

# HIV/AIDS POLICY & LAW REVIEW

VOLUME 10, NUMBER 1, APRIL 2005

## HIV/AIDS and human rights: we've only just begun

Public health and human rights often used to be seen as incompatible frameworks for action. HIV/AIDS was supposed to break that mould and be the epidemic where respecting human rights would be the most effective way to achieve the public health goal of conquering the epidemic. In this article, Joanne Csete suggests that while in theory everybody buys into the effectiveness of rights-based approaches to HIV/AIDS, the practice leaves much to be desired. The author describes the human rights framework that is the foundation for a more effective response to HIV/AIDS and stresses the urgency of paying more than lip service to the need to put human rights at the centre of the fight against HIV/AIDS in Canada and beyond.

[Other] patients did not suffer from the same degree of stigmatization as those suffering from this mysterious illness that was linked to the twin societal taboos of homosexual sex and illegal injection drugs. "Why didn't you tell us you're a hemophiliac?" a nurse in a downtown Toronto teaching hospital asked activist James Kreppner when he was in hospital with an AIDS-related illness in the 1990s. "We would have treated you much better."<sup>1</sup>

### Why are we *still* "doing" human rights?

At a recent press conference in Montréal that featured the announcement of some new work of the Canadian HIV/AIDS Legal Network, a journalist kicked off the question-and-answer period with this query: "Why, after all these years, are we still having to hear about HIV/AIDS and human rights?" Why indeed?

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## HIV/AIDS POLICY & LAW REVIEW

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### Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network is a national non-governmental organization dedicated to promoting laws and policies that respect and protect the human rights of people living with, and vulnerable to, HIV/AIDS through research, legal and policy analysis, education, advocacy, and community mobilization.

The Legal Network promotes responses to HIV/AIDS that implement the International Guidelines on HIV/AIDS and Human Rights; minimize the adverse impact of HIV/AIDS on individuals and communities; and address the social and economic factors that increase vulnerability to HIV/AIDS and to human rights abuses.

The activities of the Legal Network support its vision of a world in which the human rights and dignity of people living with HIV/AIDS and those affected by the disease are respected and fulfilled; and where laws and policies facilitate HIV prevention efforts, as well as care, treatment, and support for people living with HIV/AIDS.

Please visit our website at www.aidslaw.ca. For membership information, write to the address above or visit: www.aidslaw.ca/AbouttheNetwork/membership.htm.

## 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.

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# EDITORIAL

## **AIDS, drugs, and terrorism: do I have your attention?**

A year ago, a high-level official in the Ministry of Health of the Russian Federation told me that letting methadone loose in Russia would constitute a worse scourge for the country than heroin itself. The ministry's position on methadone means high HIV risk and for thousands, perhaps millions, of opiate users who might otherwise be able to normalize their lives with medically supervised methadone and become less easy targets for stigma and police abuse. Health officials in Russia are abetting the long-held methadone myths of the Russian narcotic drug establishment, fed dutifully and consistently to an unquestioning press.

I couldn't help thinking as I sat in that ministry office in Moscow how much that line about methadone sounded like "Saddam has weapons of mass destruction aimed at the West," also much in currency at the time. John LeCarré, the great novelist of the Cold War, describes well a technique of the current "war on terror" that everyone who fights for peace in the "war on drugs" knows by heart: politicians tell lies to the media, they see the lies in print, and they pronounce them to be public opinion. It's much easier to get away with this, of course, when the public is predisposed to believing a story, as people so often are if the story is anything about how much beyond redemption drug users are.

It takes a very big and well-disseminated lie like this to justify massive global human rights violations. The human rights situation of drug users around the world, a few exceptional countries aside, is catastrophic. The ill-

ness of chronic drug addiction is governed by laws that trample on public health principles and in too many cases can only be enforced by violating the human rights of drug users. Drug users are the easiest targets for extortion, unlawful arrest, and long incarceration for minor offences. They are highly vulnerable to a form of torture that is special to them – the use of their addiction as an instrument of coercion. They have been reduced to "collateral damage" in the "war on drugs."

The terrible tragedy in Beslan, Russia in September 2004, in which over 350 persons were killed, was in many ways Russia's September 11, a major act of terrorism on its soil. Like the September 11 attacks, the events at Beslan have been followed by a rolling back of civil liberties, in this case including new rules that enable the Kremlin to appoint provincial officials who were previously elected, and restrictions on civil society organizations. If history is any guide, sustaining those rollbacks will require some state-of-the-art lies. So should anyone have been surprised when a few weeks after the Beslan tragedy the government put out the word that "some" of the perpetrators of the crime were "drug addicts"? Whatever the merits of the accusation – others noted that drug-using equipment was never found at the site – it is a predictable tactic that, among other things, fuels public sentiment against drug users and takes the state off the hook in its responsibility to provide public health services for them, also distracting public attention from a more meaningful discussion of the roots of the Beslan tragedy.

With the US-led “war on terror,” we have also seen a US-led effort that might be called a “war on immorality.” As Paul Krugman, a *New York Times* columnist, put it: “the fight against Al Qaeda became a universal ‘war on terror,’ then a confrontation with the ‘axis of evil,’ then a war against all evil everywhere. Nobody knows where it all ends.” Alas, we know that it didn’t end before a full-scale attack against those in the HIV/AIDS movement who seek to work respectfully with sex workers, drug users, and gay and bisexual men. And so we are left, for example, with legislation in the US that authorizes assistance to HIV/AIDS programs in developing countries only for organizations that take a public stand against prostitution, which is millimetres away from making people condemn sex workers. Human rights is again a casualty in this sad turn in public policy.

A number of countries, including Canada, rarely speak of HIV/AIDS policy without espousing a human rights-based approach to fighting HIV/AIDS, an excellent thing. Canada, for example, has put considerable money in its international programs behind women’s empowerment as part of fighting HIV/AIDS and deserves credit for that. But right now, the countries that espouse rights-based approaches to HIV/AIDS – and the United Nations, which is the original “rights-based approach to HIV/AIDS” flag-waver – need to make a bold move to show that human rights is not only about women and children and other sympathetic people not tarred by the

great government-generated lies of the late 20<sup>th</sup> and early 21<sup>st</sup> centuries. There has to be someone who stands up on the global stage for the human rights of drug users, as well as sex workers, prisoners, and all people vulnerable to both HIV/AIDS and human rights abuse.

At this writing, country delegations and UN agencies are preparing for a meeting of the UN Commission on Narcotic Drugs, at which it is expected that the US will try to engineer a kind of “gag rule” to cleanse UN policies and documents of any support for harm reduction. By the time you read this, it will be known if any country or UN agency stood up to the attack. Whatever the outcome, one must wonder which UN agency will be brave enough to bring to its governing board a statement on the need to protect the rights of drug users as a central element in the fight against HIV/AIDS? Which country with a commitment to human rights will take a resolution on drug users’ rights to the UN Commission on Human Rights or a complaint about torture of drug users to the UN Committee on Torture?

That’s asking a lot of people who believe in human rights, but where else can we turn?

– Joanne Csete

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# HIV/AIDS and human rights: we've only just begun

cont'd from page 1

Before there was HIV/AIDS, protecting the human rights of individuals as patients was frequently seen to be on a collision course with the pursuit of public health goals. That is, ensuring the public's health might sometimes require that individuals be quarantined or screened for health conditions without their consent, or identified by name as carriers of a disease in violation of their right to privacy. The intellectual discipline of "health and human rights" seemed for a long time to revolve largely around reconciling this inevitable conflict between repressive public health measures and human rights.

HIV/AIDS was to change all that – but has it done so?

Even before the biology of HIV/AIDS was well understood, the human rights challenges associated with the disease were clear, though they were not always expressed in human rights terms. This was a disease that affected first and most profoundly people who already faced social marginalization and systematic human rights abuse. In its early days in North America, HIV/AIDS was known for a time as GRID, "gay-related immune deficiency." In other countries, it was sex trade workers, injection drug users, prisoners, or migrants who were most associated with AIDS in the public mind. The link between HIV/AIDS and marginalized, "different," or socially "deviant" populations in the collective consciousness has been strong from the beginning. Hence the public health and human rights question: Would further repression or isolation

of these populations be effective in containing the spread of HIV, or would working with them in a rights-respecting way be more effective?

Visionary people who are now celebrated as AIDS heroes answered that question unambiguously. They understood early on that repressive measures of the kind used to control infectious disease epidemics in the past would spell trouble when it came to this new disease. The late Jonathan Mann, the founding director of the first United Nations system-wide program on HIV/AIDS, is perhaps most associated with an articulation of the global importance of respecting the human rights of people vulnerable to, and living with, HIV/AIDS as a central strategy in fighting the disease. As he wrote early in the epidemic: "In each society, those people who before HIV/AIDS arrived were marginalized, stigmatized, and discriminated against become those at highest risk of HIV infection....The French have a simple term which says it all: HIV is now becoming a problem mainly for *les exclus*, the 'excluded ones' living at the margin of society."<sup>2</sup> Mann always concluded that more repression would only favour the epidemic.

Today there are numerous lectures and awards given in honour of Jonathan Mann. His work is spoken of worshipfully in conference after conference. Attention to the human rights of people with HIV/AIDS and those at risk is de rigueur in global analyses of the epidemic. UNAIDS has conducted worldwide campaigns on stigma and discrimination, and now on violations of women's human

rights, as important drivers of the pandemic.

The national AIDS strategies of many countries equally reflect a commitment to putting human rights at the centre of AIDS control efforts. Canada admirably exemplifies this pattern in both its domestic HIV/AIDS strategy and in the stated principles for its international assistance in the global fight against HIV/AIDS. The Canadian Strategy on HIV/AIDS is explicit in its commitment to the right of people living with HIV/AIDS to be free of discrimination and other human rights abuses.<sup>3</sup> The "guiding principles" of Canada's assistance to AIDS programs in developing countries include a central commitment to the human rights of people affected by the epidemic.<sup>4</sup>

Somewhere between the theory and the practice, this fortuitous coincidence of health and human rights has fared badly.

HIV/AIDS, then, would be the disease where human rights protection and public health goals would, happily, coincide. But somewhere between the theory and the practice, this fortuitous coincidence of health and human rights has fared badly. For example:

- Millions of sex trade workers – men, women, and transgender

persons – continue to face HIV risk that is sharply heightened by violence, police abuse, and social disdain. In Canada, recent events in Vancouver have highlighted the extreme violence faced by sex workers, the inadequacy of laws to protect them, and indeed the potential of Canada's Criminal Code to exacerbate the danger they face.<sup>5</sup> Around the world, police and other agents of the state make it impossible for sex workers to organize for their own protection and that of their clients, even though collectives of sex workers have been shown in many communities to be among the most effective agents of HIV prevention. The UN doesn't say much about this in its ostensibly human rights-based analyses of the global epidemic.

- After years of clinical and public health practice in HIV prevention and in addressing the much older health problem of narcotic drug addiction, it is well understood that the right of injection drug users to health is best respected by taking immediate measures to mitigate the worst harms of drug addiction rather than to insist on the possibility of all drug users becoming abstinent in the near future. Among the most widely studied and proven of these harm-reduction measures is needle exchange. In Canada, needle exchange is permitted and even supported by the government at various levels, but prisoners do not have access to this service in spite of their urgent and demonstrable need for it.<sup>6</sup> Around the world, it is sadly clear that millions of young drug users will die terrible and premature deaths because they

are denied needle exchange, opiate substitution, and other cost-effective and proven methods of preventing HIV, hepatitis, and death from overdose. UN officials occasionally speak about these issues, but the governing bodies of the UN agencies dealing with AIDS, drug use, and health have never come near an endorsement of human rights-friendly policies for injection drug users.

- Gay, lesbian, bisexual, and transgender persons face hostility and discrimination even in countries like Canada where homosexuality is not criminalized. In many countries, widespread violence and marginalization of gay and bisexual men, including by agents of the state, are exacerbated by repressive sodomy laws, making it impossible to reach out to this population with HIV/AIDS programs. The recent refusal of the government of India to rescind the antiquated sodomy law, dating from the 1860s, in India's penal code removes hope for official redress from the fear and abuse faced by millions of men who have sex with men in that country. The United Nations chose not to speak officially in the India case; UN officials rarely speak on the dangers of sodomy laws.
- Aboriginal people comprise 3.3 percent of the population of Canada but in 2002 they accounted for 14 percent of people living with AIDS among those whose ethnicity was known.<sup>7</sup> The legacy of subordination of Aboriginal peoples has included factors such as poverty, discrimination, social and political exclusion, violence,

and substance abuse – factors that increase the HIV/AIDS risk faced by these populations. Aboriginal people in many parts of the world face similar challenges.

- People living with HIV/AIDS, like people with other medical conditions that do not threaten contagion on casual contact, have a right to privacy regarding their HIV status in the health-service system and in their lives generally. In Canada, legal provisions in some provinces allow for revealing the HIV status of individuals in ways that do not correspond to human rights norms and to Canada's own Charter of Rights and Freedoms.<sup>8</sup> The right to privacy is particularly important in the case of HIV/AIDS because persons living with the disease are still widely stigmatized and subjected to discrimination. Around the world, confidentiality of HIV status in health systems is frequently violated.

These and many other human rights violations that drive HIV transmission or impede access to treatment and care for those living with HIV/AIDS are an affront to both justice and public health and go well beyond just "stigma and discrimination," the catch-all phrase used by the United Nations. They represent violations of a wide range of human rights laws that bind states to do better than this.

