discharge on the basis of HIV status, and employee dismissals for refusing to submit to compulsory HIV testing.

While the achievements of litigation in all of these areas have also benefited women with HIV, there is increasing international recognition of the need to address the specific gender dimensions of human rights violations in the HIV/AIDS context, which have gone largely unaddressed in the courts.

International human rights bodies have recognized that women and girls with HIV experience violations of their basic human rights in ways that, because of their sex and gender, are unique to them.⁵ Gender-based violations are especially prominent in the health-care setting. A multitude of studies from around the world have documented coercive practices and violations of informed consent in testing women for HIV during pregnancy or delivery.⁶ Many women

in these situations have their rights violated again when doctor-patient confidentiality is breached and their HIV status is reported to others without their permission.⁷ Societal and cultural notions of women as subordinate in relation to men and within the family structure contribute to the practice and acceptability of informing a woman's husband or father of her HIV status before she herself is told.⁸

Also prevalent is discrimination by health-care personnel. Women with HIV have been turned away from public health facilities⁹ or directed to private hospitals specializing in HIV care,¹⁰ subjected to delays in receiving essential treatment,¹¹ and forced to pay extra fees for services.¹² Pregnant women who arrive at health facilities in the middle of delivery are tested for HIV and directed to other facilities if the results are positive.¹³

In cases where a woman with HIV requires a caesarian section, there are reports that positive women are forced to wait until all caesarian sections on non-positive women have been completed for the day before they may have the operation.¹⁴ Some women have been encouraged to

terminate their pregnancy once their HIV status has been discovered¹⁵ and denied information on available methods to reduce perinatal transmission.¹⁶

In other instances, women who learn of their HIV status after conceiving and who wish to terminate their pregnancy face obstacles obtaining safe abortions, even where the procedure is legal.¹⁷ There have also been reports that access to abortion for HIV-positive women has been made contingent upon the woman's agreement to sterilization.¹⁸ Instances of forced or coerced sterilization of HIV-positive women have been documented in countries in Latin America, Asia, Africa and Eastern Europe.¹⁹

Some women have been encouraged to terminate their pregnancy once their HIV status has been discovered.

Litigation in the reproductive rights context

The experiences of the Center for Reproductive Rights and collaborating organizations in litigating reproductive rights cases demonstrate the potential of using litigation to address the sex and gender dimensions of health and human rights violations, such as those that occur in the HIV/AIDS context. Such litigation has addressed violations that are often similarly at issue in the experiences of women and girls with HIV

within health-care systems, and has advanced rights and principles that have important applications in this context. These include principles of government accountability for protecting its citizens from harm, and respecting women and girls' rights to physical integrity, autonomy, informed consent and access to quality health services free from discrimination, coercion and violence.

The Center was a co-petitioner in *Maria Mamerita Mestanza Chavez v. Peru*, in which a Peruvian woman with seven children was coercively sterilized in 1996 after local health officials threatened criminal action and loss of food aid if she did not undergo the procedure.²⁰ Mestanza developed complications from the procedure and died a few days later. The case was brought to the Inter-American Commission on Human Rights and was settled in 2003. Under the final settlement agreement, the Peruvian government acknowledged international legal responsibility, agreed to compensate the surviving husband and children, and agreed to implement recommendations made by Peru's Human Rights Ombudsman concerning patients' rights and sterilization procedures in government facilities.²¹

The Center and its partners have also used litigation strategies to hold governments responsible for violence against women in public health facilities (*MM v. Peru*), and to take up issues of adolescents' rights, including access to medically necessary health and reproductive health care. In *KL v. Peru*, a 17-year-old Peruvian woman carrying a fetus with a fatal anomaly (anencephaly) was denied a therapeutic abortion by Peruvian health officials, despite the exception in Peruvian law allowing for preg-

nancy termination for health reasons.

The young woman was compelled to carry the fetus to term and was then forced to feed the baby until its inevitable death several days later. The Committee issued its decision in 2005, establishing that denial of access to abortion services where legal violates women's basic human rights.²² This decision marked the first time that an international human rights body held a government accountable for failing to ensure access to legal abortion services

Conclusion

HIV/AIDS-related litigation to date has made important gains in protecting and promoting the human rights of people living with HIV/AIDS, but it has largely omitted the specific needs and experiences of women and girls, who comprise an ever-increasing proportion of HIV-positive individuals. Litigation is but one strategy to begin addressing violations to the rights of HIV-positive women, but a critical one nonetheless that can support and complement other advocacy efforts. As demonstrated in the reproductive rights context, litigation has proven effective in raising and remedying violations of women's human rights in the health-care context, and holding governments accountable for fulfilling their human rights obligations under national and international laws.

—Luisa Cabal

Luisa Cabal (LCabal@reprorights.org) is Director of the International Legal Program for the Center for Reproductive Rights in New York. Ms. Cabal's presentation at AIDS 2006 and this article are based on a forthcoming article to be published

in the *UC Davis Journal of International Law & Policy*, co-authored by Ms. Cabal and Pardiss Kebriyaii, Legal Adviser for Litigation at the Center.

¹ Canadian HIV/AIDS Legal Network and UNAIDS, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV*, UNAIDS, 06.01E, 2006. At www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=45.

² See, e.g., S. Paxton et al., *Oh! This One is Infected!": Women, HIV & Human Rights in the Asia-Pacific Region*, Expert Meeting on HIV/AIDS and Human Rights in Asia-Pacific, Bangkok, Thailand, 23–24 March 2004.

³ Canadian HIV/AIDS Legal Network and UNAIDS.

⁴ Office of the United Nations High Commissioner for Human Rights and UNAIDS, *HIV/AIDS and Human Rights: International Guidelines: Revised Guideline 6*, 2002, para. 16.

⁵ Committee on the Elimination of Discrimination against Women, General Recommendation No. 15, Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), 9th Sess., U.N. Doc. A/45/38 (1990); General Recommendation No. 24, Women and Health, 20th Sess., U.N. Doc. A/45/38/Rev.1, ch. I (1999).

⁶ See Human Rights Watch (HRW), *A Test of Inequality: Discrimination Against Women Living with HIV in the Dominican Republic*, 2004, p. 29; Asia Pacific Network of People Living with HIV/AIDS (APN+) , *AIDS Discrimination in Asia*, 2004, pp. 17, 20.

⁷ HRW, pp. 29, 35–39; APN+, pp. 17–18.

⁸ UNAIDS, *India: HIV and AIDS-Related Discrimination, Stigmatization and Denial*, 2001, p. 24.

⁹ APN+, p. 18.

¹⁰ UNAIDS, *India*, p. 26.

¹¹ *Ibid.*

¹² APN+, p. 18.

¹³ *Ibid.*, p. 19.

¹⁴ HRW, pp. 41–42.

¹⁵ *Ibid.*, p. 43.

¹⁶ APN+, p. 20.

¹⁷ *Ibid.*, p. 21.

¹⁸ International Community of Women Living with HIV/AIDS (ICW), *HIV Positive Young Women*, ICW Vision Paper I 2004, p. 3.

¹⁹ International Council of AIDS Service Organizations, *Community Monitoring and Evaluation: Implementation of the UNGASS Declaration of Commitment on HIV/AIDS*, 2006, p. 19; ICW, p. 3; APN+, p. 21; HRW, pp. 39–41.

²⁰ Maria Mamerita Mestanza Chavez v. Peru, Case 12.191, Inter-Am. C.H.R., Report No. 66/00 (2000). At www.cidh.org/annualrep/2000eng/ChapterIII/Admissible/Peru12.191.htm.

²¹ Friendly Settlement, Maria Mamerita Mestanza Chavez v. Peru, Case 12.191, Inter-Am. C.H.R., Report No. 71/03 (2003). At www.cidh.org/annualrep/2003eng/Peru.12191.htm.

²² U.N. Human Rights Committee, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/11153/2003 (2005).

Law reform and land rights for women in Tanzania

Land is the lifeline of people. In Tanzania, most people live in rural areas, where the industrial base is very poor, so issues relating to land are sensitive. This sensitivity is heightened when viewed through an HIV/AIDS lens. Denial of the right to land for people living with HIV/AIDS is tantamount to denying these people their lives. In this article, which is based on a presentation at a symposium session at the conference, Elizabeth Maro Minde examines the problems of land ownership in Tanzania, and describes the approaches used by Kilimanjaro Women's Information Exchange and Consultancy Organisation (KWIECO) to advance women's rights.

Land reforms are rooted in the historic legacies of Tanzania. Prior to the colonial era, land belonged to the community. Under Customary Law, only men could own land; women were considered dependants. In the colonial system, all land belonged to the Governor. The new system

did not have significant impact on women: Customary Law and practices continued to inhibit women from owning land.

A dual land tenure system evolved. In rural areas, land was governed by Customary Law.

Customary titles were freehold,

and the titles were recognized as belonging to a particular clan, but were not registered. Inheritance was through the male issue, and ownership of land by women was limited. Women could use land, but could not sell or bequeath it to their children. In urban areas, land was registered

and Certificates of Title issued.

A number of factors led to calls for the land laws to be reformed — including increases in the population of people and animals, which meant that land available for use decreased; increased awareness about the value of land; and changes in the mode of land ownership, which went from a clan-based system to an individual system as a result of the introduction of land markets.

In 1991, the government appointed a commission to investigate problems relating to land. One of the issues identified by the commission was gender discrimination in the distribution, inheritance and ownership of land.

The recommendations of the commission led to the adoption of a new land policy in 1993. Under the policy, all Tanzanian men and women above 18 years of age could acquire and own land, and both men and women were represented in all decision fora regarding land issues. Despite the new policy, women are still discriminated against in a variety of ways.

Discrimination persists

First, while the law has changed, the attitudes of people have not. Women in rural areas are still dependent on men, and cultural practices still dominate.

For example, one woman lost her husband due to AIDS. Two days after the husband was buried, a neighbour trespassed their land and extended his boundary about 50 metres. When the widow protested, the neighbour retorted, “I cannot discuss with a dead person,” meaning that because her husband had died, she was therefore also a “dead” person. Subsequently, a court case was filed on the woman’s behalf. But this did not end the problem. Banana trees and plants on her

land were cut down, and her young children were harassed.

The inability of an HIV-positive person to fight a sustained legal battle is known within the community. This creates a conducive atmosphere for the rights of HIV-positive persons to be abused. When the HIV-positive person happens to be a woman, the likelihood of abuse increases.

Second, in rural areas, the registration of land and the granting of titles is still resisted. People do not understand the value of titles, and are often suspicious of the government’s motives for wanting land to be registered. In most cases, women do not register themselves as owners or co-owners of land, despite the fact that the Land Act of 1999 allows women to own land either in their own right or jointly with their spouses. The prohibiting factor is culture, which respects men as owners of land.

Land is the main collateral for securing loans. Because cultural factors prevent women from owning land, women are denied access to capital and also the potential to economic empowerment. Women who are HIV-positive desperately need economic empowerment in order to provide them with the necessities of life, such a well-balanced diet, transport to hospital and counselling centres, and the provision of security for the family.

Third, women are represented in all decision making fora regarding land but they do not know what to do in those meetings. At the village and ward land committees, women are not assertive and are often unaware of women’s land issues, and of the potential impact that they themselves can make through the committees.

Fourth, inheritance laws have not changed to match changes in the land

law. Thus, while land law allows women to own land, inheritance laws are silent on the matter. Customary Inheritance Laws still recognize inheritance through the male issue.

KWIECO’s strategy

KWIECO responds to these problems with campaigns designed to change people’s attitudes and with programs providing women with support.

Dealing with attitudes requires a long-term strategy. It is important to increase awareness by educating communities about the laws and discriminatory practices that hinder gender equality. KWIECO organizes seminars, workshops, role plays and posters. As well, through its Children Legal Services, KWIECO aims to sensitize children as a long-term strategy. Children can adopt changes easily; if they are imparted with modern human rights ideals, this may eventually lead to changes in attitudes.

With respect to the granting of titles, by educating people about banking and loan systems and about the legal value of title deeds, KWIECO encourages people to register as land owners. This can have a significant positive impact on the ability of women to fight for their rights. It allows them to move away from the clan-based system that is prone to discriminate against women, and towards the constitutional system that is more likely to protect them.

Women have to put up a real fight in order to get inheritance-related land rights. Cases invariably end up in the High Court or the Court of Appeal. An HIV-positive woman lacks the energy and support to sustain the struggle. KWIECO provides assistance through court representation. This allows women to assert

their constitutional right to own land. Court precedents are created, which also help the legal machinery to appreciate the concerns about women's land rights.