### **Human rights: back to basics**

Making the link between human rights and the struggle against HIV/AIDS requires going back to the basics of human rights and the protections they offer.

Human rights are those entitlements that a person has not by virtue of citizenship or other civil status but by virtue simply of being a human being. There is no institution on earth that has the authority to take away people's human rights. Government obligations with respect to these rights include to:

- *Protect them* – that is, governments must be sure that the actions of individuals or institutions do not undermine human rights and must provide some mechanism for redress when rights are violated.
- *Respect them* – governments' own actions cannot run counter to the provisions of human rights law.
- *Fulfill them* – governments should take measures actively to promote and implement human rights law.

There is no institution on earth that has the authority to take away people's human rights.

Human rights are sometimes categorized as civil and political rights – including what North Americans may think of as the constitutionally protected civil rights of assembly and association, religious freedom, freedom of the press, freedom from discrimination and censorship, due process protections, the protection from torture and other cruel treatment, and so on; and social, economic, and political rights – including the rights to health, food, shelter, freedom from poverty, and protection of cultural institutions and expressions. These rights are embodied respectively in

the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, both of 1966. Canada is a party to both these international treaties, which are legally binding. Many other human rights instruments add other protections or make explicit the need for special attention to persons such as women, children, prisoners, refugees, and others at particular risk of discrimination and abuse.<sup>9</sup>

Some people have criticized the traditional divide between civil and political rights, on the one hand, and economic, social, and cultural rights, on the other, noting that it is impossible for people struggling for survival or wracked by hunger to enjoy political freedoms, just as it is impossible for people whose political rights are repressed to enjoy the benefits of economic security.<sup>10</sup> With respect to HIV/AIDS, both civil and political rights, on the one hand, and economic, social, and cultural rights, on the other, are crucial to responding to the epidemic, and the two are integrally linked. All people have a right to health that includes being protected from HIV by basic prevention services, and people living with HIV/AIDS have a right to treatment and care. Linked to these are many other rights, both civil or political and social or economic, such as:

- The right not to be discriminated against (based on HIV status or HIV risk) in access to health services or to health information, or in the job market, educational institutions, or other services of the state.
- The right not to be impeded by police abuse or lack of due process from access to services related, in

this case, to HIV prevention or AIDS care and treatment.

- The right to be free of the violence, abuse, or marginalization that may make it impossible for people to seek HIV prevention services or to protect themselves from exposure to HIV.
- The right to adequate food, water, shelter, and income, without which people living with HIV/AIDS risk becoming more ill. Poverty may also lead those without the disease to face greater risk, such as having to trade sex to survive.
- The right to uncensored information about HIV/AIDS, including about all means of prevention of HIV transmission and complete information on AIDS care and treatment.
- The right to keep private one's medical status to the degree that that privacy poses no threat to others, and the right to be counselled confidentially about HIV/AIDS and HIV testing.

Realizing all these rights is a tall order, but two decades of experience have shown that they are all an essential part of an effective response to HIV/AIDS.

### **Interpreting, and elaborating on, HIV/AIDS-related human rights**

HIV/AIDS is not explicitly mentioned in international human rights law. As a result, it is useful to have authoritative interpretations of the importance of various elements of human rights law for HIV/AIDS. The United Nations endorsed one such interpretation in the form of the International Guidelines on HIV/AIDS and Human Rights, published in 1998 by

UNAIDS and the UN Office of the High Commissioner for Human Rights.<sup>11</sup> The Guidelines provide detailed recommendations to governments of actions they should take to ensure that human rights of people affected by HIV/AIDS and those at risk are respected, protected, and fulfilled. Among the recommendations in the guidelines are these:

- that each country's public health laws and regulations, criminal laws, anti-discrimination laws, laws regarding the rights of women, and child-protection laws and policies be reviewed and revised to reflect the need to protect persons affected by HIV/AIDS and to ensure access to prevention, treatment, and care services;
- that the national program framework for responding to HIV/AIDS be managed in a transparent way, and so as to encourage consultation with communities affected by HIV/AIDS and to enable community organizations to participate actively in the fight against HIV/AIDS;
- that each country ensure that high-quality goods, services, and information are available and accessible for HIV/AIDS prevention, care, treatment, and support;
- that each country take measures to ensure that people affected by HIV/AIDS have access to legal support and services, that they are made aware of their rights, and that they have access to mechanisms of redress if their rights are violated; and
- that each country make it a high priority to fight discrimination and stigma by educating the public about the basic facts of

HIV/AIDS, including through mass education, training, and media-based information.

Although they originated from a widely participatory United Nations–overseen process, the Guidelines do not have the force of law, in contrast to international covenants and other human rights treaties. The Guidelines have been “welcomed” by the UN Commission on Human Rights (CHR), the premier human rights mechanism of the UN system.<sup>12</sup> When there was a chance to endorse the Guidelines formally at the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, however, that effort was blocked by the United States, which did not favour a blanket endorsement of all of the Guidelines' provisions.<sup>13</sup>

The Declaration of Commitment on HIV/AIDS from the 2001 UNGASS, endorsed by the 189 nations represented at the session, nonetheless promotes the realization of human rights as a central element of the global response to HIV/AIDS. In particular, it enjoined governments (by 2003) to ensure that their legislation addresses all forms of discrimination against people affected by HIV/AIDS; and (by 2005) to ensure that laws and policies contribute to the protection of women and girls from HIV by ensuring their equality under the law, addressing all forms of sexual violence, banning harmful traditional practices, and otherwise contributing to their empowerment so as to enable them to have greater control over their sexual lives.<sup>14</sup> Countries are required to report periodically on their progress with respect to these commitments.

In addition to the Guidelines and the Declaration of Commitment, the

human rights bodies of the United Nations system have made numerous statements related to HIV/AIDS and human rights. Notable among these have been several resolutions of the CHR asserting the right of persons living with HIV/AIDS to have access to antiretroviral treatment and treatment for opportunistic infections. This resolution passed unanimously over the abstention of the United States in 2001 and, in a similar version, was endorsed in subsequent years by all members of the CHR.<sup>15</sup> On several occasions, the CHR has also urged states to review their legislation in line with the Guidelines and especially to create mechanisms to enforce measures related to discrimination based on HIV status.<sup>16</sup>

There is effectively no international police force that can be mobilized to enforce or protect human rights.

### How do human rights come to be meaningful?

There is effectively no international police force that can be mobilized to enforce or protect human rights. The United Nations is the steward of the world's body of international human rights law. The Security Council of the United Nations has the power to mobilize armed forces or peacekeepers, but it has rarely done so even in the presence of egregious, widespread, and high-profile crimes against humanity, not to speak of the more silent destruction of an epidemic such as HIV/AIDS. Special tribunals of the

United Nations system have been established to consider cases of war crimes and related human rights abuse in particular situations, such as in the former Yugoslavia and during the Rwandan genocide. The newly established International Criminal Court will, according to its mandate, prosecute persons accused of genocide, war crimes, and crimes against humanity.<sup>17</sup> It is unlikely to focus on human rights violations directly related to HIV/AIDS, though its mandate recognizes, for example, that rape and other sexual violence can constitute crimes against humanity.<sup>18</sup>

In the absence of a global body that is likely to hear cases of human rights violations related to HIV/AIDS, it is important that those human rights most linked to the epidemic be protected in national and regional justice systems. In Canada, the Canadian Charter of Rights and Freedoms protects the human rights mentioned in this article (with the exception of the right to privacy, which is unstated in the Charter but is implicit as a principle of the Charter's protections of liberty and security of the person and against unreasonable search and seizure).<sup>19</sup> The federal government and most Canadian provinces and territories have human rights commissions that can investigate cases of discrimination related to HIV/AIDS, which are not generally able to be brought to the courts in civil lawsuits. These commissions have also played a significant role in establishing that people living with HIV/AIDS may be considered to be living with a disability and thus may be eligible for protections and support for the disabled.<sup>20</sup> Some people who have filed complaints with human rights commissions have reported that their slowness and bureaucratic require-

ments are impediments to their usefulness;<sup>21</sup> it is likely that this has been a very underused mechanism of redress for people with HIV/AIDS suffering discrimination.

Canadian courts have also made key decisions related to the human rights of people living with or affected by HIV/AIDS, particularly the right to be free from discrimination. For example, a 2000 decision of the Supreme Court of Canada recognized that discrimination based on disability may occur even when the discrimination is based only on the perception that a person is disabled rather than on visible or functional impairment, a conclusion that is relevant to the case of people living with AIDS.<sup>22</sup>

Regional courts and human rights bodies can also play an important role. For example, in 1997 the European Court of Human Rights overruled the United Kingdom's immigration service when it tried to deport a Saint Kitts citizen terminally ill with HIV/AIDS despite the absence of treatment in his home country.<sup>23</sup> The Inter-American Commission on Human Rights has on several occasions asserted the obligation of governments in the region to provide antiretroviral treatment to people living with HIV/AIDS,<sup>24</sup> though implementation of such rulings has been weak or non-existent.

National courts and to some degree human rights commissions may be able to put some teeth into enforcement of human rights protections through various sanctions and penalties, but these institutions represent only part of the struggle for realization of human rights. The protection and promotion of human rights also depends on exposing human rights violations in ways that provoke public concern or outrage, leading to pres-

sure on governments from their own people to address abusive practices. Non-governmental organizations – both global organizations such as Amnesty International and Human Rights Watch, and regional and national organizations – often have as an objective to “name and shame” governments failing to protect, respect, or fulfill human rights. National, regional, and international news media play a crucial role in this process. Initiatives of numerous non-governmental organizations around the world have helped to bring HIV/AIDS-related human rights abuses to light and have led to legal and policy changes that have reinforced relevant human rights protections.

The real benefit of Canada's leadership will depend on the example it continues to set at home and abroad in the protection, fulfillment, and respect for human rights.

## A role for Canada

As a country that has made strong public professions of its commitment to putting human rights at the centre of its domestic and international response to HIV/AIDS, Canada is a de facto leader in addressing the kinds of abuses discussed in this article. The real benefit of Canada's leadership will undoubtedly depend on the example it continues to set at home and abroad in the protection, fulfillment, and respect for human rights

embodied in its HIV/AIDS-related laws and policies.

In domestic policy, there are numerous current issues that will test that leadership, including several noted above. Legislative initiatives related to privacy will continue to be pursued at the provincial level. There must be a clear commitment at all levels to the principle that health information, including HIV status, can be disclosed without consent of the person concerned only in the most exceptional circumstances. Detailed guidance in this area has been set out by the Canadian HIV/AIDS Legal Network.<sup>25</sup> In the coming months, Correctional Services Canada will demonstrate whether its commitment to prisoners' right to health is real enough to include recognition of the urgent need for needle exchange services in Canadian prisons.

More broadly, Canada's stated commitment to harm-reduction measures should be better reflected in resource allocation. A report of the Auditor General in 2001 indicated that over 90 percent of resources to combat illicit drug use in Canada went toward interdiction and other law enforcement measures rather than public health measures.<sup>26</sup> This disproportionate response should be changed urgently. The Canadian government at all levels should ensure that human rights commissions have the staff and other resources they need to process cases in an efficient and user-friendly way. Federal and provincial/territorial governments should adopt policies that respect and protect the right to give informed consent to HIV testing, including for women during pregnancy.

Canada's role as a global citizen is equally important. Canada is the biggest donor to the World Health Organization's 3 by 5 Initiative, which

aims to ensure that three million persons living with HIV/AIDS who need antiretroviral treatment receive it by the end of 2005. The 3 by 5 Initiative, and the prospect of rapid expansion of treatment programs more generally, has led many experts to call for more extensive use of compulsory or "routine" HIV testing without informed consent, or to encourage testing without pre- and post-test counselling.<sup>27</sup> Canada's voice should be lifted in favour of protecting the voluntary and confidential nature of HIV testing and of the importance of counselling and informed consent as the default preference. Canada is also an important contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund's project submission guidelines are weak on human rights issues, and the Global Fund secretariat has committed few resources to ensuring that people with HIV/AIDS and others at risk are appropriately included in country coordinating mechanisms for Global Fund-supported projects. Canada should raise these concerns and target some support to strengthening human rights elements of Global Fund grants.

Canada should set an example on overall levels of official development assistance (ODA). Canadian ODA remains well below the target of 0.7 percent of GNP set over 30 years ago by the UN, partly through the efforts of Canadian Prime Minister Lester Pearson.<sup>28</sup> ODA levels are also a matter of human rights. Article 2 of the International Covenant on Economic, Social and Cultural Rights binds states to engage in international cooperation for the progressive realization of human rights. International cooperation is especially crucial in the global fight against HIV/AIDS.

Canada and other countries that have made a commitment to human

rights-based approaches to HIV/AIDS must be more active in pushing the United Nations to pay more than lip service to addressing human rights violations linked to HIV/AIDS. Canada should push for the United Nations to have an official policy endorsing syringe exchange, opiate substitution, and other measures as central elements of HIV/AIDS programs for drug users as a matter of human rights. UNAIDS established a Global Coalition on Women and HIV/AIDS, but it has done little to work with donors to ensure adequate resources for programs that address legal dimensions of women's equality. Canada's global AIDS strategy is particularly focused on the situation of women, and Canada should make efforts to ensure that the UN's efforts result in more than just words and reports on women and HIV/AIDS. Men who have sex with men are often cited in UN documents as a vulnerable group, but United Nations agencies have not fought systematically for the abolition of antiquated and harmful sodomy laws that so effectively hamper the delivery of HIV/AIDS-related services to this population. Canada's voice on this issue is crucial.

## Conclusion

Human rights-based approaches to HIV/AIDS are under constant attack in today's world. The rise of religious fundamentalism and its moral judgments in the halls of political power, including in the United States, has the potential to handicap greatly the work of those who understand that fighting AIDS means protecting the human rights of sex workers, men who have sex with men, prisoners, and drug users, who continue to be the objects of knee-jerk moralizing. The importance of everyone's right to basic

information on HIV transmission and AIDS care is drowned out in the din of the well-funded preaching of sexual abstinence, which placates religious extremists. Globally, the approach to narcotics drug use remains too heavily one of repressive criminalization and “wars on drugs” in spite of the clear failure of these approaches to control drug use or its harms. Wars on drugs are politically expedient. Espousing the human rights of socially unpopular people is rarely politically expedient.

But the track record of human rights-centred successes is compelling: for example, the needle exchange programs run by and for drug users that have stopped HIV transmission in its tracks in very high-risk settings; the sex worker collectives that have shown how effective sex workers are as AIDS educators and agents of HIV prevention in the community; and the courageous leadership of people with HIV/AIDS as parts of policy decision-making processes. These and many other victories are widespread, real, and well documented. The struggle is, as it always was, to support those with the courage to see beyond what is politically expedient and what placates the moralizers to human rights-friendly measures that really work against this formidable enemy.

– Joanne Csete

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<sup>1</sup> A Silversides. *AIDS Activist: Michael Lynch and the Politics of Community*. Toronto: Between the Lines, 2003, at 237-238.

<sup>2</sup> Quoted in: Doctors of the World. Jonathan Mann: International Health and Human Rights Pioneer. September 1998, available at [www.doctorsoftheworld.org/about/about\\_details.cfm?QID=1327](http://www.doctorsoftheworld.org/about/about_details.cfm?QID=1327) (retrieved 4 January 2005).

<sup>3</sup> See details of the numerous elements of the Canadian Strategy on HIV/AIDS at [www.phac-aspc.gc.ca/aids-sida/hiv\\_aids/](http://www.phac-aspc.gc.ca/aids-sida/hiv_aids/) (retrieved 3 January 2005).

<sup>4</sup> Canadian International Development Agency. CIDA's HIV/AIDS Action Plan (Second Edition). July 2000, at 1. Available at [http://www.acdi-cida.gc.ca/INET/IMAGES.NSF/vLULImages/Social\\_Development3/\\$file/aidsactionplan2.pdf](http://www.acdi-cida.gc.ca/INET/IMAGES.NSF/vLULImages/Social_Development3/$file/aidsactionplan2.pdf) (retrieved 2 January 2005).

<sup>5</sup> See, eg, Pivot Legal Society Sex Work Subcommittee. *Voices for Dignity: A Call to End the Harms Caused by Canada's Sex Trade Laws*. Pivot Legal Society: Vancouver, 2004, available at [www.pivotlegal.org](http://www.pivotlegal.org).

<sup>6</sup> See Canadian HIV/AIDS Legal Network. *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*. Montréal: Canadian HIV/AIDS Legal Network, October 2004. Available at [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm).

<sup>7</sup> Public Health Agency of Canada, Centre for Infectious Disease Prevention and Control. HIV/AIDS Epi Update, April 2003, available at [www.phac-aspc.gc.ca/publicat/epiu-aepl/hiv-vih/aborig\\_e.html](http://www.phac-aspc.gc.ca/publicat/epiu-aepl/hiv-vih/aborig_e.html).

<sup>8</sup> See Canadian HIV/AIDS Legal Network. *Privacy Protection and the Exposure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada*. Montréal: Canadian HIV/AIDS Legal Network, August 2004, at i-ii. Available at [www.aidslaw.ca/Maincontent/issues/privacy/PrivacyE/toc.htm](http://www.aidslaw.ca/Maincontent/issues/privacy/PrivacyE/toc.htm).

<sup>9</sup> Among the human rights treaties that establish rights relevant to HIV/AIDS and health are: the Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Convention on the Rights of the Child (1989), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984). The Standard Minimum Rules on the Treatment of Prisoners (1955) are UN-endorsed guidelines. The text of all these instruments is available on the website of the UN Office of the High Commissioner for Human Rights, [www.ohchr.org/english/law/index.htm](http://www.ohchr.org/english/law/index.htm).

<sup>10</sup> See, eg, E Press. Human rights – the next step. *The Nation* (New York), 25 December 2000. Available at [www.thenation.com/doc.mhtml%3Fi=20001225&s=press](http://www.thenation.com/doc.mhtml%3Fi=20001225&s=press) (retrieved 3 January 2005).

<sup>11</sup> Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23-25 September 1996. New York and Geneva: United Nations, 1998. (Guideline 6 amended at the Third International Consultation on HIV/AIDS and Human Rights, Geneva, July 2002.)

<sup>12</sup> United Nations Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities. The protection of human rights in the context of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), Sub-Commission resolution 1997/40, 1997. Available at [www.unhcr.ch/Huridocda/Huridoca.nsf/01b1454971e6aa98a8025663300508ea5?Opendocument](http://www.unhcr.ch/Huridocda/Huridoca.nsf/01b1454971e6aa98a8025663300508ea5?Opendocument).

<sup>13</sup> See, eg, F Girard, International Women's Health Coalition. Our History at the UN: Reflections on the

Declaration of Commitment Adopted by the UN General Assembly Special Session on HIV/AIDS, June 27, 2001. Available at [www.iwhc.org/global/un/unhistory/hivaidsreflections.cfm](http://www.iwhc.org/global/un/unhistory/hivaidsreflections.cfm).

<sup>14</sup> United Nations General Assembly. Declaration of Commitment on HIV/AIDS, GA Res/S-26/2, 27 June 2001, paras 16 and 58-61.

<sup>15</sup> United Nations Commission on Human Rights. Access to medication in the context of pandemics such as HIV/AIDS, CHR Resolution 2001/33, available at [www.unhcr.ch/Huridocda/Huridoca.nsf/0/a5c6e2109117dc36c1256a3b00446247?Opendocument](http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/a5c6e2109117dc36c1256a3b00446247?Opendocument).

<sup>16</sup> See, eg, United Nations Commission on Human Rights. The protection of human rights in the context of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), CHR Resolution 2003/47, 2003, available at [www.unhcr.ch/Huridocda/Huridoca.nsf/TestFrame/c73b1b5e18ebae52c1256d1f00419762?Opendocument](http://www.unhcr.ch/Huridocda/Huridoca.nsf/TestFrame/c73b1b5e18ebae52c1256d1f00419762?Opendocument).

<sup>17</sup> United Nations. Rome Statute of the International Criminal Court, Article 1. Available at [www.un.org/law/icc/statute/english/rome\\_statute\(e\).pdf](http://www.un.org/law/icc/statute/english/rome_statute(e).pdf) (retrieved 2 January 2005).

<sup>18</sup> *Ibid*, Article 7, item 1(g).

<sup>19</sup> Canadian Charter of Rights and Freedoms, available at <http://laws.justice.gc.ca/en/charter/>. For a discussion of the constitutional right to privacy under section 7 of the Charter, see *Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada*. Montréal: Canadian HIV/AIDS Legal Network, 2002-2004, at 17.

<sup>20</sup> For a discussion of discrimination law and HIV/AIDS in Canada, see D Webber. *AIDS and the Law*. 3<sup>rd</sup> ed, 2004 Cumulative Supplement. New York: Aspen, 2004, at 225-231.

<sup>21</sup> R Jürgens, B Waring, *Legal and Ethical Issues Raised by HIV/AIDS: Literature Review and Annotated Bibliography*. 2<sup>nd</sup> ed. Geneva: Canadian HIV/AIDS Legal Network & UNAIDS, 1998, at 12-18.

<sup>22</sup> *Québec (Commission des droits de la personne et des droits de la jeunesse) v Montréal (City); Québec (Commission des droits de la personne et des droits de la jeunesse) v Boisbriand (City)*, [2000] 1 SCR 665.

<sup>23</sup> European court prevents deportation of man with AIDS. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 47-48.

<sup>24</sup> International Network for Economic, Social and Cultural Rights. Case Law Detail: Jorge Odir Miranda Cortez (no. 12-249), Inter-American Commission on Human Rights, available at [www.escri-net.org/EngGeneral/CaseLawSearchResult.asp](http://www.escri-net.org/EngGeneral/CaseLawSearchResult.asp).

<sup>25</sup> *Supra*, note 8 at 57-61.

<sup>26</sup> Government of Canada, Office of the Auditor General, 2001 Report, especially Chapter 11 – Illicit Drugs: The Federal Government's Role. Ottawa, 2001.

<sup>27</sup> See, eg, M Heywood. Human rights and HIV/AIDS in the context of 3 by 5: time for new directions? *Canadian HIV/AIDS Policy & Law Review* 2004; 9(2): 1, 7-13.

<sup>28</sup> See, eg, Action Canada for Population and Development, 2002 Pre-Budget Consultations: Submission to the House of Commons Standing Committee on Finance, available at [www.acpd.ca/acpd.cfm/en/section/Resources/articleid/177](http://www.acpd.ca/acpd.cfm/en/section/Resources/articleid/177).

# A long way from there to here: human rights approaches to HIV/AIDS in a local setting

Although global and national strategies to promote a human rights-based approach to HIV/AIDS have been in place for many years, these strategies appear to have had little impact at the local level, where human rights violations are commonplace. In this article, Peris Jones and Farhana Zuberi summarize findings from a recently completed research project, the Tswelopele study, in South Africa.<sup>1</sup> The study documented human rights violations in three areas: privacy and disclosure; informed consent and HIV testing; and access to health-care services. The article describes these violations and explores why discrimination still occurs at the local level. The authors conclude that remedial action is required, targeting the persons and institutions that shape attitudes and beliefs, including churches, workplaces, schools, and the media; and that this action needs to be complemented by wider public education, activism at hospitals and in the courts and, more generally, fulfilment of socio-economic rights.

## Introduction

The plethora of legislation, policies, campaigns, and case law in recent years points to the giant steps taken in promoting a rights-based approach to HIV/AIDS. The international community has been involved in various initiatives such as the International Guidelines on HIV/AIDS and Human Rights<sup>2</sup> and the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS.<sup>3</sup> Such developments are obviously integral to coalescing a rights-based platform to confront the epidemic.

However, as Mark Heywood points out, “despite the evolution of the human rights paradigm into explanatory notes, guidelines, and best practices, human rights violations continue.”<sup>4</sup> The good ship “human rights protection” would once again appear to be foundering on the rocks of non-implementation. Plotting the course of its global voyage from UNAIDS or the United Nations Office of the High Commissioner for Human Rights (UN OHCHR) is certainly an important endeavour. But

another is surely to ask whether the human rights “project,” if we can call it that, sufficiently engages the varied national and local obstacles blocking the path of implementation in the context of HIV/AIDS.

Not least, while much work has been done and documented at global and national levels, there is scant information on the impact of the human rights approach on local communities. After all, according to Peter Piot, Executive Director of UNAIDS: “Unlocking the power of community is the key to making the transition from pilot to full-scale responses. Africa is changing gears, and it is communities who are sitting in the driver’s seat. Now is the time for the global and the local to meet.” The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL), quoting Mr Piot above, assert that “national government officials may be too far away to hear the voice of ordinary citizens.”<sup>5</sup>

There is, of course, danger in uncritically singing the virtues of the local level. In development theory and practice the “local” is often portrayed

as some kind of benign, homogenous, and apolitical container, seemingly detached from global and national dynamics, and ripe for all kinds of outside interventions.<sup>6</sup> Nonetheless, the local scale remains relevant to human rights for at least two reasons. First, this is the terrain where the majority of people living with HIV or AIDS (PLHAs) encounter daily stigma, discrimination, and barriers to accessing health services. Second, extending the benefits of human rights protection does not occur on the head of a pin: in other words, it has to be located somewhere, and consequently must confront localized obstacles to implementation.

## HIV/AIDS and human rights in South Africa

At the national level, South Africa has responded to human rights challenges in a variety of ways. South Africa is party to a range of international and regional human rights instruments.<sup>7</sup> While the majority of these instruments do not specifically mention HIV/AIDS, several provisions are applicable to the situation of PLHAs.

The Constitution of the Republic of South Africa, Act No 108 of 1996, also lists several justiciable socio-economic and civil and political rights, such as: equality; human dignity; freedom and security of the person; privacy; freedom of expression; freedom of association; freedom of movement and residence; freedom of trade, occupation, and profession; right to a healthy environment; right of access to housing, health care, food, water, and social security; and right of access to information. The Department of Health, in its *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*, has also recognized the importance of human rights in combating the spread of HIV/AIDS, and has included human rights and legal issues as one of the five key priority issues of the Plan.

One of the objectives of the study was to determine if local communities have taken ownership of human rights, and are able to access and enforce their rights.

One particular motivating force for the Tswelopele study was to identify the relevance of these human rights provisions in a specific community and area that can be classified as semi-urban and rural. One of the objectives of the study was to illustrate the extent to which the human rights approach has been localized; in other words, to determine if local communities have taken ownership of

human rights, and are able to access and enforce their rights. The study also asked whether the ideals contained in the International Guidelines and the Constitution have permeated to the local community level.