Conclusion

Women living with HIV/AIDS disproportionately suffer more land

rights infringement. Since traditional cultural attitudes are generally more to blame than a lack of constitutional equality, a major effort must be made to sensitize both men and women in communities. As well, a mechanism must exist for women's concerns to be heard and represented. The need for legal representation is critical in order

to challenge discriminatory cultural practices as well as test the new laws which purport to give women rights.

– Elizabeth Maro Minde

Elizabeth Maro Minde (kwieco@africaonline.co.tz) is Managing Director of KWIECO.

“Second on the needle”: human rights of women who use drugs

Women likely experience drug use in ways that are different than men, and may face discrimination based both on their status as drug users and their status as women. In this article, which is based on a presentation at a satellite session prior to the conference, Joanne Csete reviews existing data on women's use of drugs, and discusses the barriers in accessing health services faced by women who use drugs. The author concludes that there is an urgent need for rights-based, women-centred services for women who use drugs.

Women who use drugs often live at the intersection of two human rights crises. People who use drugs face extensive human rights abuse committed with impunity in many countries, and often abetted by harsh drug laws. The subordination that all women may face is augmented for women who use drugs by moral judgmentalism and social marginalization. Women who use or have used drugs are assumed to be unfit parents and socially irresponsible. This judgmentalism, along with the deep criminalization of drug use in many countries, is a barrier to understanding drug use among women as a health concern and applying public health solutions.

Few countries have good data on the proportion of women among those who use drugs, which may contribute to keeping women drug users hidden and their health needs low on the policy agenda. The drug-using experience of women may differ from that of men in many important ways that should be taken into account in health services and policies, but rarely are. Many studies suggest that women become addicted and experience the effects of addiction with use of a smaller amount of drugs and with use over a shorter time than men.

Studies in some countries have shown that women are more likely

than men to have begun injecting drugs at the urging of a sexual partner. Research in the U.S., the U.K. and Canada has shown that women are more likely than men in some settings to share injection equipment with a sexual partner. Some studies have described women's inability to demand clean injection equipment from men with whom they may be injecting, especially when the man in question is also a sexual partner.

Women who inject drugs need and seek help for the act of injecting much more frequently than do men. Women who are assisted in injection by men may often be “second on the needle” — that is, they inject after

the person who assists them injects, and in this circumstance women may not be able to demand a clean syringe for fear that they will lose the assistance they need to inject, or because they do not feel in control of the injection process. Just as power imbalances in sexual relationships have been identified as factors in women's inability to demand condom use in many circumstances, gender-related power imbalances may impede women's access to clean injecting equipment.

Women who use drugs face particular barriers to seeking and using health services, including services for treatment of addiction. In many jurisdictions, women fear loss of custody of their children if it is known that they use illicit drugs. In 2005, Human Rights Watch documented cases where women who use drugs were coerced by health professionals in Russia to give up custody of their children to the state or to have abortions,¹ and this practice is surely not limited to Russia. Pregnant women are given priority on waiting lists for addiction treatment in many jurisdictions, but they will not be inclined to take advantage of this service if they fear loss of their children or coercion to terminate their pregnancies.

Even where loss of child custody is not a problem, women may face a variety of impediments to health services. Women are more likely than men to be primary caretakers of children, but some drug treatment pro-

grams do not permit children on the premises or offer child-care services. Residential treatment programs may also be impractical or impossible for women who care for children or other family members. Drug treatment services in many countries are based on men's drug-using behaviours and practices; women may have little expectation of services or information oriented to their needs. Supervised injection facilities that exist in many countries rarely allow assisted injection and thus may effectively discourage utilization by women.

Women in some countries are highly criminalized for minor or auxiliary roles in drug crimes, particularly when they are unable or unwilling to give evidence against, or make deals at the expense of, male co-defendants. Mandatory minimum sentencing policies in the U.S. have hit women particularly hard, according to a study by the American Civil Liberties Union and the NGO Break the Chains.² Between 1986 and 1999, the number of women incarcerated at the state level for drug offenses alone increased more than eightfold. By 2006, more than one million women in the U.S. were behind bars, at least 40 percent of them for reasons related to drug use. Many of these women were minor or first-time drug offenders. Few have been imprisoned in institutions with women-centred drug treatment services.

There is an urgent need for rights-based, women-centred services for

women who use drugs. Women should be meaningfully involved in the design, implementation and evaluation of services geared to their needs. Women counsellors, women-run hotlines, child-friendly venues for health services, and non-judgmental services for pregnant women are urgently needed. Supervised injection facilities should find ways to allow women who need assistance injecting to receive it. More broadly, the hypercriminalization of drug use that has placed many women in prison, and is an impediment to utilization of health services by women who use drugs, should be replaced by human rights-centred and evidence-based public health approaches.

– Joanne Csete

Joanne Csete (jcsete@aidslaw.ca) is Executive Director of the Canadian HIV/AIDS Legal Network.

¹ Human Rights Watch, "Positively abandoned: stigma and discrimination against HIV-positive mothers and their children in Russia," *HRW Reports* 17, 4D (2005): 19–21. Available via www.hrw.org.

² American Civil Liberties Union, Break the Chains, and Brennan Center for Justice, *Caught in the Net: The Impact of Drug Policies on Women and Families*, 2006. Available via www.aclu.org/drugpolicy/.

Routine HIV testing: three perspectives

Testing for HIV is a starting point for any intervention: prevention, care or support. Thus, it is crucial that as many people as possible have access to HIV testing facilities. But the current push for routine testing raises a number of human rights and public health concerns, not the least of which is that routine testing may dispense with informed consent and pre-test counselling. Below are three perspectives on this issue. In an article based on part of his Jonathan Mann Memorial Lecture, delivered at a plenary session at the conference, Anand Grover summarizes the debate on opt-out routine testing and discusses the potential pitfalls of such an approach. In an article based on her presentation at a “controversy and common ground” session at the conference, Christine Stegling describes the Botswana experience with routine HIV testing, and discusses the need for testing policy to be based on human rights principles. Finally, in an article based on his presentation at the same session, Mark Heywood argues that HIV testing can be dramatically scaled up while still protecting people’s autonomy and dignity.

Opt-out routine testing: the case has not been made

For years, testing for HIV has been based on the Voluntary Testing and Counseling (VTC) model. In early 2004, Botswana actively adopted a system of opt-out routine testing. In June 2004, UNAIDS and the World Health Organization (WHO) recommended the routine offer of testing based on the Botswana model. This model is now being followed in other countries, including Kenya, the U.K. and some places in the U.S., in particular San Francisco. The recommendations recently adopted by the U.S. Centers for Disease Control and Prevention also reflect this model.

This new approach has come about primarily because of the availability of antiretroviral drugs (ARVs) and the fact that ARVs are becoming easier to access in developing countries. However, it should be noted that some commentators have recommended that opt-out routine testing

be the norm not only where ARVs are available, but also “wherever basic HIV care and prevention are available.”¹

Under the opt-out routine testing model, most patients are tested for HIV as a routine part of medical visits unless they explicitly refuse. In contrast to the VTC model, there is very little or no emphasis on pre-test counseling. Informed consent is effectively done away with.

The proponents of opt-out routine testing argue that:

- the pre-test counseling model that had been adopted earlier in the HIV epidemic may have been valid in the era when there was no treatment available, but is redundant now;
- given that treatment is now available, it is important for people to be tested so that those who test

positive can access treatment;

- pre-test counseling takes a lot of time and resources that are better utilized for testing;
- the VTC model has helped to create HIV/AIDS exceptionalism, which has fuelled societal stigma around HIV; and
- pre-test counseling has dissuaded persons from taking an HIV test, and has created a barrier to testing and, therefore, the very delivery of treatment.

Undoubtedly, the vast majority of persons living with HIV/AIDS do not know that they are HIV-positive. It is in their interest to know so that they can protect themselves by taking appropriate treatment, and also protect others. Therefore, scaling up of testing is of the utmost necessity. The real question is how this should be done and whether opt-out routine

testing is the best option globally in the circumstances that obtain today or will obtain in the near future.

Availability of treatment

In my opinion, the opt-out routine testing model is conditional on their being universal access to treatment. Unfortunately, we are far from achieving universal access. At the global level, the WHO's 3 by 5 initiative was able to reach only approximately 50 percent of its target. In India, anywhere from 500 000 to 700 000 people require ARVs. However, the Government of India's target is to provide free first-line treatment to only 188 000 people, and even that is to be achieved only in 2010. As of today, there are only 36 000 people living with HIV/AIDS on treatment. As yet, there is no provision for the second-line drugs that will be increasingly required.

Informed consent

Another concern that I have with opt-out routine testing is that it does away with consent, which is a precious human right. In common law countries, the law is quite clear. As U.S. Supreme Court Justice Cardozo, put it: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation on his patient without his patient's consent commits an assault, for which he is liable in damages."²²

International human rights instruments contain the same principle. Do we need to sacrifice such an important principle in order to scale up HIV testing? There would have to be compelling reasons to do so, and I do not think that the case has been made.

Most common law jurisdictions now accept that consent means informed consent and implies at least informing the patient about the benefits, risks and alternatives. However, while in developed countries informed consent is well-rooted, not only in the law but also in practice, particularly in the health care setting, that is not the case in most developing countries.

If opt-out routine testing were to be recommended globally, the clear message for all the medical fraternity in the developing world would be to test all persons without consent.

In India for instance, while the principles of consent are readily followed by judicial authorities, these principles are not strongly rooted in the field. For example, consent is a formality (and not really voluntary) in cases of admission to a hospital and surgical interventions. In this context, if opt-out routine testing were to be recommended globally, the clear message for all the medical fraternity in the developing world would be to test all persons without consent — i.e., mandatory testing.

Even the proponents of opt-out routine testing fear that such a policy may turn out to be coercive. Kevin De Cock has said: "Careful guidance is required, however, to determine how to implement such testing without coercion and how to limit the negative social consequences of a

pre-marital diagnosis of HIV infection, especially for young women."²³

Counselling

Opt-out routine testing would effectively do away with pre-test counselling. Counseling strategies were developed in the era when treatment was not available. Pre-test counselling prepared a person not only for the test, but also for the consequence of coping with a positive result without any treatment. As treatment became more widely available, both pre- and post-test counselling ought to have been drastically overhauled. However, this does not appear to have been done.

In Botswana, Dr. Howard Moffat, Medical Superintendent at Princess Marina Hospital in Gaborone, said that "[p]eople who were not sure they wanted to know their HIV status often emerged from counseling determined not to be tested.... I think the medical profession itself ... played a major role in creating this fear of AIDS and this quite irrational reluctance to be tested."²⁴ This raises questions about the manner in which counseling was being administered in Botswana. In light of these questions, do we really think that the Botswana model should be adopted globally?

Stigma and discrimination

The proponents of opt-out routine testing say that the model should be accompanied by guarantees of confidentiality and assurances of protection against discrimination and ostracism. But it is difficult to understand how these guarantees or assurances could possibly be enforced in real life. Unfortunately, it is impossible to control stigma because it operates in silent, secretive and sub-

versive ways. The law only steps in much later, after the event, when the damage has already been done.

The real challenge is to control stigma within communities. We need a massive investment in programs to de-stigmatize HIV and to make persons living with HIV/AIDS acceptable in society.

Conclusion

The content of pre-test counseling has to change so that HIV testing is seen as a positive step for an individual to take. Pre-test counseling is essential not only because it is the only entry point of information for persons, whether they test negative or positive, but also so that persons

who test positive can be given messages concerning safety, treatment availability and adherence. The more ARV therapy becomes the norm, the more money and resources will have to be spent on counseling. In this context, I respectfully disagree with Justice Edwin Cameron who said that although pre- and post-test counseling are both useful, they should not be carried out at the expense of draining away time and energy of health care personnel whose priority should be diagnosis, testing and treatment.⁵ The point is not to pit one against the other, but rather to view counseling as an essential aid to testing.

— Anand Grover

Anand Grover (anandpgrover@hotmail.com) is a practicing lawyer in the Bombay High Court, and the Director of the Lawyers Collective HIV/AIDS Unit, both in India.

¹ K. M. De Cock et al, "Unfinished business — expanded HIV testing in developing countries," *New England Journal of Medicine*, 354, 5 (2006): 440–442 at 440.