### **Hammanskraal and Temba**

The study was undertaken in Hammanskraal and Temba, which under the demarcation of 2000 fall within the Tshwane (Pretoria) Municipality. The area also crosses provincial boundaries, creating a situation of overlap for various services, including health and education. Thus, both the Tshwane Municipality (Gauteng Province) and the Moretele Local Municipality (North-West Province) are involved in service delivery. While there is an elected local council, there are also tribal authorities that are still prominent in the area. The population<sup>8</sup> of the area is 80,573 (9,664 in Hammanskraal and 70,909 in Temba). The majority of the population is African,<sup>9</sup> with low levels of education, employment, and income. The HIV/AIDS prevalence rate is estimated to be in line with the rest of the country at 21.5 percent.<sup>10</sup>

There are approximately 24 governmental and community-based organizations providing a range of HIV/AIDS services (excluding research) in the area. There are 26 primary health clinics and two mobile health clinics; six clinics offer nevirapine as part of the government's prevention of mother-to-child transmission (PMTCT) program, and 16 clinics offer voluntary counselling and testing (VCT) services. Jubilee is the public hospital for the locality; it offers VCT and PMTCT services, but has not been selected as a site for the

government's antiretroviral treatment (ARV) rollout. Despite the number of services available, and the fact that two provinces and two municipalities are involved, effective service delivery is very limited. In general, resources are clustered in Temba and although there have been HIV/AIDS initiatives within the community there is little or no coordination of these activities.

### **Key findings from the research**

The study was based upon data collected between February and May 2004. The primary data-collection methodology was focus group discussions with PLHAs from the local hospice, and non-PLHAs such as members of social clubs, youth groups, local government councillors, health-care workers, and volunteers at AIDS service organizations (ASOs). This was supplemented by key informant interviews and with observations undertaken in health-care settings such as hospitals, clinics, and other government service delivery points.<sup>11</sup> For the purposes of the analysis, people were classified into two categories: (1) PLHA groups, which comprised those people who were attending the local hospice and openly living with HIV or AIDS; and (2) non-PLHA groups, which comprised everyone else.

A particular concern of the project was to investigate stigma and its construction as the basis of discrimination. Stigma was revealed as a complex and dynamic phenomenon embedded in community and gender relations, with gossip acting as an important conduit. The major human rights violations stemming from stigmatization were identified and are described below.

### Privacy and disclosure

The issue of privacy was a major concern for PLHAs, who indicated the importance of deciding how, when, and to whom to disclose one's status. PLHAs recounted stories of having status disclosed without consent, and how this impacted on them. In many cases, the person who disclosed without consent was a health-care worker from a clinic or hospital. While this was deemed totally unacceptable and often traumatic, PLHAs stated that they had nowhere to turn to complain or for redress. When they turned to the police, they were not taken seriously; complaints to the health-care institution also amounted to nothing. There was overall agreement that if only one could afford a lawyer, then one could see justice done.

The non-PLHA groups also mentioned the importance of privacy and disclosure, with most people recognizing the importance of keeping one's status private. Linkages were made between stigma and disclosure: "If there was no stigma against people who are HIV positive, people would easily disclose their status. People want to disclose but they are afraid of the reaction from their community and how the community will treat them once it knows their status." However, non-PLHAs thought it was precisely because of the lack of disclosure that PLHAs were vilified in the community. They held the view that it was necessary for people to disclose in order for HIV/AIDS to be demystified and treated just like any other disease. As non-PLHAs saw it, privacy had led to the creation of HIV/AIDS as "special." Some non-PLHAs saw privacy as very problematic, stating that the focus on privacy was leading to the spread of the disease.

Volunteers at ASOs and health-care workers also saw privacy and confidentiality as problematic because confidentiality was seen as limiting the extent of assistance they could provide to PLHAs. They argued that the inability to disclose the status of a person to colleagues and others such as family members impeded patients from receiving the best care available. For health-care workers this was more related to the need to protect the family member/caregiver from possible infection, rather than to ensure that the patient was given the best possible treatment at home.

"If there was no stigma against people who are HIV positive, people would easily disclose their status."

### Informed consent and HIV testing

Most people, including health-care workers and PLHAs, shared stories of being tested without having given consent, and without pre- and post-test counselling. One respondent recounted being told by a health-care worker, "You are going to die, you have the virus." Respondents agreed that testing was a traumatic experience and that it took a great deal of courage to finally have a test. Most women, including nurses, had been tested during pregnancy, often years ago, and had not been retested since.

Observation undertaken at the clinics illustrated that there was little in the way of confidentiality and privacy when going for an HIV test. Most clinics did what they could with limit-

ed resources; often the counselling took place in a room that doubled as a medicines storeroom, with people coming in and out. When the clinic was busy, people who came in for tests could be turned away due to lack of personnel to do the counselling and testing. The need for individual pre- and post- test counselling was seen as unrealistic in the already under-resourced and overburdened public health system.

HIV testing was seen to be on the increase because of the access to disability grants, and both health-care workers and non-PLHAs regarded this with some cynicism.<sup>12</sup> The non-PLHA community groups expressed worry about welfare abuse by people claiming to be living with HIV or AIDS. There was a perception that unscrupulous doctors were signing the requisite forms for healthy individuals, making them eligible for grants.

When challenged on how to deal with this issue, one community respondent indicated that there was a need to retest all PLHAs in the area, even if this involved locking them in a stadium and forcing them to retest – in other words, the need to curb welfare fraud would override the need for informed consent. Forced testing also came up in one focus group and key informant interview relating to the need to test pregnant women in an effort to protect the unborn child from infection.

Finally, there was a broader discussion about what constituted informed consent, and whether it was possible to get informed consent from someone who was sick.

### Access to health-care services

Both PLHAs and non-PLHAs complained about the treatment they had

received at the hospital and clinics in the area. Non-PLHA groups complained about the waiting period, and about the fact that there were no doctors available, that the drugs were never in the pharmacy, and that the level of service at Jubilee was less than acceptable. As one woman said about having to go to Jubilee: “I won’t go there, I will stay away.” They alleged that it was useless to complain since the suggestion boxes at the institutions were opened and suggestions were reviewed by the supervisors, who simply destroyed all complaints.

Access to health care and treatment was a major concern for all the PLHA groups. PLHAs regarded their ill treatment by health-care workers as directly related to their HIV status. The majority of the PLHAs indicated that they would not go to the hospital, even when they were very ill, and would prefer the treatment they received at home, which was far from adequate, to the treatment they received at the hands of health-care workers.

Most PLHAs were able to recount stories of being forced to wait to use the bathroom or being told to “go yourself”; of staff disclosing status and gossiping about patients in front of others; of staff passing “funny remarks”; of staff refusing treatment or giving the wrong medication; of staff violating a right to privacy by identifying HIV-positive patients with a special diagnosis code (Code 279) written on charts; and of HIV patients being segregated in specific wards.

In one focus group, it was stated: “Sometimes when you are taken to the hospital and they [nursing sisters] can see that you are very ill, they don’t attend to you, they just say take this person there, there is nothing we

can do for him. They don’t want to understand that this person is in pain and needs an urgent help, therefore they must give him the special attention; they just become harsh on him.” Nurses were seen to have “an attitude,” especially against those with HIV or AIDS.

Nurses, on the other hand, vehemently denied that they treat PLHAs differently and that people with HIV were segregated in specific wards.<sup>13</sup> They suggested that people had unrealistic expectations of them and that no matter what they did, it was never seen as good enough. Nurses complained of being overworked, and being affected psychologically by the number of people who were dying, and whom they dealt with daily. They also complained about visitors coming to “snoop around” rather than to visit patients.

Nurses blamed families for treating people with HIV badly and cited examples of family members dumping patients in the hospital and not coming to collect discharged patients; and patients being admitted when they were dirty and with bedsores, showing that they were not cared for at home. Nursing sisters themselves felt stigmatized: “So we like our jobs even though the community labels and stigmatizes us and even God knows we are doing our best. We wake up in the morning knowing what kind of patients we will see but we still go to work and do our best.”

Many people saw human rights as a problem rather than as a means of empowerment.

## Is a human rights approach at the community level sufficient?

In Hammanskraal and Temba, it was clear that human rights violations continued against PLHAs despite the human rights protections espoused in international and national legislation and policies. This could arguably be attributed to a number of factors, including the following:

- Most people did not know about human rights. They had not read or been exposed to the Bill of Rights.
- It is difficult to make rights real. Is this even possible in an environment of poverty and unemployment?
- The community was not aware of how to enforce the rights that had been violated, and there were few if any organizations in the community that could provide assistance.
- Many people saw human rights as a problem rather than as a means of empowerment.

These factors will be discussed briefly in turn.

### Lack of information

When asked about the Constitution, the majority of people interviewed were able only to recognize it, but not give any details about what was in it. Questions were met with silence or vague answers about rights. Thus, there had been little in terms of dissemination of the practical content of rights at the community level. This impacted on people’s ability to claim their rights – if a person does not know what a human right is in a practical sense, he or she will not be in a

position to recognize a violation and claim redress or enforcement of the right.

Other laws that deal with non-discrimination, such as the Employment Equity Act, No 55 of 1998, were also not known to the community.

### **Making rights real**

One respondent said, “I believe if people can know their rights, things will be better. I sometimes believe it is useless to know your rights if you do not know how to exercise them.”

Many people indicated that it was not possible for them to exercise their rights. They felt helpless and disempowered in trying to access rights such as the right to health-care services, giving examples of complaints falling on deaf ears, with no changes ever being made. For example, people complained about the lack of local government delivery in the area with respect to water, electricity, and other basic services; importantly, they felt that they had no recourse, or anywhere to complain to make a difference.

It was suggested that people in the community could not make rights real because they prioritized other issues such as poverty, and human rights were seen as secondary, or almost a “luxury” item. The focus on work and simply making a living meant that human rights played a less significant role in life. A teacher in the community reinforced this sentiment by indicating that, although she was discriminated against after disclosing her status at school, she did not have any time to deal with the violations because she was busy working, as she had a family to support.

Another reason given for the failure to access human rights was the link between stigma and discrimination. The link was recognized in many

groups, and fear of stigmatization was seen as one of the primary reasons why people did not speak out and try to enforce their rights in the community.

### **Few organizations to assist with enforcement**

Even when violations occurred and were recognized, most community members did not know where to go for assistance. The stakeholders that were mentioned – such as the police, traditional leaders, and local government – were seen as being totally unable or unwilling to help. Many people interviewed could not name any organizations in the area that could be of assistance. People mentioned having to go from one place to another trying to obtain help. For example, in trying to deal with family violence, women were usually sent to the police and then the courts, and often did not have sufficient funds for transport. Other people mentioned that they do not know where to go to report abuses such as unauthorized disclosure by health-care workers and doctors.

Institutions such as the Department of Labour and the South African Human Rights Commission were mentioned in very vague terms. People who were interviewed were not able to give details of whom to contact and the mandate of such institutions. While municipal officials indicated that it was possible for people to come to them for assistance, most people felt that the municipality had little to offer.

One of the focus groups of PLHAs mentioned that large AIDS organizations such as the National Association of People Living with AIDS (NAPWA) and the Treatment Action Campaign (TAC) should be able to provide assistance with problems, but

said that they did not play a role in Hammanskraal. The large organizations were treated with some suspicion, and were seen to be visible only when they needed support for campaigns. It was actually difficult to find any organizations in the community that dealt specifically with human rights violations. Those that supposedly did were not accessible even to the researchers during the course of the study.

**There is a disjuncture between thinking at global and local levels that will obviously need to be addressed for a rights-based approach to be effective.**

Repeated attempts were made to contact both the TAC and NAPWA to meet with them and discuss their involvement in the area, but these proved unsuccessful. Many PLHAs had paid for membership in NAPWA, but were not clear about the services it offered or even whether or not there was a branch in Hammanskraal or Temba. During the research period, there was a planned relaunch of NAPWA. While several people waited at a meeting venue for several hours, NAPWA representatives did not arrive. Thus, it appears that the TAC and NAPWA, the largest national AIDS organizations in the country, played little (if any) role in the area.

### **Human rights: solution or problem?**

Many people saw human rights as a problem rather than as a solution. The

police saw the Bill of Rights as preventing them from doing their job properly, and argued that community education campaigns with respect to rights in the Constitution did not include information about accompanying responsibilities. The traditional leader interviewed claimed that human rights were eroding the traditional way of life in the villages, and causing the breakdown of traditional values. PLHAs alleged that access to information about sex made young people more likely to engage in sexual behaviour, thus leading to a spread of HIV. Nurses thought that access to child-care grants made young women fall pregnant, which led to the spread of HIV. As discussed above, many people suggested that confidentiality and informed consent were unimportant, and that non-consensual HIV testing should take place.

It is important to pay attention to these issues since they display a disjuncture between thinking at global and local levels and will obviously need to be addressed for a rights-based approach to be effective.

## Conclusion

The research findings suggest that although global and national strategies have been in place for many years, the rights-based approach has made little difference to the lives of people in the community. Additional findings on labelling, blame, gossip, and social exclusion of PLHAs, or those suspected to be HIV-positive, showed an apparent disjuncture between rights and reality. While some people might know what their rights are and how to exercise them – including the rights of the infected or affected – the lived reality of PLHAs and the communi-

ties from which they come may be quite different.

People are still subject to human rights violations and have difficulty making their rights real. Importantly, people often believe that human rights are a burden or a luxury, and only relevant to those with enough money to enforce them. Much still needs to be done to ensure that people can understand and benefit from a human rights approach. Taking human rights into an effective AIDS response means intervening at the level of community and personal gossip, at the places where perceptions are formed; this could mean targeting persons and institutions that shape attitudes and beliefs, including churches, workplaces, schools, and the media. This needs to be supported by formal action – at hospitals, through the courts, paralegal training, and wide public education – in an effort to find ways in which a different social construction can be developed to make people trust the law and appreciate that rights can work for the wider social good.

Above all, if a human rights discourse is to be relevant in a context where local residents face severe poverty and unemployment, a critical dialogue is required between human rights and socio-economic needs. The justiciability of socio-economic rights may be rapidly gaining ground at a national level in South Africa, but it still requires connection to local-level struggles and especially implementation in areas like Hammanskraal for it to be regarded as relevant locally.

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<sup>1</sup> HIV/AIDS stigma and human rights: A localised investigation of Hammanskraal communities. A report of the Tswelopele Research project of the Centre for the Study of AIDS. Available via [www.csa.za.org](http://www.csa.za.org).

<sup>2</sup> Accessible via [www.ohchr.org](http://www.ohchr.org).

<sup>3</sup> Accessible via [www.unaids.org](http://www.unaids.org).

<sup>4</sup> M Heywood. Human Rights and HIV/AIDS in the context of 3 by 5: time for new directions? *Canadian HIV/AIDS Policy and Law Review* 2004; 9(2): 1, 7-13.

<sup>5</sup> AMICAALL recognizes the need for action at the local level, and the vital role that is to be played by municipalities. For more information, refer to the AMICAALL website at [www.amicaall.org](http://www.amicaall.org).

<sup>6</sup> G Mohan, K Stokke. Participatory development and empowerment: the dangers of localism. *Third World Quarterly* 2000; 21(2): 247-268.

<sup>7</sup> A complete list of international instruments, current as of 1 October 2004, is available from the OHCHR website at [www.ohchr.org/english/bodies/docs/RatificationStatus.pdf](http://www.ohchr.org/english/bodies/docs/RatificationStatus.pdf). The list of ratifications of regional instruments is available at the AU website at [www.africa-union.org/home/Welcome.htm](http://www.africa-union.org/home/Welcome.htm).

<sup>8</sup> Demographic information is from the 2001 census, available at the Demarcation Board website at [www.demarcation.org.za](http://www.demarcation.org.za).

<sup>9</sup> During apartheid, populations in South Africa were classified as White, Indian, Coloured, and African. For ease of classification, the government has retained this system.

<sup>10</sup> UNAIDS. 2004 Report on the Global AIDS Epidemic. Available via [www.unaids.org](http://www.unaids.org).

<sup>11</sup> For information on focus groups, key informants interviews, and the observations undertaken, see Appendix 1 of the Tswelopele report (supra, note 1).

<sup>12</sup> On the other hand, access to disability grants was a vital issue, raised in all PLHA focus groups, and seen to be necessary for livelihood as PLHAs perceived that they had even less access to employment and services than others in the area.

<sup>13</sup> The issue of segregation in specific wards in Jubilee was one that was raised in many groups. People from the community had heard of specific wards where HIV-positive patients were admitted. However, the alleged segregation was denied by the nurses, who argued that, no matter which ward an HIV-positive person was admitted into, it was seen by the community as a ward for HIV-positive persons simply due to ignorance.

# Protection against discrimination based on HIV/AIDS status in Canada: the legal framework

Respecting, protecting, and fulfilling the human rights of people living with, and vulnerable to, HIV/AIDS has been recognized as an essential element of ethical and effective responses to the epidemic. Human rights law provides one critical tool for implementing a human rights-based approach to HIV/AIDS. Freedom from discrimination is a foundational human rights principle, and is a touchstone of both international and domestic human rights law. This article examines the ways in which Canadian law currently protects people against discrimination based on HIV/AIDS status. The article also reviews the equality rights provision of the Canadian Charter of Rights and Freedoms; federal, provincial, and territorial anti-discrimination statutes and policies; and some of the key cases that have applied and developed these legislative protections. Finally, the article looks at the issue of remedies for discrimination under Canadian law. (Other forms of discrimination relevant to people living with HIV/AIDS – specifically, discrimination based on grounds relevant to people from groups disproportionately affected by HIV/AIDS-related stigma – will be analyzed in similar detail in a future issue of the Review.)

## Introduction

More than 20 years after the emergence of HIV/AIDS, stigma and discrimination remain a reality for people living with the disease and for groups associated with the epidemic, particularly those who are socially and economically excluded. A recent survey of Canadians' attitudes about HIV/AIDS yielded mixed results.<sup>1</sup> About 85 percent of respondents said they could be friends with someone who has HIV/AIDS, although one in ten still believes that people infected with HIV through sex or drug use have got what they deserve. But when asked about their comfort with a person with HIV/AIDS in various scenarios, a disturbing picture emerges.

Almost one-third of respondents indicated they would not be comfortable working in an office with someone who is HIV-positive or shopping

in a grocery store whose owner is HIV-positive. Only 55 percent of respondents said they would be somewhat or very comfortable if their child were attending a school where one of the students is known to be HIV-positive. And half of respondents said that people living with HIV/AIDS should not be allowed to serve the public in positions such as dentists or cooks. Smaller-scale research projects in recent years have also reported that people living with HIV/AIDS continue to experience, and to fear, discrimination based on their serostatus or diagnosis of AIDS.<sup>2</sup>

In light of such findings, and of experiences regularly recounted by people living with HIV/AIDS, what protection and redress does the law in Canada provide for people who experience HIV/AIDS-related discrimination?

Canada is a federal state consisting of a federal government, ten

provinces, and three territories, with legislative authority over various spheres divided between these different levels of government. As a result, protection against HIV/AIDS-related discrimination is found in several different laws, applicable at different levels and to different actors or situations.

Constitutional equality rights protect individuals against discrimination by government, at whatever level, throughout the country. In addition, at both the federal level and in every province and territory, human rights statutes prohibit discrimination not only by governments but also by private actors (eg, private persons, corporations), in areas such as: employment; services, goods and facilities; contracts; accommodation; and membership in unions or other associations.<sup>3</sup>

In almost every jurisdiction, these anti-discrimination statutes also create a commission to receive and investi-

gate complaints of discrimination contrary to the act and a tribunal that can adjudicate such complaints if they proceed past the investigation stage and settlement attempts. These statutes often have a clause in them stating that they are superior to other statutes in that jurisdiction, unless the legislature clearly intends otherwise in the case of a particular statute. Even when such a clause is not present, the Supreme Court of Canada has ruled that a human rights act takes precedence over other statutes,<sup>4</sup> and has described them as quasi-constitutional in nature.<sup>5</sup>

The full scope of civil, political, economic, social, and cultural rights recognized in the international treaties ratified by Canada does not find expression in domestic Canadian law.

It is important to understand that, while they are often named “Human Rights Acts,” these statutes are primarily focused on only one human right – namely, freedom from discrimination.<sup>6</sup> Many other human rights, as recognized in international law, are reflected in other Canadian laws – most obviously, those rights that enjoy constitutional protection under the Canadian Charter of Rights and Freedoms.

But the full scope of civil, political, economic, social, and cultural rights recognized in the international treaties ratified by Canada does not, at this

time, find expression in domestic Canadian law – and in some cases, such as the right to the highest attainable standard of health, which binds Canada under the International Covenant on Economic, Social and Cultural Rights, governments have actively resisted recognition of these rights as subject to judicial application before Canadian courts.

In the case of protecting against discrimination, however, Canadian law is among the most progressive, at least on paper if not always in implementation. On balance, albeit with some lamentable exceptions, Canadian courts have taken relatively progressive approaches to interpreting and applying constitutional guarantees of equality.

In all jurisdictions – federal, provincial and territorial – discrimination on the following grounds is prohibited by the jurisdiction’s human rights statute: age, race, ethnicity, colour, religion, sex (including pregnancy), marital status, disability (or “handicap” in some statutes), sexual orientation, and place of origin. Some human rights codes also include provisions explicitly prohibiting discrimination based on family status, source of income, (pardoned) criminal conviction, and gender identity (in one jurisdiction).

Courts and tribunal decisions have, in some cases, expanded the scope of protection through their interpretations of the prohibited grounds that are explicitly mentioned in these statutes. Specific types of discrimination – such as discrimination against people with AIDS, or people with a chemical dependency – have been found to be covered by human rights tribunals or courts through their interpretation of terms such as “disability.” Some of the variation between

jurisdictions is reflected in the accompanying table.

### Defining “discrimination”

Not all distinctions, and not all unfavourable treatment, amount to unlawful “discrimination.” The leading definition of discrimination, which has been widely applied by Canadian courts and tribunals, was set out in *Andrews v Law Society of British Columbia*, a 1989 decision of the Supreme Court of Canada:

discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual’s merits and capacities will rarely be so classed.<sup>7</sup>

Discrimination may be direct, such as a landlord’s open refusal to rent an apartment to someone living with HIV/AIDS. Or, it may operate more indirectly, such as by applying rules or policies that, although facially neutral, have the effect of discriminating on a prohibited ground.

Under Canadian human rights statutes and jurisprudence, there is a legal duty of accommodation – that is, a duty to take reasonable steps, short of “undue hardship,” to accommodate difference (at least on the grounds recognized in human rights law).<sup>8</sup> Legitimate (*bona fide*) requirements may be defensible as permissible

**Table – Protection against discrimination based on HIV/AIDS status as a "disability" or "handicap"**

<b>Federal Law</b>	
<b>Canada</b>	Canadian Human Rights Act prohibits discrimination in goods, services, facilities, accommodation, and employment.  Canadian Human Rights Commission has a Policy on HIV/AIDS.
<b>Provincial and Territorial Laws</b>	
<b>Alberta</b>	Human Rights, Citizenship and Multiculturalism Act prohibits discrimination in public accommodation, tenancy, and employment.
<b>British Columbia</b>	Human Rights Code prohibits discrimination in public facilities, tenancy premises, purchase of property, and employment.
<b>Manitoba</b>	Human Rights Code prohibits discrimination with respect to employment or occupation; any service, accommodation, facility, good, right, licence, benefit, program, or privilege available or accessible to the public; contracts; membership in a union, employers' organization, occupational association, professional association or trade association; leasing or other lawful occupation of residential or commercial premises; purchase of real property.  Manitoba Human Rights Commission has published a Fact Sheet: Prohibiting Discrimination Based on AIDS/HIV Infection.
<b>New Brunswick</b>	Human Rights Code prohibits discrimination with respect to employment, housing, accommodation, and services.  New Brunswick Human Rights Commission has adopted General Criteria for the Investigation of Complaints of HIV/AIDS Discrimination.
<b>Newfoundland</b>	Human Rights Code prohibits discrimination with respect to employment, access to public services, and commercial residential tenancies.
<b>Northwest Territories</b>	Human Rights Act prohibits discrimination with respect to employment, goods, services, accommodation, and facilities customarily available to public.
<b>Nova Scotia</b>	Human Rights Act prohibits discrimination with respect to services and facilities, accommodation, purchase and sale of property, employment, volunteering public service, publication, or membership in a trade union.
<b>Nunavut</b>	Human Rights Act prohibits discrimination with respect to employment, goods, services, accommodation, and facilities customarily available to the public.
<b>Ontario</b>	Human Rights Code prohibits discrimination with respect to services, goods, and facilities; occupancy of accommodation; contracts; employment; membership in trade union, trade, occupational association, or self-governing profession.  Ontario Human Rights Commission has adopted a Policy on HIV/AIDS-related Discrimination.
<b>Prince Edward Island</b>	Human Rights Act prohibits discrimination with respect to accommodation, property, and employment.
<b>Québec</b>	Charter of Human Rights and Freedoms prohibits discrimination with respect to accommodation, access to public places, and employment.
<b>Saskatchewan</b>	Human Rights Code prohibits discrimination in employment, purchase of property, accommodation, public places, and education.
<b>Yukon</b>	Human Rights Act prohibits discrimination with respect to employment, accommodations, and services.

kinds of distinctions. There is an extensive body of case law considering the parameters of the duty to accommodate and what constitute legitimate requirements.<sup>9</sup> It would, for example, be discrimination if an employer failed to reasonably accommodate an HIV-positive employee with a sufficiently flexible work schedule to allow for medical appointments.

**It would be discrimination if an employer failed to reasonably accommodate an HIV-positive employee with a sufficiently flexible work schedule to allow for medical appointments.**

Harassment is a form of discrimination, and has been expressly addressed in the human rights statutes of some jurisdictions. In other jurisdictions, as a matter of policy, it has been treated as falling under the general prohibition on discrimination.

Whether by statute or policy, harassment has generally been defined to include “sexual harassment” (including sexual advances or conduct of a sexual nature that is likely to be offensive or humiliating, or that places a condition of a sexual nature on something like hiring or promotion), as well as any course of abusive or vexatious conduct, on the basis of any prohibited ground of discrimination, that the person knows, or ought reasonably to know, is or would be unwelcome. Derogatory comments in the workplace that people with HIV/AIDS “deserve what they get” would constitute harassment prohibited by law.