² *Schloendorff v Society of New York Hospital*, 211 NY 125, pp. 129–130 (1914).

³ K.M. de Cock et al at 441.

⁴ A. Zavis, "Botswana adopts new approach to HIV tests," *South African Press Association*, 5 January 2006. At <http://www4.aegis.org/news/sapa/2006/SA060102.html>.

⁵ E. Cameron, "AIDS: Building on Hope and Reason," speech delivered at Oxford University, U.K., 23 June 2006.

HIV testing in the era of increased treatment access: a human rights perspective from Botswana

The public health goal of increased access to testing needs to be understood within the context of human rights, including the right to health, the right to information and the right to privacy. All these rights are inter-linked and ultimately contribute to well-informed citizens making intelligent choices about their lives, looking after their health and, therefore, contributing to the general well-being of our communities.

Initially the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) was very excited about the idea of routinely offering HIV tests at health facilities. In 2003, BONELA organized a consultative meeting with government officials,

NGO activists, development partners and people living with HIV/AIDS to discuss this new approach. The meeting agreed that a routine offer for an HIV test should be made at all points of entry to the health system, but that patients needed to give their informed consent to such a test.

This approach was based on the understanding that it is imperative to uphold the patient's right to autonomy — i.e., to make decisions about his or her body. However, the actual policy that has now become practice in Botswana is based on an opt-out approach that does not require the patient's expressed informed consent.

In the current set-up, it seems doubtful that patients understand their

right to opt out of an HIV test, considering power imbalances between the health care worker and ordinary citizens. In many of the debates about testing, the missing link seems to be the societal context in which testing is taking place. Stigma and discrimination are realities in Botswana, despite the fact that anti-retroviral therapy is available. Part of this societal context is the fact that provider-initiated testing has a disproportionate impact on women, who have more contact with the health system, especially through antenatal health care services.

BONELA runs a legal aid clinic with an attorney providing legal assistance to those who have expe-

rienced discrimination. It is a distressing reality that, on average, two clients a day present to the clinic with complaints such as unfair dismissal, refusal of employment and unfair treatment at the workplace.

Botswana has not enacted any legislation that protects the rights of those infected with HIV. In 2003, the Botswana Court of Appeal issued a judgment saying that it is legal for employers to test for HIV as a prerequisite for employment, and that the employer can decide not to employ HIV-positive applicants.¹ This judgment has never been challenged and no legislation has been introduced in reaction to it.

There are other parts of the Botswana legislative framework that raise questions as to whether there exists an enabling and protective environment for those living with the virus. For example, Botswana has adopted the concept of “shared confidentiality,” which severely limits, and at times violates, a person’s right to privacy. And, as in so many other countries, laws protecting women from domestic violence and marital rape have not been passed yet.

However, even if protective and anti-discriminatory legislation were

in place, BONELA would still not support HIV testing without informed consent. People need to be part of the decision-making process concerning their health care because it is only when we assist people in becoming agents of their own destiny, in an environment that protects and respects their human rights, that we will make a real change to the HIV epidemic in Botswana. A top-down government approach to the epidemic does not facilitate a process in which people take responsibility for themselves.

In many of the debates about testing, the missing link seems to be the societal context in which testing is taking place.

We need to ask ourselves: Testing to what end? Do we have evidence that people who have not consented to being tested for HIV actually live positively, protecting themselves from re-infection or infection, and going onto antiretroviral therapy and

adhering to it? Is knowing one’s HIV status synonymous with positive behavior change and seeking care and support? It seems that recently people have engaged in a numbers game — pointing to the increase in testing numbers, but not qualifying such numbers with data about the actual impact that this has in terms of the wider response to the epidemic. There is a definite need for independent research and monitoring of routine testing programs, involving persons living with HIV/AIDS and NGOs, to understand the actual outcomes from such programs.

What all of us need to refocus on is how to enable people to make good, informed and conscious choices and become willingly agents of their own destiny.

— Christine Stegling

Christine Stegling (director@bonela.org), is the Director of the Botswana Network on Ethics, Law and HIV/AIDS. A similar article, also based on the presentation Ms. Stegling made at AIDS 2006, has been published by AIDS Law Quarterly, September 2006 edition.

¹ Civil Appeal No. 37 of 2003 (Botswana Court of Appeal).

The routine offer of HIV counselling and testing: a human right

Human rights and public health are not and should not be at odds on this question of scaling up HIV testing. I favour an approach that is different to that adopted by Botswana, even

though I respect the motivation of the government of Botswana for dramatically trying to increase the numbers of people who know their HIV status.

In 2005, a friend of mine, Ronald

Lowe, who was a law lecturer in KwaZulu-Natal, died of AIDS. His death prompted Edwin Cameron, a well-known human rights activist, to propose that we need to funda-

mentally change the approaches that we have worked with around voluntary testing and counselling (VTC). Edwin Cameron argues, perhaps correctly, that Ronald would not have died if a doctor or medical practitioner had offered him an HIV test rather than depending upon Ronald overcoming his personal fears and stigmas to request that HIV test.

On that basis, Cameron suggests a total shift of paradigm, saying that the benefits of HIV testing now fundamentally outweigh the risks of HIV testing, and that we can therefore largely do away with the principle of informed consent and with the requirements of pre-test counselling. I disagree with this argument. I believe that what Edwin Cameron is proposing is a dangerous shortcut which will lead us into a very difficult situation.

The advent of access to treatment has indeed changed things dramatically. In South African health facilities, there has been a dramatic increase in VTC in the context of access to treatment. But this has been accompanied by low VTC training rates of health care workers. And, despite high HIV-positive rates in health facilities, systems for ongoing follow-up of clients are often lacking or weak. This should ring alarm bells. These are the issues that should concern us as much as the question of increasing the numbers of people who know their HIV status and who are tested for HIV.

I would make the following observations about the debate around HIV testing:

- A lot of this debate takes place on the back of anecdote rather than sound science. There is a significant lack of monitoring and assessment of HIV testing.

- There is a lack of investment in testing, in the promotion of testing, and in counselling.
- We have been inclined to blame VTC itself for low HIV testing uptake. But the real problem has been the lack of access to VTC, and very often the lack of incentives for VTC.
- HIV testing is a human resources issue. In the South African health system, an estimated 60 000 people provide informal health services to the public health system. Most of them provide counselling and testing services. We have to formalize that resource basis.

We need to raise the standard of care of other diseases to the level of HIV, not bring HIV down to the standard of care of other diseases.

We have to scale up HIV testing. The time has come for a dramatic increase in the numbers of people who know their HIV status. But we have to do so in a fashion that continues to respect people's autonomy and dignity.

What is the purpose of counselling? It is not a luxury. It is a necessity to help people with issues such as disclosure, with living with a life-threatening virus, and with adherence to treatment following an HIV-positive diagnosis. Counselling is a medical intervention; it is not just a human rights imposition. We need to raise the standard of care of other diseases to the level of HIV, not begin

to bring HIV down to the standard of care of other diseases, tuberculosis in particular.

The way forward would be for countries and the World Health Organization to move to a policy of health care providers routinely offering and recommending HIV testing, and providing appropriate counselling. This is more than just a neutral offer of testing by health care providers.

But we cannot stop there because, to do so, means that we would be catching people who are already ill with opportunistic infections, and who are already visiting our health facilities, and we would be leaving out a much larger number of people who are asymptomatic, who are vulnerable still, and who may not be HIV-negative. Therefore, we need active promotion of testing outside of health facilities. We need to target people at risk of acquiring HIV infection and the people at risk of transmitting HIV. We need to link HIV testing to prevention messages and to services.

And, finally, we need to improve prevention and treatment education across whole populations, so that people enter health facilities with a knowledge of HIV infection, which is not what happens throughout most of the developing world at the moment.

– Mark Heywood

Mark Heywood (heywoodm@alp.org.za) is Executive Director of the AIDS Law Project in South Africa.

HIV and the decriminalization of sex work in New Zealand

The decriminalization of sex work in New Zealand will protect the rights of sex workers and improve their working conditions and general well-being. It will also improve HIV prevention programs. In this article, which is based on a presentation at a “learning from practice” session at the conference, Catherine Healy describes the situation prior to decriminalization, and discusses the features of the new law and accompanying guidelines.

The New Zealand Prostitutes Collective (NZPC) was established by sex workers for sex workers in 1987, for the purpose of decriminalising prostitution and seeking an end to discrimination and stigma.

Sex workers wanted to have the same rights as any other person. In 1988, NZPC contracted with the Ministry of Health to create a supportive social environment for sex workers, and to provide a range of HIV/AIDS-prevention services to people working in the sex industry.

This loosely connected group of male, female and transgendered sex workers and allies became an effective lobby group, and drove the agenda to decriminalize sex work and create a legislative environment in which sex workers could realize their human rights.

Until recently, New Zealand had a legal framework similar to many countries, one that was designed to penalize and criminalize sex workers. This framework did not support the human rights of sex workers, and it compromised their occupational safety and health. It was difficult for sex workers to admit candidly to their involvement in sex work to health professionals, and to seek support from the police or other authorities when they were in dangerous circumstances.

In relation to HIV and AIDS, government agencies were at odds over their approaches to sex workers. While the Ministry of Health funded sex workers to distribute safer sex products and engage their peers in imparting information, the police would use these resources to argue that prostitution laws were being broken.

NZPC found that its community outreach programs were sometimes unduly affected by police actions. In this illegal environment, police assumed power over the lives of sex workers. They regarded sex workers as criminals who should be monitored and sometimes arrested. This, in turn, led to many intrusions that destabilized the lives of sex workers. There was always a fear that the next client could be an undercover police officer.

After extensive lobbying by sex workers and their allies, organizations and individuals in the wider community called for the decriminalization of prostitution. The *Prostitution Reform Act 2003*¹ was introduced by an individual Member of Parliament, not as part of government policy, but nevertheless received cross-party support. The proponents for law reform supported the aims of the new law, which were to safeguard the human rights of sex workers and protect them from exploitation, to promote

the welfare and occupational health and safety of sex workers, to be conducive to public health, and to prohibit the use in prostitution of persons under 18 years of age.²

The Act enables sex workers to have more control over their work and provides them with options as to where and how they work. Street-based workers, who had traditionally been the focus of police raids, are able to stand their ground and work in their neighbourhoods, building stable environments for themselves that are more conducive to their health and well-being. In the context of HIV prevention, this is very important. Furthermore, some street workers have been able to move indoors without the police acting as gatekeepers. Indoor workers are able to work for managers who can now be held accountable to employment and contract law, and laws affecting occupational safety and health, as well as criminal law.

Shortly after the law changed, occupational safety and health guidelines were developed by the Department of Labour in consultation with sex workers. The guidelines contain specific references to supporting sex workers in maintaining conditions that are conducive to their well-being. The guidelines not only promote best practice in the provi-

sion of commercial sexual services, but also include information about HIV education.³ The ability to manage negotiations with clients to promote sexual services that are safe is enhanced in this decriminalized environment.

Other features of the law enable sex workers to collectivize in competition with large brothels and to work from their homes, like any home-based occupation. In small or large brothels, sex workers' anonymity is protected. There is no mandatory

testing, and clients are dissuaded from asking about the HIV status of sex workers, because brothel operators would be in breach of the law if they revealed this.⁴

While there are many strong legal features supporting the human rights of sex workers contained in the *Prostitution Reform Act 2003*, implementation of the law requires commitment from government agencies and others. For some people, the change is massive, and they are in the process of reorienting their

responses away from prosecution and towards protection.

— Catherine Healy

Catherine Healy (pcdp@globe.net.nz) is National Co-ordinator of NZPC.

¹ *Prostitution Reform Act 2003*, 2003 No. 28 [27 June 2003].

² *Ibid.*, s. 3.

³ Occupational Safety and Health, *A Guide to Occupational Safety and Health in the New Zealand Sex Industry*, Department of Labour, 2003.

⁴ *Prostitution Reform Act 2003*, s. 9.

Providing legal aid to members of vulnerable minorities in Ukraine

The rights of vulnerable groups — particularly injection drug users, people living with HIV/AIDS and sex workers — are routinely violated in Ukraine. In this article, which is based on a presentation from an abstract-driven session at the conference, Andrei Tolopilo describes a legal aid project undertaken to help people understand and defend their rights.