Under Canadian law, discrimination can be found to exist even if there was no intention to discriminate. As the Supreme Court of Canada put it succinctly in *O’Malley*: “It is the result or the effect of the action complained of which is significant.”<sup>10</sup> Furthermore, Canadian law prohibits discrimination based on a person’s *perceived* characteristics or membership in a particular group.<sup>11</sup> If, for example, a person is denied accommodation or employment because s/he is perceived to be HIV-positive or possibly HIV-positive, this is illegal discrimination.

### **Legal sources of protection against HIV/AIDS-based discrimination**

#### **(1) Constitutional protection: the Charter’s equality rights clause**

The Canadian Charter of Rights and Freedoms is part of the Constitution of Canada, enacted in 1982 (although the equality rights section did not come into force until three years later).<sup>12</sup> The Constitution is the supreme law of the country. Any law that is inconsistent with constitutional provisions is “to the extent of the inconsistency, of no force or effect,”<sup>13</sup> and may be struck down or modified by courts to render it constitutionally acceptable. This means that any other legislation – including the anti-discrimination statutes described in this article – must be consistent with the requirements of the Charter.

This includes the guarantee of equality rights, found in section 15 of the Charter, which states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in

particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.<sup>14</sup>

The term “disability” in this section has been interpreted to include HIV/AIDS (as it has in various anti-discrimination statutes, as discussed below). This means that people living with HIV/AIDS enjoy constitutional protection against discrimination by the state based on this status.<sup>15</sup>

Section 15 uses the phrase “in particular” in listing, for greater certainty, some specific grounds on which discrimination is prohibited. This means the scope of the equality rights protection in section 15 is not limited just to the grounds that are listed. Grounds that are similar (“analogous”) to those which are expressly mentioned are also included.<sup>16</sup> This has enabled courts to “read in” other grounds and thereby expand constitutional protection against discrimination in line with the spirit of the Charter. (This issue, which is relevant to the scope of protection offered by the Charter for various groups who are vulnerable to both HIV/AIDS and discrimination, will be explored further in a subsequent, companion article.)

The legally correct approach to interpreting section 15 has been in flux over the last decade. Under the Supreme Court of Canada’s current interpretation, in order to show a breach of section 15 equality rights, a person must show that the government’s law, policy or practice has drawn a distinction on a ground that is either listed in section 15 or is similar, and also that the distinction constitutes a “violation of essential human dignity.”

Until the late 1990s, it was sufficient to show a distinction based on a prohibited ground, at which point the onus then shifted to the government to

justify the discrimination, if it could, under the justification provision in section 1 of the Charter (see below). However, in some more recent decisions, the Supreme Court has added this extra requirement that human dignity be violated.<sup>17</sup>

While a concern for human dignity certainly lies at the heart of protecting equality rights, this additional criterion has been criticized, including by Canada's leading constitutional scholar, as "vague, confusing and burdensome to equality claimants,"<sup>18</sup> as weakening the test for governments of justifying discriminatory distinctions,<sup>19</sup> and as a step backward from the previously clear approach in Canadian constitutional law to analyzing cases claiming infringements of section 15's equality rights guarantee.<sup>20</sup> Notwithstanding this criticism, the Supreme Court has reiterated the human dignity element of the test in some of its most recent judgments, while hearkening back to some earlier jurisprudence in stressing that the purpose of section 15 is to "prevent the perpetuation of pre-existing disadvantage through unequal treatment" and to "ameliorate the position of disadvantaged groups within society."<sup>21</sup>

As has just been noted, the Charter includes a provision recognizing that rights are not absolute, and may justifiably be limited in some circumstances. Section 1 states that the Charter guarantees the rights set out in it "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

Once it has been shown that a Charter right, such as the guarantee of equality in section 15, has been infringed, the onus then falls on the government in question to justify that

Once it has been shown that a Charter right has been infringed, the onus then falls on the government to justify that infringement.

infringement. In fleshing out the meaning of section 1 of the Charter, the Supreme Court of Canada has set out the tests the state must meet if it is to defend its legislation or other action that breaches Charter rights:

- (1) the objective of the legislation, policy or practice in question must be of sufficient importance to warrant overriding a constitutionally protected right or freedom;
- (2) the measure must be rationally connected to the achievement of that objective, and not arbitrary, unfair or based on irrational considerations;
- (3) the measure should impair as little as possible the right or freedom in question; and
- (4) the benefits gained by limiting the right or freedom must be proportional to the negative effect on the right or freedom.<sup>22</sup>

The Charter applies to all levels of government and to all government acts,<sup>23</sup> whether by the legislative, executive or judicial branches of government (including the courts, and human rights commissions and arbitrators exercising judicial functions).<sup>24</sup> This includes municipalities (which are created by provincial governments and exercise the powers delegated to them)<sup>25</sup> and to Aboriginal band coun-

cils (which form part of the system of governance established by the federal Indian Act).<sup>26</sup>

The Charter also applies to Crown corporations (at least in respect of their activities in carrying out government functions).<sup>27</sup> It also applies outside the sphere of government to private persons or bodies if they are exercising authority granted by a statute,<sup>28</sup> or if they are implementing a specific government policy or program (eg, a hospital providing medically necessary services).<sup>29</sup>

The Charter does not otherwise apply to acts by private citizens or entities,<sup>30</sup> meaning that discrimination by an employer, a landlord, or a private establishment is not a breach of constitutional equality rights (although it can be addressed under other anti-discrimination laws, as described below).

## **(2) Protection against HIV/AIDS-based discrimination under federal law**

### **a) Canadian Human Rights Act**

The Canadian Human Rights Act (CHRA) was first enacted by the federal Parliament in 1977.<sup>31</sup> It prohibits discrimination on a wide range of grounds in areas such as employment; accommodation; the provisions of goods, services, and facilities; and membership in a union or employee organization.

"Disability" is among the prohibited grounds of discrimination in the CHRA,<sup>32</sup> and is defined as "any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug."<sup>33</sup> Harassing an individual on a prohibited ground is explicitly included in the definition of "discriminatory practice."<sup>34</sup>

Unlike the Charter, the CHRA (and its counterparts at the provincial and territorial levels) applies to both public and private sector entities. In the case of the federal Act, it protects against discrimination by federal government departments, agencies, and Crown corporations, and by First Nations band councils. In the private sphere, it protects against discrimination by federally regulated entities such as chartered banks, airlines, TV and radio stations, interprovincial communications and telephone companies, buses and railways that travel between provinces, and other federally regulated industries (eg, certain mining operations).<sup>35</sup>

Courts and tribunals have recognized HIV/AIDS as a disability within the meaning of the Canadian Human Rights Act.

**b) Jurisprudence**

Courts and tribunals have recognized HIV/AIDS as a disability within the meaning of the CHRA. For example, in one of the first such cases anywhere in the country, the Canadian Human Rights Tribunal ruled in 1989 that a man had been discriminated against, on the basis of disability, when his employment as a cook for a Canadian Pacific railway crew was terminated after it was discovered that he had HIV.<sup>36</sup> That decision was upheld by the Federal Court of Appeal.<sup>37</sup> This interpretation of the CHRA was affirmed again in *Thwaites*<sup>38</sup> in 1993, in which an HIV-positive man succeeded in his human

rights complaint against the Canadian Armed Forces for discrimination based on disability.

**c) Policy**

In 1996 the Canadian Human Rights Commission, the body established by the CHRA to receive and investigate complaints of discrimination contrary to the Act, adopted a Policy on HIV/AIDS.<sup>39</sup> The policy expressly states that the prohibition in the CHRA against disability-based discrimination extends to discrimination based on HIV/AIDS status.

The policy also recognizes that people who are not actually HIV-positive may nonetheless be subject to discrimination by virtue of a real or perceived membership in a risk group, or by an association with a person or people living with HIV/AIDS. According to the policy, these individuals are also entitled to protection, under the Human Rights Act, against discrimination on the grounds of perceived disability.

**(3) Protection against discrimination under provincial and territorial law**

**a) Legislation**

Each province and territory in Canada has its own anti-discrimination statute.<sup>40</sup> While the law in each province and territory prohibits discrimination based on a person's HIV/AIDS status, there is no explicit reference to HIV/AIDS in the various anti-discrimination statutes. Rather, they refer to "disability" or "handicap" (the language varies from jurisdiction to jurisdiction). Where more detailed definitions of this term are provided in the statute, it is clear that infection with HIV or a diagnosis of AIDS is covered by this term.

For example, the Northwest Territories statute defines "disability" to include "any degree of physical disability, infirmity, malformation or disfigurement that is caused by ... illness."<sup>41</sup> Similar definitions are found in several of the provincial and territorial statutes.

Interestingly, the Nova Scotia Human Rights Act not only prohibits discrimination based on physical disability, but also on "an irrational fear of contracting an illness or disease,"<sup>42</sup> which is listed as a separate ground on which discrimination is prohibited. This provision is of obvious relevance in combating the stigma and discrimination that too often continue to surround HIV/AIDS and adversely affect people living with HIV/AIDS or people from groups associated with the disease in the minds of many, such as gay men or drug users.

**b) Jurisprudence**

As has been the case with the federal anti-discrimination statute, courts and tribunals have decided cases of HIV/AIDS-based discrimination under several of the provincial and territorial statutes, further confirming that Canadian law protects the right of people living with HIV/AIDS to freedom from discrimination.

The 1988 case of *Biggs v Hudson* was one of the first reported decisions to address HIV/AIDS-based discrimination in Canada.<sup>43</sup> The BC Council of Human Rights, as the tribunal tasked with adjudicating complaints under BC's Human Rights Act was then called, found that AIDS constitutes a physical disability within the meaning of that phrase in the Act. The Council also considered whether, under the Human Rights Act, a person is entitled to protection from discrimination on the basis that the person

falls within a group considered to be at high risk of contracting HIV. After reviewing both Canadian and US case law, the Council said:

Unfortunately, myths and fears about HIV are varied and prevalent. That being so, individuals may be perceived by people outside these groups as being carriers of HIV and would, therefore, transmit the virus to others.<sup>44</sup> ...

[A]ny person who belongs to groups widely regarded as especially vulnerable to HIV infection but who are not HIV infected or whose HIV status is unknown ("high risk" groups), may be protected under the term "physical disability" in the Act. Similarly, any person who associates with persons in the groups described above or those who are seropositive may be protected under the term "physical disability" in the Act. Again, subject to any consideration of *bona fide* occupational requirement as may be applicable, these persons or classes of persons will be protected under ... the Act if there is discrimination because of a perception or impression that the person or classes of persons would be a carrier or transmitter of HIV or the commonly used term, AIDS.<sup>45</sup>

Courts and tribunals have similarly recognized that HIV/AIDS-based discrimination is prohibited under other provincial and territorial human rights statutes. In the case of employment discrimination in unionized workplaces, labour arbitrators have also ruled that HIV/AIDS-based discrimination is prohibited by human rights codes. (Under Canadian law, arbitrators have jurisdiction to decide all workplace disputes arising under a collective agreement, and the Supreme Court of Canada has affirmed that the applicable human rights code is deemed to be an

implied term of every collective agreement.<sup>46</sup>)

Some court, tribunal, and arbitration decisions establishing protection against discrimination based on HIV/AIDS status include:

- In *Pacific Western Airlines Ltd v Canadian Air Line Flight Attendants Association*, the Arbitration Board held in 1988 that dismissing a flight attendant from his job on the basis of his HIV status amounted to prohibited discrimination.<sup>47</sup>
- In *Centre d'accueil Sainte-Domitille v Union des employés de services, local 298 (FTQ)*, the arbitrator ruled that an employer does not have the right to require a medical examination where the purpose is merely to obtain evidence that the employee is HIV-positive, when that status poses no danger to others.<sup>48</sup>
- In *Re "Alain L"*, the Québec Human Rights Commission received a complaint from a registered nurse who alleged that a hospital had refused to hire him because he was HIV-positive. The Commission issued a preliminary "decision" in the matter, a step taken to assist parties to a dispute reach a settlement (failing which, the Commission may refer the case to a tribunal). The Commission was of the view that such conduct by the hospital would amount to discrimination on the basis of "handicap" contrary to the Québec Charter of Human Rights and Freedoms.<sup>49</sup>
- In a 1989 Alberta case, *STE v Bertelsen*, the Board of Inquiry

found that firing a musician with AIDS was discrimination contrary to what was then the province's Individual's Rights Protection Act.<sup>50</sup> Importantly, the Board clarified that HIV could not be transmitted through casual contact, and the subjective belief or fear of infection held by others could not justify their discriminatory conduct.