To address the problem of drug addiction, Ukraine has adopted a very repressive approach, coming down hard on drug users. Drug-dependent and HIV-positive persons are stigmatized and discriminated against. Human Rights Watch has documented cases involving the use of torture against drug-dependent persons.¹ Sex workers in the Ukraine have also been treated harshly.

In response to this situation, a project entitled “Protection of the Rights and Interests of Representatives of Vulnerable Social Groups” was

launched in Ukraine with the support of the International Harm Reduction Development Program (Open Society Institute) and the International Renaissance Fund. The goal of the project is to provide legal aid to persons who are addicted to narcotic drugs, people living with HIV/AIDS, and sex workers.

The project, which is being implemented in ten regions within Ukraine, brings together different organizations acting together. From July 2004 to August 2006, the project was able to provide direct legal aid to cli-

ents and to advocate on their behalf. Legal aid was provided by lawyers to clients face-to-face in drop-in centres and over the telephone (through the use of a hotline).

The project also trained clients on their rights and on how to make representations to authorities (27 training sessions in eight regions). Additional training sessions were held for law students volunteering in the legal clinics, and for medical and social workers. Finally, training sessions were organized for officials from law enforcement organizations

in an effort to increase the level of observance of the rights of vulnerable minorities.

As part of the project, educational materials were developed and distributed on a number of topics — including HIV/AIDS and the law; drug use; administrative detention; criminal law and process; rights, freedom and duties of individuals as per the Constitution of Ukraine; and the Family Code of Ukraine.

The project has been very useful in identifying legal problems experienced by members of vulnerable populations. The following is a partial list of the issues raised by clients of the legal aid clinics:

Injection drug users — illegal arrest; illegal search; extortion of money by officials of law enforcement bodies; illegal seizure of documents by officials of law enforcement bodies; renewal of lost documents; registration of a residence; requests for documents from places of imprisonment; problems in the exercise of administrative detention, personal

inspection and searches; availability of a free-of-charge legal aid for those with moderate means; welfare payments to single mothers having children; refusal to provide medical assistance; housing problems; problems with employment; family law problems; and the legal consequences of rehabilitation (treatment for drug addiction) in cases where drug trafficking offences were committed.

Persons living with HIV/AIDS — discriminatory attitudes on the part of hospital personnel; inaccessibility of treatment; infringement of confidentiality by medical workers related to HIV+ status; societal stigma; registration of disability status; problems obtaining pensions; issues concerning taking HIV-positive children to kindergartens and schools; and drawing up complaints to protest wrongful actions.

Sex workers — extortion of money and other illegal actions by officials of law enforcement bodies; false arrest and search; restoration of parent

rights; finding employment opportunities; attempts to register children in pre-school establishments; and refusal to provide medical service.

In the first two years of operations, the project handled a total of 3681 cases of rendering legal aid. In addition, project lawyers made applications, petitions and complaints to appropriate bodies, defended the interests of their clients in court, and provided practical help in other ways to clients.

— *Andrei Topolilo*

Andrei Topolilo is the Chairman of the Board of the Odessa human rights group, Veritas, and Head of the project “Protection of the Rights and Interests of Representatives of Vulnerable Social Groups.” The project is described on the website of Veritas, (the site is in Russian) at <http://www.veritas.org.ua/>.

¹ Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS*, March 2006. At <http://hrw.org/reports/2006/ukraine0306/ukraine0306web.pdf>.

Reflections on 25 years of AIDS

We need to re-politicize AIDS and make it part of a larger movement for social and economic justice, says Gregg Gonsalves. In this article, which is based on a presentation at a special session at the conference, Gonsalves provides some personal reflections on the first 25 years of the epidemic.

Peter Piot, Executive Director of UNAIDS, told the New York Times earlier this year that “2005 was the least bad year in the history of the

AIDS epidemic.”¹ But I think that we are losing the struggle against this disease. Five million new infections in 2005, and three million dead. It

was the worst year yet for those we’ve lost.

Famine Crimes, Alex de Waal’s description of how the humanitar-

ian aid industry has worsened and perpetuated famines, particularly in Africa, provides an analytical framework through which we need to interrogate our work on AIDS. De Waal concludes that we have created a vast infrastructure that is:

- largely unaccountable;
- self-justifying, pursuing organizational survival and expansion;
- privileging the policy preoccupations of the major industrialized countries: generalized, international responsibility instead of specific, local political accountability; and technical skill and experience over local knowledge; and
- promoting development or assistance instead of social change.²

No wonder things aren't getting better. We've created a system designed to fail. Yet in the margins of this system, there remain men and women, true heroes, who are largely forgotten, unknown, ignored or reviled by those who make this machine run. It's not Bill Gates or Bill Clinton who have made a difference in this epidemic despite their being treated at this conference as some sort of royalty — the seduction of the money and power they represent have blinded us to what they've really delivered.

The real heroes are the thousands of people like Christopher Moraka, Gugu Dhlamini, Ashok Pillai, Dasha Ocheret, Mandla Majola, Fanny Ann Eddy, Sou Southeavy, Paul Kasonkomona, Thomas Cai, Loon Gangte, Frika Chia Iskandar, Rolake Nwagwu, Othman Mellouk, Banta Leimapokpam, Jay Lipner, Gennady Roschupkin, Nikolai Nedzelskii, Leena Menghaney, Ezio Santos Filho, Joseph Scheich, Michael Callen,

Scott Slutsky, Lillian Mworeko, Sunil Pant, Paisan Suwannawong, Andy Zysman — all of whom have changed history, often at great personal risk, while most people took no notice.

In my opinion, we need to reinscribe the fight against AIDS as part of a larger movement for social and economic justice. It's no surprise that where we find HIV/AIDS, we often find other infectious and chronic diseases, including TB, diabetes, obesity, heart disease, asthma, mental illness and social epidemics of crime, violence and poverty. Unless we start looking at the factors that drive health disparities — in other words, why some of us get sick and some of us don't — broadly within our communities, we will be always treating one illness, while the "patient" dies of another. It's also no coincidence that these multiple epidemics exist among marginalized communities across the globe, among the poor, women, drug users, sex workers, gay men, prisoners and migrants.

The social, economic and political policies that create this marginalization in the first place also push us into the path of oncoming epidemics. Yet, we continue to place our hopes in prevention programs that narrowly construct risk around individual behaviour or in some new technology that will save us. Even those who profess to be deeply concerned about HIV prevention have little stomach for facing the structural and environmental factors that are the fuel for this great fire of an epidemic. They watch the flames grow higher, because to act on these issues moves beyond charity and, far too close for their comfort, to politics.

We need to re-politicize AIDS. Some people have made the case

that we need to "de-exceptionalize" and "re-medicalize" AIDS. I agree that HIV testing must be re-thought and that accepting that millions of people live and die without knowing their status is unacceptable. I support making HIV testing easier to do in medical settings, integrating sound and evidence-based public health strategies into our approaches to HIV/AIDS, and integrating HIV/AIDS into strengthened systems of care and prevention of infectious and chronic disease in general.

It's so unfashionable these days to talk of rights and particularly then to fight for them as if one really meant it.

However, the presumption that we need to abandon a rights-based approach to HIV/AIDS in order to do so is frankly reactionary. The calls to de-exceptionalize AIDS and return it to its proper medical context can easily become calls to turn us back into patients and victims, and passive actors in this epidemic. No doctor likes patients who talk back and neither do their governments. The calls to de-exceptionalize AIDS can become calls to ignore or downplay the social and economic aspects of HIV and push AIDS back into the realm of medicine, where the solutions are only biomedical. They can become calls to make AIDS as "unexceptional" as all the other ills, both medical and otherwise, that affect our communities, when we

should be claiming health for all and social and economic justice as a human right. It's so unfashionable these days to talk of rights and particularly then to fight for them as if one really meant it.

AIDS is essentially a crisis of governance, of what governments do and do not do to and for their people. We have the drugs to treat HIV infection, and we have the tools to confront the risks that drive HIV transmission and prevent infection itself. What we don't have is national political will necessary to scale-up our response. We have demanded too little from our leaders, and excused far too much. Except for the cries from a few brave activists, most people in countries around the world affected by the epidemic have not risen up to hold our leaders to account — to say these are our rights and these are your obligations.

Why aren't there millions of people around the world demanding action or telling their leaders to stand down? I understand some of us work in places where this kind of action is

difficult or impossible, but it is possible in more places on the planet than one might think. Perhaps those of us with the resources, the ability to change things ourselves or support this kind of work, have a real inability to see the epidemic for what it is, a political crisis — or we have made a decision not to see this, because complicity with the systems of power that perpetuate and worsen the epidemic is easier for us. We are at a terrible anti-political moment right now, where the powers-that-be have taken our rhetoric and told us that everything is fine— “we're on your side; you can demobilize and leave the epidemic to us.” That is the pernicious message of this conference. Don't believe a word they say.

It has been the worst year of the epidemic for so many of us. The question is whether we're going to stand up and make a promise today as one of my heroes, the late, great, Vito Russo did back in 1988:

We're so busy putting out fires right now that we don't have the time to

talk to each other and strategize and plan for the next wave, and the next day, and next month and the next week and the next year.

And, we're going to have to find the time to do that in the next few months. And, we have to commit ourselves to doing that. And then, after we kick the shit out of this disease, we're all going to be alive to kick the shit out of this system, so that this never happens again.³

— Greg Gonsalves

Gregg Gonsalves (gregg.gonsalves@gmail.com) is Coordinator of the Regional Treatment Literacy and Advocacy Programme for the AIDS and Rights Alliance of Southern Africa, a network of AIDS and human rights organizations in the countries of the Southern African Development Community.

¹ L. Altman, "Report shows AIDS epidemic slowdown in 2005," *New York Times*, 18 May 2006.

² A. de Waal, *Famine Crimes: Politics & the Disaster Relief Industry in Africa* (London: Villiers Publications, 1997).

³ Speech delivered by Vito Russo at ACT-UP demonstrations in Albany, N.Y. and Washington D.C. in 1988.

Controlling HIV among injecting drug users: the current status of harm reduction

HIV among injecting drug users is now a critical issue in global HIV control. Harm reduction strategies have been considered effective, safe and affordable for at least 15 years. In this article, based on a plenary presentation at the conference, Alex Wodak argues that the scientific debate about harm reduction is now over and that the paramount need is to overcome the conventional reliance on drug law enforcement, the major barrier to implementing harm reduction strategies in time and at sufficient scale.

Global spread of HIV among injecting drug users (IDUs) is now critical. Of all HIV infections in the world today, 30 percent are outside sub-Saharan Africa. Furthermore, of all HIV infections outside sub-Saharan Africa, 30 percent now involve IDUs.¹ This means that IDUs account for about

one in every ten new HIV infections in the world. That proportion is increasing. Also, in at least half a dozen countries, generalized HIV epidemics started among IDUs.

Injecting drug use has now been reported in 144 countries, and HIV has been reported among IDUs in 128 countries.² Illicit drug production continues to increase inexorably: heroin production in Afghanistan was up last year by 49 percent.³ The value of the global retail illicit drug market in 2003 was estimated to be US\$322 billion.⁴ A recent U.K. Cabinet report estimated that profits account for 26–58 percent of the illicit drug industry turnover.⁵

The importance of harm reduction

A package of measures has been known to be effective in controlling HIV among IDUs for at least 15 years. These measures are needed in both community and prison settings. First, IDUs need simple, explicit, peer-based and factual education about HIV. Second, needle syringe programs (NSPs) are needed to increase the availability of sterile injecting equipment and decrease the availability of used equipment. Third, IDUs need a choice of effective, attractive and accessible drug treatments, especially substitution treatments (such as methadone and buprenorphine for heroin injectors). Fourth, community development of IDUs is needed to encourage drug users to become part of the solution.

Harm reduction means that reducing the health, social and economic problems of psychotropic drugs is even more important than reducing drug consumption. Setting and achieving realistic but sub-optimal objectives is more effective than

setting but failing to reach utopian goals. Harm reduction means that “80 percent of something is better than 100 percent of nothing.”

The prolonged scientific debate about harm reduction is now over. Harm reduction is effective in reducing new HIV infections, is free of any serious adverse effects (especially increasing illicit drug use), and is cost-effective. This evidence is overwhelming for needle syringe programs⁶ and methadone or buprenorphine treatment.⁷ The earlier and more vigorously harm reduction is implemented, the better the results. No country which has started harm reduction programs has ever regretted that decision and then reversed its commitment.