- In 1990 a Board of Inquiry affirmed that "conditions such as AIDS and its related illnesses" constitute physical disabilities under the Nova Scotia statute (although the case in question was not a case of HIV/AIDS-based discrimination).<sup>51</sup>
- In 1992 an Ontario Board of Inquiry dealt with a case alleging discrimination by a dental practice against an HIV-positive person. Although it found, on the facts of the case, that there had been no discrimination, it did confirm that discrimination based on HIV status is covered by the prohibition on discrimination based on "handicap."<sup>52</sup> The following year, another tribunal decision affirmed that AIDS was a "handicap" within the meaning of the Ontario Human Rights Code, in a case in which a man known to be living with HIV/AIDS was denied service or received unequal service by the proprietors of a succession of fast-food restaurants in one location in Toronto.<sup>53</sup> In 1998, another case concluded that the Code provides protection to a person who suffers discrimination because he or she is perceived to have HIV/AIDS.<sup>54</sup>
- In 1993, a BC human rights tribunal heard yet another case of

alleged refusal of a dentist to treat a person living with HIV. The tribunal reiterated that “AIDS” is a disability, and found that the dentist’s fear of contracting the disease was a significant factor in his statement that he did not wish to treat the patient.<sup>55</sup> However, upon judicial review, in a decision that is likely incorrect, the BC Supreme Court overturned this ruling, in essence saying it was the patient’s decision to then seek treatment elsewhere; therefore, it dismissed the complaint of discrimination.<sup>56</sup>

- Also in 1993, the case of *Hamel v Malaxos* confirmed that an HIV-positive person is a person with a “handicap” within the meaning of that term in the Québec Charter of Human Rights and Freedoms, when a man with asymptomatic HIV infection succeeded in his action against a dentist for refusing to treat him. The court concluded this amounted to discriminatory treatment contrary to the provincial statute.<sup>57</sup> This position was reaffirmed in a similar case two years later, in which a dentistry practice was found liable for having breached the Québec statute by refusing to accept a patient because of his HIV-positive status.<sup>58</sup>
- In 1999, building on the analysis in the earlier *Biggs* case, the BC Human Rights Tribunal found that the provincial statute also prohibits discrimination based on the perceived propensity of a person to become disabled in the future – and it therefore found that an insurance company had engaged in prohibited discrimination by

refusing to sell life insurance to an HIV-negative man married to an HIV-positive woman.<sup>59</sup>

- In 2000 the Supreme Court of Canada issued a landmark ruling setting out a broad, progressive interpretation of the term “disability” as it appears in the Québec anti-discrimination statute. In the joint *Boisbriand* and *Montreal* judgment, the Court ruled that people are protected against discrimination based on disability even if their condition does not give rise to any functional limitation but the discrimination is based on the perception that they are disabled, which the Court decried as the “social phenomenon of handicapping.”<sup>60</sup> Although none of the cases giving rise to this decision dealt with HIV/AIDS, the Supreme Court’s unanimous judgment makes explicit reference to the status of being HIV-positive as an example of a condition covered by the prohibition against discrimination based on disability or perceived disability.

Several provinces have policies in place that assist in communicating to the public that discriminating against people living with HIV/AIDS is illegal.

**c) Policy**

Several provinces have in place policies that specifically address issues related to discrimination and HIV/AIDS, which assist in communi-

cating to the public (including such audiences as employers, landlords, and service providers) that discriminating against people living with HIV/AIDS is illegal.

- The Manitoba Human Rights Commission has produced a fact sheet addressing discrimination based on HIV/AIDS infection. The document explains that the province’s human rights act prohibits discrimination based on a person’s physical or mental disability, actual or perceived, and that this includes protection against discrimination that is based on a person having AIDS or HIV infection.<sup>61</sup>
- The province of New Brunswick has in place General Criteria for the Investigation of Complaints of HIV/AIDS Discrimination.<sup>62</sup> Under these criteria, the New Brunswick Human Rights Commission will accept complaints that allege discrimination on the basis of physical disability where a person has, or is perceived to have, HIV or AIDS, or because of an association with persons identified by a prohibited ground of discrimination.
- Ontario also has in place a Policy on HIV/AIDS-related Discrimination,<sup>63</sup> in which the Ontario Human Rights Commission explains that AIDS and other HIV-related medical conditions are “handicaps” under the Human Rights Code.
- Finally, in Québec, the provincial statute’s prohibition of discrimination against persons with HIV/AIDS is outlined in a number of

policy documents, including an official policy statement found in a 1995 report by the provincial human rights commission.<sup>64</sup> This policy has also underscored the fact that an asymptomatic HIV-positive person does indeed fall within the category of “handicap” under the Québec Charter, even if there is no obvious manifestation of a physical impairment. The Commission has also published papers specifically addressing the question of employment-related medical examinations and the rights of children with HIV/AIDS in the context of childcare services.<sup>65</sup>

## Remedies for discrimination in Canada

### (1) Court action for breach of Charter equality rights

In the case of discrimination by any level of government, acting in pursuit of its governmental functions – such as passing legislation or regulations, implementing policies, enforcing the law, providing government services – one remedy is to initiate a legal proceeding before a court alleging a breach of the equality rights guaranteed by the Charter (s 15). A “court of competent jurisdiction” has authority under the Charter (s 24) to grant “such remedy as the court considers appropriate and just in the circumstances.”<sup>66</sup> This can include such things as:

- declaring legislation unconstitutional and striking it down as being “of no force or effect” to the extent that it conflicts with Charter equality rights (under s 52);

- “reading down” an unconstitutional law by severing the offending portions, or “reading in” words to a statute to make it constitutionally acceptable;
- issuing a temporary or permanent injunction prohibiting the government from continuing or repeating the infringement of equality rights, or a *mandamus* order that compels the government to take certain action to comply with constitutional rights;
- staying a court or tribunal decision pending an appeal or review by a higher body; and
- awarding monetary damages to the person whose Charter rights have been breached by the government or its agents.

### (2) Human rights complaints

In cases of discrimination that do not involve a government carrying out governmental functions, the remedy is to pursue a complaint under the applicable human rights statute, whether federal or provincial/territorial, alleging discrimination on one or more of the grounds prohibited by that statute. This would include all cases where discrimination is alleged against an employer, a landlord, a business providing goods or services, or in relation to membership in a union or other vocational association.

In most jurisdictions, the relevant human rights commission receives and investigates the complaint, and also undertakes mediation efforts between the person alleging discrimination (complainant) and the person or entity accused of discrimination (respondent) in an attempt to settle the matter. If these efforts prove unsuccessful, the commission will make a determination as to whether the case

will proceed to an independent tribunal, at which point the commission takes “carriage” of the complaint and argues its merits on behalf of the complainant.

If the commission decides not to refer the case to a tribunal, this is the end of the complaint, meaning the commission acts as a “gatekeeper” to tribunal hearings of discrimination complaints. However, it also means that the costs to the individual of a human rights complaint are minimal, making this remedy more accessible to those without the resources to hire a lawyer.

In British Columbia, the Human Rights Commission was abolished in 2003. This means that complainants now have direct access to a hearing before a human rights tribunal. The Tribunal’s Rules of Practice and Procedure state that individuals will now be given much more control over their own complaints.<sup>67</sup> Specifically, individuals will be responsible for formally initiating their own human right complaints, and will no longer have to worry about the possibility of their complaint being rejected before ever reaching a tribunal.<sup>68</sup> However, this also means that complainants must argue their own cases before the tribunal, without any legal advice or representation if they cannot afford it. One concern about access to justice has been replaced with another.

In contrast, in Québec there is both a commission and a tribunal, and the commission does not play this role of “gatekeeper.” Unlike most other jurisdictions, under the Québec Charter of Human Rights and Freedoms, after the Commission has performed the initial processing and investigation of a complaint, an individual can proceed with that complaint before a tribunal even if the Commission

decides not to take it forward on their behalf.

Only a minority of human rights complaints proceed to a full tribunal hearing. Complaints must usually be filed with the relevant human rights commission within a certain period of time after the discrimination occurred; if not, they will likely be dismissed out of hand by the commission unless there is adequate justification for the delay. Commissions may also dismiss complaints that are frivolous, vexatious, or in bad faith; that have no basis in the law; or that are outside the commission's jurisdiction. Of complaints that do proceed to an investigation, many are settled between the parties without a hearing.

Only a minority of human rights complaints proceed to a full tribunal hearing.

The Canadian Human Rights Commission and Tribunal have jurisdiction over complaints that arise against the federal government or private actors in federally regulated sectors. Provincial and territorial human rights commissions and tribunals deal with complaints against the provincial government or provincially or territorially regulated entities. A number of cases outlined above are decisions of those tribunals (which are referred to in some jurisdictions as Boards of Inquiry).

### (3) Grievances before labour arbitrators

In the case of non-unionized employees who experience discrimination in

employment, the only remedy is to pursue a human rights complaint with the appropriate commission. However, in the case of a unionized employee alleging discrimination in employment, another option is to have the union file a grievance on the employee's behalf, alleging a breach of the collective agreement with the employer. As noted above, Canadian law has determined that the applicable human rights statute (either federal or provincial/territorial, depending on whether the employer is in a federally or provincially/territorially-regulated sector) is automatically an implied part of every collective agreement, and arbitrators are empowered to interpret and apply human rights statutes in deciding grievances.

In some cases, human rights commissions, citing provisions in the applicable human rights code, will refuse to address any complaint of discrimination if another statute (eg, a labour relations act) enables them to have their case dealt with in another forum (eg, filing a grievance through their union).<sup>69</sup> In such cases, pursuing a grievance under a collective agreement would de facto be a person's only option.

### (4) No ability to sue for discrimination

Aside from these statutory remedies for discrimination based on human rights codes, Canadian law has been hostile toward other remedies. In its controversial judgment in *Seneca College v Bhadauria*, the Supreme Court of Canada unanimously overturned a lower court judgment that had recognized a tort of discrimination, which would have enabled an individual to bring a civil lawsuit for damages for discrimination.<sup>70</sup> The

court held that the federal and provincial legislatures have "covered the field" of legal protection for victims of discrimination, leaving no room, nor any need for, a tort of discrimination.<sup>71</sup> (Roughly speaking, a tort may be defined as a civil wrong, other than a breach of contract, that gives rise to a right to sue for damages or other relief.)

The Supreme Court's controversial decision has been followed in many subsequent cases, but in several other cases, courts have attempted to distinguish the case in front of them from the *Bhadauria* decision in order to permit civil suits for discrimination to proceed. At the moment, unless and until the Supreme Court revisits the *Bhadauria* decision, the basic position is that Canadian law does not recognize a tort of discrimination, and those seeking redress for discrimination must pursue a remedy using the mechanisms established to enforce the human rights statutes in place in every jurisdiction. Creative legal arguments in future cases may eventually alter the state of Canadian law on this point.

## Conclusion

Beyond what statutes say formally, in practice, successfully using Canadian law to remedy and challenge discrimination remains a challenge for many people living with HIV/AIDS or members of other groups facing discrimination, given systemic problems within the human rights enforcement mechanisms or the costs of litigating to defend Charter rights.

Strengthening access to legal services and representation for people living with HIV/AIDS is, therefore, one important part of a larger strategy to overcome HIV/AIDS-related stigma and discrimination in Canada, as is

strengthening human rights education and advocacy efforts across the country. The Canadian HIV/AIDS Legal Network has called on governments to take such measures, including adequate funding for legal aid services, resources to support the work of community workers and lawyers in addressing discrimination and defending the rights of people living with or vulnerable to HIV/AIDS, and funded campaigns challenging HIV/AIDS-related stigma.<sup>72</sup>

This is in line with the International Guidelines on HIV/AIDS and Human Rights, which recommend that states should ensure speedy and effective legal and/or administrative procedures for seeking redress for discrimination, should implement legal support services that provide free legal services to enforce the rights of people infected or affected by HIV/AIDS and to utilize means of protecting those rights, and support education, training, and media programming designed to change stigmatizing attitudes associated with HIV/AIDS.<sup>73</sup>

In the Declaration of Commitment on HIV/AIDS, adopted in June 2001 by Canada and all other UN Members, states committed to strengthen legislation and other measures to eliminate discrimination against people living with HIV/AIDS and members of vulnerable groups.

While Canada's legal framework on HIV/AIDS-related discrimination is strong, there is much that remains to be done to make these legal provisions practically applicable to the daily lives of people living with HIV/AIDS and other members of Canadian society.

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<sup>1</sup> Ekos Research Associates. *HIV/AIDS – An Attitudinal Survey*. Final Report. 24 June 2003. For more detail, see: T d Bruyn, D Garmaise. Survey reveals knowledge and attitudes of Canadians regarding HIV/AIDS. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 31-32.

<sup>2</sup> V Leauene et al. Sondage "Attitudes envers les personnes vivant avec le VIH dans la population générale du Québec." Institut national de santé publique du Québec, 2003; J Leech. Survey reveals human rights abuses in Alberta. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(1): 24 (and see full results at [www.aidsalgar.org/programs/humanRightsQuestion.shtml](http://www.aidsalgar.org/programs/humanRightsQuestion.shtml)); A Handa, A Negash. HIV Endemic Task Force: Report on Phase Two of Community Consultation, April 2003; HIV Endemic Task Force. Complete Report of the Community Forum "For Us, By Us, About Us": An Opportunity for African and Caribbean Communities to Address the Issue of HIV/AIDS Related Stigma and Denial. Toronto: The Task Force, 2001; C Olivier. HIV-related discrimination in New Brunswick increasing. *Canadian HIV/AIDS Policy & Law Newsletter* 2000; 5(2/3): 52; S Matiation. *Discrimination, HIV/AIDS and Aboriginal People: A Discussion Paper* (2d ed). Montréal: Canadian HIV/AIDS Legal Network, 1999; S Kellington et al. Listen Up! Women are Talking About... The social determinants of women's risk for HIV infection and illness progression in lower mainland British Columbia. Vancouver: Positive Women's Network, 1999; Alliance for South Asian AIDS Prevention. *Discrimination and HIV/AIDS in South Asian Communities: Legal, Ethical and Human Rights Challenges – An Ethnocultural Perspective*. Toronto: ASAAP, 1999; W Lau et al. *Legal, Ethical and Human Rights Issues Facing East and Southeast Asian-Canadians in Accessing HIV/AIDS Services in Canada*. Toronto: Asian Community AIDS Services, 1999.