Harm reduction is now accepted by most major UN agencies including the World Health Organization, UNAIDS, UNICEF, the World Bank and, increasingly, the United Nations Office on Drugs and Crime (UNODC). The International Red Cross and a steadily growing number of countries and organizations around the world have officially endorsed harm reduction.

In contrast, the number of organizations and countries that reject harm reduction is shrinking. Harm reduction is now explicitly rejected by only one UN organization with responsibility for drug policy, the International Narcotics Control Board, and by the U.S. and a few other countries. At a critical UNAIDS meeting in 2005, 21 countries wanted to include references to harm reduction, NSPs and substitution treatment. Only the U.S. opposed including these references.

All 25 members of the European Union now provide NSPs and methadone treatment. In Asia, home to

more than half the world’s population, harm reduction is today accepted in almost all of the most populous countries.

Forty eight countries now provide methadone treatment, while 34 countries provide buprenorphine treatment. Global uptake of NSPs is also increasing rapidly with 65 countries now providing at least some service.⁸ Although programs are now being started in many countries, coverage is generally still very poor, especially where it is most needed in Central and Eastern Europe, and Central, South, South East, and East Asia. Coverage in prisons worldwide is even worse.

Our current anti-heroin policies may inadvertently have pro-HIV effects.

The barriers to harm reduction

The most important barrier to harm reduction is excessive reliance on drug law enforcement. A recent study carried out in 89 large cities in the U.S. estimated the number of IDUs per capita and HIV seroprevalence among IDUs.⁹ These estimates were compared with three per capita legal measures: drug arrests, police employees and corrections expenditures. No legal measure correlated with the numbers of IDUs per capita, but in each city the greater these measures were, the higher the HIV prevalence among IDUs. The authors concluded that because legal measures had little deterrent effect on the

number of IDUs but may increase the spread of HIV, alternative methods of maintaining social order had to be considered.

There have been similar warnings previously. Five years before the first announcement of AIDS, a prophetic study with the arresting title, “The pro-heroin effects of anti-opium policies,” found that within 10 years of prohibiting opium in three Asian countries, requests for treatment from opium smokers disappeared only to be replaced by requests from heroin injectors.¹⁰ Our current anti-heroin policies may inadvertently have pro-HIV effects.

The contrast between the effectiveness of harm reduction and the ineffectiveness and high costs of the “war against drugs” has inevitably triggered a reconsideration of drug prohibition. As U.S. Secretary of Defense Donald Rumsfeld said, “if demand persists, it’s going to find ways to get what it wants. And if it isn’t from Colombia, it’s going to be from someplace else.”¹¹

Although it is still leading the global opposition to harm reduction, the U.S. had an annual AIDS incidence of 14.7 per 100 000 in 2003, the highest in the industrialized world.¹² Since the HIV epidemic began, more than one-third of AIDS cases in the U.S. have been attributed (directly and indirectly) to injection drug use.¹³

Western Europe, Japan and the U.S. spend \$US350 billion annually on agricultural protection.¹⁴ What options do drug producer nations have? If Afghanistan cannot sell onions and potatoes to Europe at a reasonable price, surely it will sell heroin. If Caribbean countries cannot sell bananas to the U.S. at a reasonable price, surely they will sell

cocaine. Fairer international trade policies are part of the bigger picture that has to be considered in gaining global control of HIV among injecting drug users.

Harm reduction still has some trenchant critics. This debate is essentially a conflict between “consequentialists” who evaluate interventions by considering their impact and “non-consequentialists” who evaluate interventions by considering their moral righteousness. However, all participants in this debate have to consider the morality of ignoring clear scientific evidence and condemning future generations to endemic HIV.

All participants in this debate have to consider the morality of ignoring clear scientific evidence and condemning future generations to endemic HIV.

Where to from here?

It is time to regard drugs primarily as a health and social problem, though there will always be a need for drug law enforcement as a secondary support. Expanding coverage of harm reduction strategies to the scale needed to control the HIV epidemic is now *the* major priority in most countries. Funding for health measures needs to be raised to the same level as that enjoyed by drug law enforcement. All major stakeholders should be involved in planning, including law enforcement and IDUs.

Unless HIV prevention policy is based firmly on science and the protection of the human rights of drug users, control of HIV in this critical population will never be achieved. Failure to control HIV among IDUs condemns the general community to high levels of HIV for generations to come.

Even though they undoubtedly take major risks, IDUs, often poor, uneducated, unemployed and living in a developing country, are not the real risk takers. The risks IDUs take are insignificant compared to the risks taken by policymakers who are usually well educated, powerful and working in fancy offices. Policymakers often chose policy options defying a vast body of strong evidence. They are often obscenely and indulgently in denial.

The UNODC slogan at the 1998 United Nations General Assembly Special Session on Drugs was “A drug-free world — we can do it!” In 2003, UNODC claimed improbably that the world was making “[e]ncouraging progress towards still distant goals.”¹⁵ This is denial on a global scale. Achieving control of HIV among IDUs requires policies based on the world we live in rather than some fantasy world. If the international community is to achieve control of HIV among injecting drug users, the entire UN system will need to commit to just one drug policy — harm reduction.

— Alex Wodak

Dr. Wodak (awodak@stvincents.com.au) is Director, Alcohol and Drug Service, St. Vincent’s Hospital in Darlinghurst, New South Wales, Australia.

¹ UNAIDS, *Overview of the Global AIDS Epidemic: 2006 Report*. At http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH02_en.pdf.

² S.A. Strathdee and F.I. Bastos, "Injection drug use and HIV infection," *Encyclopaedia of Public Health*. At <http://health.enotes.com/public-health-encyclopedia/injection-drug-use-hiv-infection>.

³ UNODC, *Afghanistan 2006 Annual Opium Poppy Survey*. At <http://www.unodc.org/pdf/execsummaryafg.pdf>.

⁴ UNODC, *2005 World Drug Report*. At www.unodc.org/unodc/world_drug_report_2005.html.

⁵ Government of the U.K., *Strategy Unit Drugs Report: Phase 1 — Understanding the Issues*, 12 May 2003. At www.strategy.gov.uk/downloads/work_areas/drugs/drugs_report.pdf#search=%22Strategy%20Unit%20illicit%20drugs%20UK%20report%22.

⁶ A. Wodak and A. Cooney, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users*. Evidence for action techni-

cal papers. World Health Organization, 2004. At www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf.

⁷ WHO/UNODC/UNAIDS, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*. Position paper, 2004. At www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf#search=%22methadone%20WHO%20UNODC%20UNAIDS%22.

⁸ C. Aceijas et al, "Global overview of injecting drug use and HIV infection among injecting drug users," *AIDS* 18, 17 (2004): 2295–2303.

⁹ S.R. Friedman et al, "Relationships of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas," *AIDS* 20 (2006): 93–99.

¹⁰ J. Westermeyer, "The pro-heroin effects of anti-opium

laws in Asia," *Archives of General Psychiatry* 33 (1976): 1135–1139.

¹¹ "Rumsfeld tells senators his views on drug war," *The Los Angeles Times*, 12 January 12 2001.

¹² See the website of Avert at www.avert.org/ausstatg.htm.

¹³ Centers for Disease Control and Prevention, *Drug-Associated HIV Transmission Continues in the United States*. Fact Sheet. At www.cdc.gov/hiv/resources/factsheets/idu.htm.

¹⁴ N.D. Kristof, "Farm subsidies that kill," *New York Times*, 5 July 2002.

¹⁵ UNODC, *Encouraging Progress Towards Still Distant Goals*, Report by the Executive Director, 2003. At www.unodc.org/pdf/document_2003-04-08_2.pdf.

Using human rights law to advocate for syringe exchange programs in European prisons

The *European Convention on Human Rights* can be used to advocate for the provision of syringe exchange programs in prisons, says Rick Lines in this article, which is based on a presentation at an abstract-driven session at the conference. The author outlines the arguments that states might use to avoid having to implement syringe exchange programs, and counters these arguments with reference to human rights law and jurisprudence.

The *European Convention on Human Rights* is the binding human rights instrument within the 46-member Council of Europe. Unlike some human rights treaties, the Convention contains no explicit right to health. However, within the context of detention, the right to health is engaged under the Article 3 prohibition of "torture or ... inhuman or degrading treatment or punishment."¹

The *European Committee for the Prevention of Torture*, which monitors prison conditions throughout the

Council of Europe, has expressed the position that, "[a]n inadequate level of health care can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment.'"² This raises the potential to use Article 3 as a tool to advocate for HIV prevention measures in prisons, including syringe exchange programs.

Article 3 imposes upon states a positive obligation, or "duty to protect" the well being of the people it holds in custody.³ The jurispru-

dence is clear that the duty to protect the physical integrity of prisoners includes the obligation to provide them with health care.⁴ This positive obligation applies "irrespective of the victim's conduct,"⁵ even if that conduct is unlawful or violates prison rules.⁶ Therefore, the state's positive obligation to protect the physical integrity of prisoners who inject drugs remains despite the prohibited nature of the activity.

Article 3 also imposes the responsibility on states to take "effective"

measures to “ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment or punishment.”⁷ Thus, in prisons, the positive obligation of the state to protect the health of prisoners who inject drugs is not satisfied simply by providing other forms of drug services that do not address the specific health risks posed by sharing syringes. Taking effective measures, in this context, requires that prisons provide sterile syringes, as this is the intervention proven most effective at preventing the transmission of blood-borne diseases among people who inject drugs.⁸

Successfully arguing that Article 3 obligates the state to provide syringe exchange programs in prisons would require that the European Court of Human Rights interpret circumstances that in the past might not been judged as amounting to inhuman or degrading treatment — i.e., the denial of sterile syringes — as constituting a violation of Article 3 in light of present day knowledge and standards.

The state would likely argue that the denial of sterile syringes does not constitute inhuman or degrading treatment; that the prohibition of syringe exchange programs does not exceed “the practical demands of imprisonment;”⁹ that expecting that prisoners refrain from using illegal drugs is a legitimate aim of incarceration; and that the refusal to provide sterile syringes is therefore part of a reasonable punishment, not an undue limitation on the rights guaranteed under the Convention. The state might also contend that its positive obligation to protect the well-being of prisoners does not extend to providing sterile injecting equipment because drug use is an illegal activity

and a form of self-inflicted harm.

However, the state’s aspirations to drug-free prisons do not override its positive obligation to protect the health of people in detention. Nor does the prohibited or illegal nature of the activity reduce the state’s positive obligations in this regard. Syringe exchange programs in no way conflict with a drug-free policy, as illustrated by the operation of state-funded syringe exchange programs in countries across Europe in a legislative context where drug use remains illegal. The extensive scientific evidence of intravenous drug use, syringe sharing, and HIV and hepatitis C transmission resulting from unsafe injecting in many European prison systems also makes it difficult for the state to suggest that a totally drug-free prison is even a realistic proposition, let alone one that addresses the risks to health from unsafe injecting in a manner consistent with its positive obligations under Article 3.

The state might argue that the decision to provide prisoners with sterile syringes is a matter of domestic policy in which the Court should not intervene. Furthermore, it could suggest that the small number of European states providing syringe programs in prisons illustrates the “existence of little common ground between the Contracting States” on this issue, and that, as a result, it is an area in which states should enjoy a wide degree of discretion.¹⁰

However, there is broad international consensus that people in prison have a right to be provided with a standard of health care equivalent to that available in the community.¹¹ This principle of equivalence is endorsed by the Council of Europe¹² and is in the European Prison Rules,¹³

as well as in national prison legislation or policy in most European states.¹⁴ The state’s discretion on syringe exchange programs should be interpreted within this international consensus on health and human rights norms.

Finally, the state would likely argue that provision of sterile syringes to prisoners would create an undue security risk, thus jeopardizing the safety of prison staff; and that a Court finding in favour of the applicant would, contrary to the existing jurisprudence, “impose on the authorities an intolerable or excessive burden.”¹⁵

However, existing research and experience shows that prison syringe exchange programs have no negative outcomes on health or institutional security.¹⁶ Furthermore, the Court’s jurisprudence is also clear that the financial constraints of a state cannot excuse prison conditions found to be in violation of Article 3.¹⁷

Based upon the jurisprudence of the European Court, and the obligations of the state to protect the health of people in detention under Article 3, the *European Convention on Human Rights* offers a useful tool to advocate for the provision of syringe exchange programs in European prisons.

— Rick Lines

Rick Lines (rlines@iprt.ie) is the Executive Director of the Irish Penal Reform Trust in Dublin. This article is based upon a longer one to be published in the *European Human Rights Law Review* in 2007.

Editor’s Note: For an overview of the issues related to HIV/AIDS and prisons discussed at the conference, see R. Jürgens, “From evidence to action on HIV/AIDS in pris-

ons: a report from the XVI International AIDS Conference.” *Infectious Diseases in Corrections Report* September 2006. At www.idcronline.org/archives/sept06/article.html.

280A, para. 79; *Kudla v Poland* (2000) 35 EHRR 11, para. 94.

⁵ *Chahal v United Kingdom* (1996) 23 EHRR 413, para. 79; see also, *Kudla v Poland* (n 5), para. 90; *Novoselov v Russia* Application No 66460/01 (judgment of 2 June 2005), para. 38.

⁶ *McFeeley v United Kingdom* (1981) 3 EHRR 161, paras. 45–46; *Iorgov v Bulgaria* Application No 40653/98 (judgment of 11 March 2004), para. 85.

⁷ *Z v United Kingdom* (2002) 34 EHRR 3, para. 73.

⁸ WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, 2005, p. 11.; WHO/UNODC/UNAIDS, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, 2004, Doc. No. WHO/HIV 2004.3, p. 2.

⁹ *Kudla v Poland* (n 5), para. 94.

¹⁰ *Cossey v United Kingdom* (1990) 13 EHRR 622, para. 40.

¹¹ E.g., UN, Basic Principles for the Treatment of Prisoners, UN General Assembly Res 45/111, annex, 1990, 45 UN GAOR Supp (No 49A) at 200, UN Doc A/45/49, para. 9; WHO, *Guidelines on HIV Infection and AIDS in Prisons*, 1993, Doc. No. UNAIDS/99.47/E, para.

A(1); UNODC/WHO/UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, p. 10.

¹² Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison, Recommendation No R (98)7 (8 April 1998), Council of Europe.

¹³ Council Of Europe Committee Of Ministers Recommendation Rec(2006)2 of the Committee of Ministers to Member States on the European Prison Rules (adopted 11 January 2006), para. 40.3.

¹⁴ *Ibid*, para. 30.

¹⁵ *Pantea v Romania* (2005) 40 EHRR 26, para. 189.

¹⁶ See H. Stöver and J. Nelles, “10 years of experience with needle and syringe exchange programmes in European prisons: a review of different evaluation studies,” *International Journal of Drug Policy* 14 (2003): 437; R. Lines et al, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, Canadian HIV/AIDS Legal Network Montreal, 2004.

¹⁷ *Poltoratskiy v Ukraine* (2003) Eur Ct HR—V, para. 148.

¹ *European Convention for the Protection of Human Rights and Fundamental Freedoms* (3 September 1953) 213 UNTS 222 (ECHR), art 3.

² European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *3rd General Report on the CPT's activities covering the period 1 January to 31 December 1992, 1993*, para. 31.

³ *Keenan v United Kingdom* (2001) 33 EHRR 38, para. 91.

⁴ E.g., *Hurtado v Switzerland* (1994) Eur Ct HR ser A

Drug addiction treatment in Russia: no substitution therapy

Current approaches to drug addiction treatment in Russia are not based on sound research. Instead, they are characterized by low effectiveness, violations of ethical standards, and disregard of the right of patients to high-quality care and assistance. In this article, based on a presentation at a concurrent session at the conference, Vladimir Mendelevich presents and critiques the arguments advanced by drug addiction specialists in Russia who oppose the use of substitution therapy.

Although the number of drug users with HIV has substantially increased in recent years, HIV prevention in Russia does not include opioid substitution treatment, a harm reduction strategy proven to be effective all over the world. Perhaps the explanation for this lies in the fact that Russian society believes that the problem of drug use is more impor-

tant than the problem of HIV/AIDS (69.3 percent consider drug use a problem, versus 34 percent for HIV/AIDS).¹

One can conclude from this, firstly, that HIV/AIDS is not perceived as a high priority either by the public or by drug addiction specialists (referred to as narcologists in Russia); and, secondly, that while HIV/AIDS and

drug use often go together, public attitudes towards them are different.

Russia's population is estimated at 143 million, of whom as many as six million may use narcotic drugs.² Out of 340 000 officially registered HIV cases in Russia (unofficial estimates are up to 1.4 million), 68 percent of new cases are among people who inject drugs.³

According to various studies, only one out of ten people in need of drug treatment receives such services.⁴

The effectiveness of drug treatment services is estimated to be between seven and 10 percent at most.⁵

Surprisingly, more than 73 percent of narcologists are nevertheless happy with service quality.⁶

Drug treatment services in Russia are highly centralized and government controlled. Drug addiction treatment in private practice is illegal. A qualified doctor cannot treat an opioid-dependent patient outside of a state or municipal institution. Specialists in private practice are only allowed to provide psychological rehabilitation, without psychopharmacology.

The overwhelming majority of treatment offered is nothing more than detoxification. The majority of patients resume their drug use within one month of being released from a drug treatment clinic. Rehabilitation programs are short-term, very limited and ineffective.

Probably the biggest problem in drug treatment in Russia is the total ban on substitution maintenance therapy. Prior to 1970, methadone and other opioid agonists were used in the Soviet Union to treat drug addiction. In 1977, their use was prohibited for ideological, not scientific, reasons. For decades, substitution therapy was prohibited, as were academic debates on the topic. Scientific journals refused to publish evidence-based articles about methadone. Some advocates of substitution therapy either lost their jobs or were forced to disown their ideas.

In 1998, new federal legislation outlawed even debates about substitution treatment, even though some of the other countries of the former

Soviet Union were starting to change their anti-substitution therapy policies.

In Russia, the problem remains excessively politicized. In March 2005, the *Medical Newspaper* published a memorandum entitled "Say No to Methadone Programs in the Russian Federation," signed by heads of Russia's psychiatry and narcology.⁷ The memorandum described substitution therapy as ineffective and inhumane, and as changing one drug for another, rather than treatment. The memorandum lacked any scientific rationale.

Surveys conducted in Russia in 2004 and 2006 show that the proportion of narcologists who are against substitution treatment has decreased from about 45 percent in 2004 to just under 39 percent in 2006.⁸ At present, about half of practicing narcologists in Russia advocate for opioid substitution treatment as a method of harm reduction and, in particular, of HIV/AIDS prevention. Nevertheless, the debates continues to rage, with most public health officials categorically opposed to substitution treatment.

Debates on whether Russia should introduce substitution treatment focus on three questions:

- Is HIV is transmitted primarily through injections?
- What is the actual number of opioid-dependent individuals testing positive for HIV?
- Does convincing evidence exist that substitution treatment can reduce the risk of HIV transmission?

Russian narcologists maintain that "AIDS has left the drug scene." The National Research Centre of Narcology of the Russian Ministry

of Health reports that HIV is found "only in 12 percent of people with opiate addiction."⁹ These data are inconsistent with recent findings of other research centres and clinics, which estimate HIV prevalence in their drug use patients at 23–25 percent.¹⁰ Furthermore, as indicated above, more than 60 percent of new HIV infections are linked to injection drug use.

The debates among narcologists as to whether HIV is transmitted primarily through injections, and whether the number of new HIV infections among people who inject drugs is falling, suggest that opponents of substitution treatment are prepared to justify their opposition to its introduction by alleging (falsely) that this route of transmission is not important. But, even if one were to assume that this route of HIV transmission is less important than it used to be, something still needs to be done to eliminate it altogether. And, so far, no method of prevention more effective than substitution treatment has been proposed.

With respect to the question of whether strong evidence supports the effectiveness of substitution treatment as a method of HIV prevention, Russian narcologists do not accept as valid the results of numerous international studies nor the position of the World Health Organization. The main counter-argument of Russian narcologists is that the best method of HIV prevention among people who inject drugs is good quality, drug-free treatment of opioid addiction.

Russian narcologists maintain that the effectiveness of drug-free treatment is currently between 35 and 60 percent.¹¹ The facts suggest otherwise. Keeping an opioid-dependent person drug free for one year

following drug-free treatment is possible in 15 percent of cases at most.¹² However, even if one accepted the statements of Russian narcologists about the high rate of effectiveness of the drug-free approach to addiction treatment, the question remains: What do we do with those who are resistant to the drug-free treatment? But Russian narcologists do not even ask this question.

By opposing harm reduction measures such as substitution therapy, Russian narcologists lose valuable tools to help people and combat the growing HIV epidemic.

Nevertheless, today, a growing number of Russian narcologists support a shift in policy and would be prepared to reform their services.

– Vladimir Mendelevich

Dr Vladimir Mendelevich (mend@tbit.ru) is Director of the Institute for Mental Health Research, and Head of the Department of Medical and General Psychology, at Kazan State Medical University, Russia.

¹ V. Mendelevich, *Drug Addiction and Narcology in Russia*, (Kazan, Russia: Kazan State Medical University Publishing

House, 2006), with references, p. 12.

² Ibid., p. 8.

³ P. Aksenov, "HIV and drug addiction" (presentation), Seminar for the Federal Drug Control Agency (FKSN), World Health Organization, Volgograd, 2006.

⁴ V. Mendelevich, p. 8.

⁵ Ibid., p. 34.

⁶ Ibid., p. 14.

⁷ V. Krasnov et al, *Medical Newspaper*, 31 March 2006, p. 6.

⁸ V. Mendelevich, p. 21.

⁹ N. Ivanets, "Drug addiction in Russia" (presentation), International Conference on "Health of the nation and fight against narcoterrorism," Moscow, 2006.

¹⁰ V. Mendelevich, p. 49.

¹¹ N. Ivanets.

¹² V. Mendelevich, p. 23.

Taking the fight to their realm: the role of patent oppositions in the struggle for access to medicines

When it amended its patent laws in 2005, in accordance with the TRIPS (Trade-related Aspects of Intellectual Property Rights) agreement, India was forced to recognize a 20-year period of patent protection for pharmaceuticals, placing the continued ability of Indian generic companies to manufacture affordable antiretroviral drugs (ARVs) in jeopardy. In this article, which is based on a presentation at an abstract-driven session at the conference, Chan Park discusses the successes and challenges experienced by Indian health groups in their novel efforts to oppose the granting of patents for critical drugs.

In an effort to ensure that patents are not granted on ARVs and essential medicines, civil society organizations in India decided to take the conventional campaign for access to

treatment to a heretofore unfamiliar domain: into the patent examiner's office. By filing patent oppositions against patent applications for key drugs, the civil society has scored

some remarkable victories in ensuring that patents are not granted at the cost of human lives.

Enacted amidst a political firestorm, the Indian Patents

(Amendment) Act of 2005 (“the Act”) was the product of a political compromise between people advocating for a robust protection of patent rights, and those who insisted that it was India’s duty and obligation under the Doha Declaration to implement TRIPS in a manner that did not impede “access to medicines for all.”¹ Although the final product did not come close to maximizing the flexibilities available within TRIPS, the tireless campaigning by patients groups, health activists and other civil society groups resulted in a few key concessions.² Two provisions of particular relevance were Sections 3(d) and 25 of the Act.

Section 3(d), unique to Indian patent law, states that “the mere discovery of a new form of a known substance which does not result in the enhancement in the known efficacy of that substance; or the mere discovery of any new property or new use for a known substance” is not considered an invention under the Act.³ Thus, the ability of pharmaceutical companies to engage in “evergreening” — the subsequent patenting of minor modifications to a known drug designed to artificially extend the patent term of the original patent — was curtailed. This section, in conjunction with Section 25, which allows any person to formally oppose a patent application prior to its being granted,⁴ gave Indian groups an opportunity to oppose the patenting of key drugs.

Following upon the Cancer Patients Aid Association’s success-

ful opposition against Novartis AG’s patent application for Gleevec,⁵ persons living with HIV/AIDS (PLHA) groups in India filed the first opposition against GlaxoSmithKline’s (GSK) Combivir, a fixed dose combination of lamivudine and zidovudine, in March 2006.⁶ The patent application for Combivir is a typical example of evergreening. The alleged “invention” in the application concerned combining two already known drugs along with a glidant to manufacture a tablet form of the drugs.⁷ However, glidants are commonplace substances (e.g., silicon dioxide, talc) that have been used widely throughout the industry for years to aid in the manufacture of drugs in tablet form.⁸

In addition to formally opposing the Combivir patent in India, on 7 August, 2006 Indian PLHA groups joined with Thai PLHA groups to simultaneously stage demonstrations in front of GSK offices in Bangalore and Bangkok, demanding that GSK withdraw its patent application for Combivir. Two days later, GSK announced that it was withdrawing its application in both countries.⁹ This is a palpable demonstration of how the legal pressure of patent oppositions, combined with the political pressure of public outcry, can improve access to critical medicines.

Because patent oppositions can be a powerful tool in improving access to medicines, capacity building amongst civil society in patent law and basic pharmaceutical science should be undertaken in developing nations in which access to ARVs

and other essential drugs is critical. Ultimately, however, patent oppositions must be seen as but one aspect of a larger movement in the struggle for access to medicines — one that can and should be combined with empowerment and mobilization of PLHA groups and other key stakeholders.

– Chan Park

Chan Park (aidslaw1@lawyerscollective.org) is an advocacy officer at the Lawyers Collective HIV/AIDS Unit in New Delhi, India, and is coordinating the efforts of the Affordable Medicines and Treatment Campaign in India.

¹ World Trade Organization, Declaration on the TRIPS Agreement and Public Health, 2001.

² See, e.g., B. Baker, *India’s 2005 Patent Act: Death by Patent or Universal Access to Second- and Future-Generation ARVs?*, a background paper available at www.healthgap.org/press_releases/05/09/1905_HGAP_BP_India_patent_baker.html, for an analysis of the extent to which India utilized its TRIPS flexibilities.

³ *Patents Act, 1970*, s. 3(d).

⁴ *Ibid.*, s. 25(1).

⁵ Indian Patent Office, Chennai, Decision in the Matter of an Application for a Patent No. 1402/MAS/98 Filed on July 17, 1998. On file with the Lawyers Collective HIV/AIDS Unit.

⁶ Pre-Grant Opposition by Way of Representation Re: Patent Application No. 2044/CAL/1997 Filed on 29 October 1997, titled “Pharmaceutical Compositions.” On file with Lawyers Collective HIV/AIDS Unit.

⁷ *Ibid.*, p. 3.

⁸ *Ibid.*, p. 5.

⁹ GlaxoSmithKline, “GSK patents and patent applications for *Combivir*,” news release, 10 August 2006. At www.gsk.com/ControllerServlet?appld=4&pagelid=402&newsid=874.

Free trade negotiations can be harmful to your health

When negotiating free trade agreements (FTAs), the U.S. uses its considerable power to get countries to agree to intellectual property (IP) provisions that go beyond what is mandated in international IP accords. In this article, which is based on a poster presented at the conference, Gaëlle Krikorian describes the tactics used by the U.S. and explains how the results of its efforts can impede access to newer medicines in developing countries.

The TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement came into effect when the World Trade Organization (WTO) was created in 1994. In recent years, the U.S. has embarked on a series of bilateral and regional negotiations imposing IP provisions that are even stronger than the WTO standards. Many countries have already signed FTAs with the U.S.;¹ more countries are currently involved in negotiations.²

All of these FTAs include IP provisions that are likely to impact access to medicines, such as the establishment of data exclusivity for 3–5 years, extensions of the patent term, the expansion of the patentability criteria, the disappearance of the pre-granting opposition, limitations of grounds for compulsory licensing and government use, and the establishment of linkage between patent and drug registration.

The full impact of these provisions on access to medicines is still difficult to assess. Very few of these countries have actually implemented the IP chapters; even once they do, it will take time to monitor price changes. This handicaps defenders of public health. It helps brand-name pharmaceutical companies, who point to the absence of proof of any negative impact to bolster their case.³

However, researchers have demonstrated the harm strengthening IP provisions does to public health in developing countries,⁴ and studies conducted in Colombia and Thailand, for example, clearly demonstrated the inevitable price increases that result from market exclusivity.⁵

Thus, these agreements will prove particularly problematic for access to newer medicines, such as second- or third-line antiretroviral therapies that will be developed in the future.

The U.S. negotiates comprehensive agreements, where IP is only one of many issues on the table. Through these agreements, the U.S. is attempting to solve what it sees as flaws in the TRIPS text and conflicts regarding its interpretation.

In most cases, the claimed benefits of the FTAs are questionable and appear to be based more on ideology than on strong evidence. Moreover, the use of threats is a major element in the negotiation process. Scare tactics include the argument “What if you don’t sign an agreement with us when all your neighbours do?” as well as the use of the “301 list,” which allows the U.S. to withdraw the benefits of trade agreements or impose duties on goods from foreign countries. In this context, it is hard to heed public health concerns,

especially when the potential impact of these agreements on health is not assessed before entering the negotiations.

The actors most willing to sign an FTA typically hail from the top of the political hierarchy (e.g., king, president, prime minister), and consultation with the public or with legislatures is often lacking. Under U.S. pressure, drafts of the agreement are kept secret until the agreement is ratified.

The U.S. introduces these drafts when it enters the negotiations. Through the succession of negotiations with different countries, the U.S. elaborates models of the different chapters of the agreements. Once an agreement is signed with one country, it serves as a start for negotiations with another.⁶ Any new negotiations allow for improvements to the model. Countries negotiating with the U.S. rarely have a similar precedent. Moreover, so far, the U.S. has refused to consider alternative IP texts proposed by developing countries.

Thus far, the coalitions raising concerns about the impact of the FTAs on access to medicines have not managed to concretely influence the outcome of these negotiations. Nevertheless, civil society mobiliza-

tion plays a crucial role, helping civil servants and negotiators raise concerns and providing them with more bargaining power. In the same way that comprehensive FTAs cover multiple issues, the opposition to these agreements builds cross-sectoral alliances in civil society (e.g., people living with HIV, farmers, workers and bankers).

In addition, public opposition to FTAs tends to swell over time and, to some extent, continues even once the agreement has been ratified. While this may lead to conflicts with the U.S., it may also cause local authorities to take a stronger stand defending access to health in the future.

Finally, FTAs raise the issue of how much space such agreements

leave developing countries to exert their sovereignty. The way FTAs are imposed upon populations, and the fact that they mandate important legal changes in developing countries — especially on such social issues as access to medicines and healthcare, food, education and knowledge or protection of the environment — seem to be generating an organized social reaction that goes beyond simple acts of reactive resistance.

— *Gaëlle P. Krikorian*

Gaëlle Krikorian (galk@free.fr) is with the Research Center on Health, Social Issues and Politics (CRESP) in Paris, France.

¹ Vietnam and Jordan in 2000; Laos, Chile and Singapore in 2003; Morocco, Bahrain and Australia in 2004;

Salvador, Guatemala, Honduras, Nicaragua, Costa Rica and Dominican Republic (Central American Free Trade Agreement) in 2004; Oman and Peru in 2005; and Colombia in 2006.

² Virtually all of the countries in South, Central and North America (Free Trade Agreement of the Americas), United Arab Emirates, Thailand, Malaysia, Ecuador, Panama and South Korea.

³ Interview by the author with Claude Burcky, Abbott representative, former U.S. Trade Representative, May 2006.

⁴ See, for example, World Health Organization, *Globalization and Access to Drugs: Perspectives on the WTO/TRIPS Agreement*, WHO/DAP/98.9, Revised 1999; also, J. Dumoulin et al, "World market strategies for drugs to fight AIDS," in J.P. Moatti et al (eds), *Economics of AIDS and Access to HIV/AIDS Care in Developing Countries: Issues and Challenges* (Paris, France: National Agency for AIDS Research, 2003), pp. 213–244.

⁵ Pan American Health Organization, *Modelo prospectivo des impacto de la proteccion a la propiedad intelectual sobre el acceso a medicamentos en Colombia*, November 2004; also, data produced by the Thai Ministry of Health to estimate the cost of extension of market exclusivity resulting from the FTA.

⁶ P. Drahos, *Developing Countries and International Intellectual Property Standard-Setting*, Commission on Intellectual Property Rights, Study Paper 8.

Vulnerable populations in Nepal face hostile environment

Members of sexual and gender minorities in Nepal frequently have been denied their rights, have been excluded from services and have been the victims of violence. In this article, adapted from a presentation at a concurrent session at the conference, Sunil Pant provides examples of these problems and describes how the Blue Diamond Society (BDS), an organization which promotes human rights and which fights against HIV/AIDS for lesbians, gay men, bisexuals, transgendered persons and men who have sex with men, has responded.

Staff and members of BDS have faced severe stigma and discrimination from Nepali authorities and society. BDS outreach staff have been raped and severely beaten by armed

police. Many workers have been arrested while doing HIV prevention education and condom distribution, and have been accused of promoting homosexuality.

When BDS tried to support a lesbian couple and provide them protection, staff received death threats from relatives of the couple and were physically intimidated. The relatives also

filed a legal case against BDS accusing the organization of “trafficking.”

In 2004, there was an attempted murder and throat-slashing of a BDS member; no investigation or arrests have been made to date.

The arbitrary detention of transgendered persons (known as metis in Nepal), lesbians, gay men and other men who have sex with men, many of them staff or members of BDS, happens on a regular basis. In 2005, 39 persons were arrested and charged with being a “public nuisance.” In the first half of 2006, another 27 were arrested. In 2003, two metis were raped, beaten and left to die by the police.

A writ was filed in Nepal’s Supreme Court by an individual demanding to close down BDS, accusing the organization of promoting unnatural and illegal behaviour. The government-controlled and some private print media regularly attack the organization.

Stigma and discrimination extends to the health care system. Many metis, men who have sex with men, people who inject drugs and sex workers who are HIV-positive are unable to access hospital beds. They are treated poorly, if they are treated at all. If one of them dies, ambulance drivers frequently refuse to pick up the body. Cremation services are usually impossible to access.

To counter the stigma and discrim-

ination, BDS works to protect and promote the health of sexual minorities through its outreach work on HIV/AIDS, which includes a condom and lubricant distribution program and outreach training. BDS was successful in convincing the National AIDS Program to include men who have sex with men as a vulnerable group in the National AIDS Strategy. This has helped to sensitize health care workers and other officials to the needs of sexual minorities.

BDS has also provided social support to people who have been harassed, attacked or abandoned; built partnerships with supportive government departments and national and international NGOs; publicized incidents through local, national and international media; and obtained the release on bail of many imprisoned metis.

In 2003, BDS organized a key meeting between police authorities and 50 metis and gay men. After this meeting, the Inspector General of the police issued a letter to all police stations indicating concern for the level of violence committed by police. The letter advised against such violence and noted future attacks would be prosecuted.

In 2004, BDS organized a public hearing to promote human rights and raise awareness about the violence faced by sexual minorities. The hearing drew well-known human rights

activists and a deputy representative from the Parliament as speakers.

This event had a strong impact in the government and media, and sparked discussions among major political parties about their policies towards sexual minorities. It also served to remind police authorities that their acts against sexual minorities would not be sanctioned or ignored.

BDS has also been an active participant in the recent democratic movement in Nepal. It was one of the few organizations to publicly oppose the code of conduct introduced by the previous autocratic government to control NGOs and civil society.

Nepal is currently a country in transition. A constituent assembly and a constitution drafting process are under way. BDS has been lobbying to be included in the process, but with little success so far. The majority of the political parties and human rights organizations do not have a liberal or progressive view of homosexuality, which they see as the result of bad Western influence.

BDS receives no funding for its human rights work.

– Sunil Pant

Sunil Pant (sunil@bds.org.np) is Director of the Blue Diamond Society.

The Convention on the Rights of the Child in a world with HIV and AIDS

Even though the Convention on the Rights of the Child (CRC) has been ratified more quickly and by more governments than any other human rights instrument, the basic principles of the CRC are being repeatedly violated in the response to HIV/AIDS. In this article, based on a presentation at a conference bridging session, Michael Kelly provides examples of how the rights of children are being infringed and concludes that the best solution is to strengthen the capacity of families to protect and care for the children.

The CRC enshrines four general principles that set out fundamental rights that, at the same time, serve as the yardsticks against which the realization of all other rights in the Convention are analysed, implemented and evaluated. These principles deal with non-discrimination (art. 2); the best interests of the child (art. 3); life, survival and development (art. 6); and participation and voice (art. 12).

The principle of non-discrimination requires that all children be protected from every form of discrimination so that they can enjoy their rights with full equality of opportunity. This right is infringed when children from AIDS-affected families experience discrimination, stigma or taunting in school or elsewhere. It is also infringed when infected children do not have access to life-preserving ARVs, when girls from an AIDS-affected family do not have the same educational opportunities as boys, and when children with a disability are not provided with appropriate sexual and reproductive health education.

The principle of the best interests of the child requires that when the state or other authorities take decisions that affect children, the children's best interests must be a pri-

mary consideration. In the response to HIV and AIDS, this right is often infringed. It is not in the child's best interests that a narrow, moralizing approach should deny him or her access to the education, information and services that would provide some measure of protection against HIV infection.

The child's best interests are not being served when the sexual abuse of minors, especially girls, cannot be vigorously pursued through the normal justice channels. Limitations on the ability of health and education systems to employ the qualified personnel they need, so that they can offer accessible and affordable health care and schooling, do not serve the best interests of the child.

The principle of the right to life, survival and development implies the right of children to benefit from social and economic policies that will promote their physical, mental, emotional, cognitive, social and cultural development. Given that 570 000 children died of AIDS in 2005, and that the prevention of mother-to-child transmission reaches less than 10 percent of the mothers in need, it is clear that this right is not being realized in a world with HIV and AIDS. The epidemic has highlighted the urgent need for states to take action

to respect, protect and fulfil this right and the many related rights it implies — i.e., the right to identity and birth registration; to social security; to protection from violence and abuse; to compensation for lack of family environment; to health; to education; to rest, leisure and play; and to protection from exploitative child labour and all forms of trafficking and sexual abuse.

The principle of participation and voice relates to the right of children to be heard and have their views taken seriously. This right is flagrantly violated when, on the death of a parent, relatives "share out" the surviving children, without the views of the orphans themselves being taken into account, or when orphaned children or street-children are summarily sent back to the villages from which the parents are believed to have come. It is also violated when teenagers and young people find that they have not been included as equal partners in HIV/AIDS programs and services, despite the fact that they constitute a very large and high-risk group, accounting each year for over half of all new HIV infections.

Each of the CRC principles recognizes children as rights-bearers — i.e., individuals endowed with equal and inalienable rights that

states must respect, protect and fulfil. But the fourth principle, participation and voice, adds the perspective of children as developing in age and maturity and becoming, as they do so, active agents in their own lives.¹

The preamble to the Convention recognizes that this development takes place best in a family environment, where there is an atmosphere of happiness, love and understanding. This finds expression in the foremost

key strategy for the protection, care and support of orphans and vulnerable children: strengthen the capacity of families to protect and care for children by prolonging the lives of parents and providing economic, psychosocial and other support. In a world with HIV and AIDS, children can be offered no better hope than strong family units.

— *Michael J. Kelly*

Michael J. Kelly (mjkelly@jesuits.org.zm) is a Jesuit priest and retired University of Zambia professor of education. Of Irish origin, he has lived and worked in Zambia for more than fifty years.

¹ S. Gruskin and D. Tarantola, "Human rights and children affected by HIV/AIDS," in G. Foster, C. Levine and J. Williamson (eds), *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (New York: Cambridge University Press, 2005), p. 141.

Removing requirement for self-disclosure of HIV status from Canada's Application for a Temporary Resident Visa

In the lead up to AIDS 2006, a Working Group was able to help bring about changes to the questions posed to visitors who were applying for a Canadian visa — questions that effectively required disclosure of HIV status by HIV-positive persons who were aware of their status. In this article, which is based on a presentation at an abstract-driven session at the conference, Lori Stoltz outlines the collaborative efforts of the Working Group and describes the changes that were made.

The Working Group was brought together on behalf of the AIDS 2006 Toronto Local Host (Toronto Local Host), in preparation for the XVI International AIDS Conference, to respond to a requirement in Canada's Application for a Temporary Resident Visa for self-disclosure of a person's HIV positive status.¹

In November 2004, the Toronto Local Host became aware that all visitors² to Canada from countries for which a visa was mandated

were required by Citizenship and Immigration Canada (CIC) to complete an application form containing broadly worded questions requiring self-disclosure by any person who knew his or her HIV-positive status:

12(a) Have you or any member of your family ever ... been treated for any serious physical disorders or any communicable or chronic diseases?

If the answer to any of the above is "yes," give details.³

The Working Group took the position that these questions effectively required disclosure of HIV-positive status by every person applying for a Canadian visa regardless of individual circumstances. It argued that this "blanket" requirement for disclosure was overly broad and inconsistent with current legal requirements mandating a minimally-intrusive approach to human rights, including the right to non-discrimination and the right to privacy. Specifically:

- the questions sought disclosure of highly sensitive personal health information that, in the vast majority of cases, would serve no legitimate purpose and yet could allow for further and improper questioning, examination or rejection of such applicants; and
- applicants who disclosed their HIV status might find themselves the subject of discriminatory treatment or threats to personal health and safety if the confidentiality of that information could not be assured (of particular concern since visa applications are generally submitted and processed in applicants' home countries).

The Toronto Local Host, the International AIDS Society and the Conference Co-Organizers⁴ maintained that this requirement for self-disclosure of HIV status was inconsistent with the principle that the International AIDS Conferences only be held in countries where unrestricted, non-discriminatory entry could be assured for people living with HIV.

These representations led to a process during which CIC representatives worked closely with other government departments and with the Working Group to develop a different approach that allowed CIC to meet the legislative requirements under the

Immigration and Refugee Protection Act, but without compelling visa applicants to disclose unnecessary details of their health status.

Effective May 2005, CIC adopted the following questions to replace the former questions:

12(a) Within the past two years, have you or a family member had TB of the lung or been in close contact with a person who has TB of the lung?

(b) Do you, or an accompanying family member, have any physical or mental disorder for which that person will require social and/or health services, other than medication, during the stay?

Conclusion

This experience demonstrates that the legitimate interests of government can be addressed consistent with respect for human rights. Progressive policies, however, may not tell the whole story; it is essential to monitor the application of those policies in practice.

Candidate countries for the International AIDS Conference should continue to be evaluated on the basis of their ability to assure non-discriminatory entry for people living with HIV/AIDS. As in the case of Canada's Application for a Temporary Resident Visa, this scru-

tiny may provide the impetus for changes in government practices that may benefit people living with HIV/AIDS and the broader population of all people living with serious medical conditions.

– Lori Stoltz

Lori Stoltz (lstoltz@adairmorse.com) is a lawyer with Adair Morse LLP in Toronto.

¹ The multi-disciplinary Working Group members (and co-authors of the abstract that was accepted for presentation at the conference) were L. Stoltz, J. Anderson, G. Flintoft, R. Elliott, L. Samson, L. Binder, M. Battista and R. Shalin.

² In Canada, the term "temporary residents" includes visitors (who will be in the country for six months or less), students and people who hold work permits.

³ Failure to answer this question truthfully would constitute a misrepresentation that could result in a finding of inadmissibility for a period of up to two years and a fine of up to \$100,000, or imprisonment for up to five years, for misrepresenting or withholding material facts: *Immigration and Refugee Protection Act* (Canada), ss. 40(1), 127 and 128.

⁴ UNAIDS, the International Coalition of AIDS Service Organizations, the Global Network of People Living with HIV/AIDS, the International Community of Women Living with HIV/AIDS, and the Canadian AIDS Society.

Community attitudes towards rationing ARVs: a qualitative study of justice and equity

Medical rationing of anti-retroviral therapies (ARVs) may conflict with the right to health, but rationing is nevertheless a reality in developing countries. In this article, which is based on a poster presentation at the conference, Stuart Rennie presents the preliminary findings of a study on community attitudes towards rationing ARVs in the Democratic Republic of Congo (DRC).

Medical rationing is a global phenomenon. No health system offers patients unlimited access to desired medical resources in infinite supply.¹ In the past, the rationing of medical resources was inconspicuous, if only because physicians often had little to offer their sick patients. With the explosive proliferation of new and often expensive drugs, devices and services, gaps between medical need and access to health care have become obvious in the world's richer countries. In developing nations, providing medical care under stark conditions of scarcity and sacrifice has long been the norm.²

Medical rationing is not necessarily incompatible with the right to health. It would be incompatible if the right to health entailed that every person has a right to every medical intervention with a potential health benefit. Instead, many defenders of the right to health advocate universal access to an affordable level of health services ensuring a decent minimum of human functioning.³

However, it can be argued that access to effective drugs for life-threatening conditions falls under the right to health, given that restricting access spells death for those left out. Medical rationing of ARVs among HIV-positive persons in need, therefore, conflicts with the right to health. Since the right to health is relational,

states have a corresponding ethical duty to provide reasonable treatment access.⁴

In reality, ARVs are being rationed among those who need it, particularly in developing countries.⁵ The World Health Organization states that fair distribution of ARVs in high prevalence, low-income countries remains a key ethical and human rights challenge.⁶

In the DRC, only about two percent of people in need of ARVs currently have access to them. The *Programme Nationale de Lutte Contra le Sida* has an ambitious plan to increase access to 69 percent by 2009.⁷

In 2005-2006, my colleagues⁸ and I conducted a qualitative study of community attitudes towards rationing of ARVs in Kinshasa, DRC. The purpose of the study was to provide input into a future deliberative process in the DRC about fair access to ARVs.

During in-depth interviews, participants ranked 14 social groups in terms of priority for free ARVs and discussed their choices in detail. Using a series of vignettes, focus group participants were asked to discuss whether and how gender, age, current state of health, income, having dependents, social status, likelihood of adherence, and time of arrival for treatment affected their

judgments concerning who should have priority access to ARV.

Our preliminary analysis reveals seven key factors cited by the community with respect to determining who has priority: responsibility for HIV infection, vulnerability, importance to society, preservation of family, spiritual considerations, ability to pay for treatment, and risk of HIV infection to others. Community attitudes seem to be divided between religiously-influenced egalitarian attitudes (widest possible ARV access, especially for vulnerable groups) and a "consequentialist" concern that ARV be rationed in ways that will help ensure the survival of the DRC.

Responsibility (or lack thereof) for HIV infection was often cited as a reason to give certain social groups higher or lower priority for ARV, particularly in regard to sex workers or infants. Perceived importance to Congolese society, particularly in regard to health care workers, also played an important role in community attitudes. Many respondents expressed distrust in politicians while affirming that universal ARV access is the ethical responsibility of the state.

Scaling-up ARV access fairly in the DRC will require the establishment of a decision-making process characterized by transparency and accountability that involves all rel-

evant stakeholders.⁹ This will pose an enormous challenge in a country plagued by poverty, human rights abuses and distrust in government.

– *Stuart Rennie*

Stuart Rennie (stuart_rennie@denistry.unc.edu) is a Research Assistant Professor (Bioethics), Departments of Dental Ecology and Social Medicine, University of North Carolina-Chapel Hill.

¹ N. Daniels and J.E. Sabin, *Setting Limits Fairly: Can We Learn To Share Medical Resources?* (Oxford: Oxford University Press, 2000), p. 1.

² C. Olweny, "Bioethics in developing countries: ethics of scarcity and sacrifice," *Journal of Medical Ethics* 20, 3 (1995): 169–174.

³ M. Powers and R. Faden, *Social Justice: The Moral Foundations of Public Health and Public Health Policy* (Oxford: Oxford University Press, 2006), p. 57.

⁴ A.E. Buchanan, "The right to a decent minimum of health care," *Philosophy and Public Affairs* 13, 1 (1984): 55–78.

⁵ S. Rosen et al, "Rationing anti-retroviral therapy for HIV/AIDS in Africa: choices and consequences," *PLoS Medicine* 3, 3 (2006).

⁶ UNAIDS/WHO, *Guidance on Ethics and Equitable*

Access to HIV Treatment and Care, 2004. At www.who.int/ethics/Guidance%20on%20Ethics%20and%20HIV.pdf.

⁷ Programme Nationale de Lutte Contra le Sida, *Plan National d'Extension de l'accès aux Traitements Antirétroviraux en RDC (2005-2009)*. WHO/UNAIDS, 2005.

⁸ A. Nsitu, Center of Neuropsychiatry, Kinshasa; E. Birindwa, UNC-DRC Center for AIDS Research, Kinshasa; A. Comeli, Family Health International, Durham, North Carolina; R. Strauss, Center for AIDS Research, University of North Carolina-Chapel Hill.

⁹ N. Daniels, *How To Achieve Fair Distribution of ARTs in 3 by 5: Fair Process and Legitimacy in Patient Selection*. UNAIDS/WHO, 2005. At: www.who.int/ethics/en/background-daniels.pdf.