<sup>3</sup> Some jurisdictions also prohibit the publication or display of notices, signs, etc. that imply or incite discrimination, and some jurisdictions also prohibit telecommunications that incite hatred or contempt of persons on the basis of prohibited grounds of discrimination.

<sup>4</sup> *Winnipeg School Division No 1 v Craton*, [1985] 2 SCR 150.

<sup>5</sup> *Insurance Corporation of British Columbia v Heerspink*, [1982] 2 SCR 145; *Ontario Human Rights Commission and O'Malley v Simpson-Sears Ltd*, [1985] 2 SCR 536 [O'Malley].

<sup>6</sup> There are some exceptions. For example, the Yukon Human Rights Act also includes provisions on freedom of religion and conscience, freedom of expression, freedom of assembly and association (ss 3-5). The Québec Charter of Human Rights and Freedoms explicit protects the right to privacy (ss 5 & 9).

<sup>7</sup> *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143.

<sup>8</sup> Eg, *Eaton v Brant County of Board of Education*, [1997] 1 SCR 241; *Granovsky v Canada*, [2000] 1 SCR 703; *Eldridge v British Columbia*, [1997] 3 SCR 624.

<sup>9</sup> *O'Malley*, supra, note 5.

<sup>10</sup> *Ibid*; see also *Rodriguez v British Columbia (Attorney General)* (1993), 85 CCC (3d) 15 (SCC); *Eldridge*, supra, note 8.

<sup>11</sup> *Québec (Commission des droits de la personne et des droits de la jeunesse) v Montréal (City); Québec (Commission des droits de la personne et des droits de la jeunesse) v Boisbriand (City)*, [2000] 1 SCR 665; 2000 SCC 27.

<sup>12</sup> Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, (UK) 1982, c 11 [Charter].

<sup>13</sup> Constitution Act, 1982, c 52(1).

<sup>14</sup> Note that section 15 actually protects equality in four different forms: equality before the law, equality under the law, equal protection of the law, and equal benefit of the law.

<sup>15</sup> *Brown v British Columbia (Minister of Health)* (1990), 66 DLR (4th) 444 (BCSC); *Wakeford v Canada* (1998), 166 DLR (4th) 131 (Ont Ct Gen Div).

<sup>16</sup> *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143.

<sup>17</sup> *Law v Canada*, [1999] 1 SCR 497; *M v H*, [1999] 2 SCR 203; *Corbiere v Canada*, [1999] 2 SCR 203; *Granovsky v Canada*, [2000] 1 SCR 703; *Lavoie v Canada*, [2002] 1 SCR 769.

<sup>18</sup> P Hogg. *Constitutional Law of Canada, Looseleaf Edition*. Toronto: Carswell, at section 57.2(b).

<sup>19</sup> *Ibid*.

<sup>20</sup> *Ibid*.

<sup>21</sup> *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, 245 DLR (4th) 1 at paras 25 and 27.

<sup>22</sup> *R v Oakes*, [1986] 1 SCR 103, as modified by *Dagenais v Canadian Broadcasting Corporation*, [1994] 3 SCR 835; applied in *Thomson Newspaper Co v Canada (Attorney General)*, [1998] 1 SCR 877.

<sup>23</sup> Charter, s 32; *R v Rahey*, [1987] 1 SCR 588; *British Columbia Government Employees' Union v British Columbia*, [1988] 2 SCR 214; *Slaight Communications v Davidson*, [1989] 1 SCR 1038.

<sup>24</sup> This would seem to include the act of governments making contracts of employment with their employees: *Douglas/Kwantlen Faculty Association v Douglas College*, [1990] 3 SCR 570; *Lavigne v OPSEU*, [1991] 2 SCR 211.

<sup>25</sup> *Godbout v Longueuil (City)*, [1997] 3 SCR 844.

<sup>26</sup> *Corbiere v Canada (Minister of Indian and Northern Affairs)* (1996), 206 NR 85 (FCA). Whether the Charter applies to Aboriginal governments exercising an inherent right of self-government is a more contentious issue. This is the conclusion favoured by the Royal Commission on Aboriginal Peoples, but with the caveat that the Charter must also be interpreted in light of other relevant provisions – namely, the recognition of self-government as an inherent Aboriginal right that is constitutionally protected (s 35) and the direction that Charter rights are not to be interpreted in a way that abrogates or derogates from any Aboriginal, treaty, or other rights or freedoms of Aboriginal peoples in Canada (s 25). See: Royal Commission on Aboriginal Peoples. *Final Report*. Ottawa: Minister of Supply & Services, 1996; P Hogg, ME Turpel. Implementing self-government: constitutional and jurisdictional issues. *Canadian Bar Review* 1995; 74(2): 187; S

Matiation. *Discrimination, HIV/AIDS and Aboriginal People: A Discussion Paper* (2d ed). Montréal: Canadian HIV/AIDS Legal Network, 1999 (available via [www.aidslaw.ca](http://www.aidslaw.ca) under "Aboriginal Communities and HIV/AIDS").

<sup>27</sup> *Canadian Union of Postal Workers v Canada Post Corp* (1987), 40 DLR (4th) 67 (Alberta QB); *Canada Post Corporation v CUPW* (1991), 84 DLR (4th) 150 (Ont Ct Gen Div).

<sup>28</sup> P Hogg, *supra*, note 18 at section 57.2(b).

<sup>29</sup> *Eldridge*, *supra*, note 8.

<sup>30</sup> *McKinney v University of Guelph*, [1990] 3 SCR 229.

<sup>31</sup> SC 1976-77, c 33; RSC 1985, c H-6 [CHRA].

<sup>32</sup> CHRA at s 3(1).

<sup>33</sup> *Ibid* at s 25.

<sup>34</sup> *Ibid* at s 14.

<sup>35</sup> For more information about the CHRA, see the website of the Canadian Human Rights Commission at [www.chrc-ccdp.ca](http://www.chrc-ccdp.ca).

<sup>36</sup> *Fontaine v Canadian Pacific Ltd* (1989), 29 CCEL 192.

<sup>37</sup> *Canadian Pacific Ltd v Canadian Human Rights Commission*, [1991] 1 FC 571 (CA).

<sup>38</sup> *Thwaites v Canada (Canadian Armed Forces)*, [1994] 3 FC 38 (TD).

<sup>39</sup> Canadian Human Rights Commission. Canadian Human Rights Commission Policy on HIV/AIDS. Ottawa: The Commission, June 1996, available at [www.chrc-ccdp.ca/legislation\\_policies/aids-en.asp](http://www.chrc-ccdp.ca/legislation_policies/aids-en.asp), and also reprinted in *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 3(1): 7-8.

<sup>40</sup> Human Rights, Citizenship and Multiculturalism Act, RSA 2000, c H-14 [Alberta]; Human Rights Code RSBC 1996, c 210 [British Columbia]; Human Rights Code, CCSM 1987, c H175 [Manitoba]; Human Rights Act, RSNB 1973, c H-11 [New Brunswick]; Human Rights Code, RSNL 1990, c H-14 [Newfoundland & Labrador]; Human Rights Act, SNWT 2002, c 18 [Northwest Territories]; Human Rights Act, RSNS 1989, c 214 [Nova Scotia]; Human Rights Act, SNU 2003, c 12 [Nunavut]; Human Rights Code, RSO 1990, c H.19 [Ontario]; Human Rights Act, RSPEI 1988, c H-12 [Prince Edward Island]; Québec Charter of Human Rights and Freedoms RSQ 1975, c C-12 [Québec]; Saskatchewan Human Rights Code, SS 1979, c S-24.1 [Saskatchewan]; Human Rights Act, RSY 2002, c 116 [Yukon].

<sup>41</sup> Human Rights Act, SNWT 2002, c 18, s 1(1).

<sup>42</sup> NSHRA, s. 5(1)(p).

<sup>43</sup> (1988), 9 CHRR D/5391.

<sup>44</sup> *Ibid* at para 40354.

<sup>45</sup> *Ibid* at para 40360.

<sup>46</sup> *Weber v Ontario Hydro* (1995), 125 D.L.R. (4th) 583 (SCC); *Parry Sound (District) Social Services Administration Board v OPSEU Local 324*, [2003] 2 SCR 157, 2003 SCC 42.

<sup>47</sup> (1987), 28 LAC (3d) 291 (Canada Labour Arbitration Board).

<sup>48</sup> [1989] TA 439 (Tribunal d'Arbitrage).

<sup>49</sup> File No 8706004809-001-0; COM-327-8.1.1.14 (Quebec Human Rights Commission).

<sup>50</sup> (1989), 10 CHRR D/6294 (Alberta Board of Inquiry).

<sup>51</sup> *Morrison v O'Leary*, [1990] NSHRBID No 3 (QL) at para 61 (NS Board of Inquiry).

<sup>52</sup> *Jerome v DeMarco* (1992), 16 CHRR D/402 (Ontario Board of Inquiry).

<sup>53</sup> *McCarthy v Kays Toronto Trading Ltd* (1993), 19 CHRR D/485 (Ontario Board of Inquiry).

<sup>54</sup> *Moffat v Kinark Child and Family Services*, [1998] OHRBID No 19 (QL) (Ontario Board of Inquiry).

<sup>55</sup> *Hinkel v Wood*, [1993] BCCHRD No 24 (QL) (BC Council of Human Rights).

<sup>56</sup> *Hinkel v Wood*, [1994] BC No 2104 (QL).

<sup>57</sup> (1993), 20 CCLT (2d) 272, [1994] RJQ 173 (Court of Québec, Civil Division – Small Claims Court). For a summary, see: D Patterson. Québec court finds asymptomatic HIV infection a Charter "handicap." *Canadian HIV/AIDS Policy & Law Newsletter* 1994; 1(1): 1, 3.

<sup>58</sup> *PM et Commission des droits de la personne v G*, [1995] RJQ 1601, (1996) 24 C.H.R.R. D/21.

<sup>59</sup> *J v London Life Insurance Co*, [1999] BCHRTD No 35 (BC Human Rights Tribunal). However, an Ontario court has also ruled that, in light of the special exemptions granted to insurance companies under that province's human rights code, it was not discrimination when an HIV-positive man was denied long-term disability benefits under his employee benefit plan. The plan's "pre-existing condition" clause disqualified an employee from receiving benefits for any disability resulting from a cause for which the employee visited a doctor within 90 days prior to the date his or her group insurance coverage becomes effective: *Thornton v North American Life Assurance Co* (1995), 123 DLR (4th) 709, 23 CHRR D/1 (Ontario Divisional Court), affirming 17 CHRR D/481 (Ontario Board of Inquiry).

<sup>60</sup> *Québec (Commission des droits de la personne et des droits de la jeunesse) v Montréal (City); Québec (Commission des droits de la personne et des droits de la jeunesse) v Boisbriand (City)*, [2000] 1 SCR 665, 2000 SCC 27.

<sup>61</sup> Manitoba Human Rights Commission. *Fact Sheet: Prohibiting Discrimination Based on AIDS/HIV Infection*. Winnipeg: Manitoba Human Rights Commission (undated), available at [www.gov.mb.ca/hrc/english/publications/](http://www.gov.mb.ca/hrc/english/publications/)

[factsheets/aids.html](http://factsheets/aids.html) (accessed 17 February 2005).

<sup>62</sup> New Brunswick Human Rights Commission. *General Criteria for the Investigation of Complaints of HIV/AIDS Discrimination*. Moncton: New Brunswick Human Rights Commission, 1997, available at [www.gnb.ca/hrc-cdp/e/gaids.htm](http://www.gnb.ca/hrc-cdp/e/gaids.htm).

<sup>63</sup> Ontario Human Rights Commission. Policy on HIV/AIDS-Related Discrimination. Toronto: Ontario Human Rights Commission, 1996 ([www.ohrc.on.ca](http://www.ohrc.on.ca)).

<sup>64</sup> Commission des droits de la personne du Québec. *La Prévention de la Discrimination Contre les Personnes Atteintes du VIH/SIDA et la Protection de leurs Droits au Québec: Contribution de la Commission au Rapport d'Information aux Nations Unies*. Québec: Commission des droits de la personne et de la jeunesse, 1995. See also the Commission publication *Le SIDA et le respect des droits et libertés de la personne* (April 1998). Both publications are available via [www.cdpcj.qc.ca/fr/publications](http://www.cdpcj.qc.ca/fr/publications) (under "SIDA").

<sup>65</sup> See the Commission's publications *Les examens médicaux en emploi* (June 1998) and *Le droit au service de garde pour les enfants atteints du VIH/SIDA* (May 1995), both available via [www.cdpcj.qc.ca/fr/publications](http://www.cdpcj.qc.ca/fr/publications) (under "SIDA").

<sup>66</sup> One of the leading cases on the appropriate use of some of these constitutional remedies is the Supreme Court's decision in *Schachter v Canada*, [1992] 2 SCR 679. There is a series of decisions from various courts analysing the circumstances in which it is appropriate to award monetary damages for breach of Charter rights (what have also been called "constitutional torts").

<sup>67</sup> British Columbia Human Rights Tribunal Rules of Practice and Procedure (March 31, 2003), available at [www.bchrt.bc.ca/popt/rules\\_practice\\_procedure](http://www.bchrt.bc.ca/popt/rules_practice_procedure) [BCHRT, Rules of Practice and Procedure].

<sup>68</sup> See BCHRT, Rules of Practice and Procedure, *ibid*, Part 4, ss 10(2) and 11.

<sup>69</sup> Eg, Ontario Human Rights Code, s 34.

<sup>70</sup> *Seneca College v Bhaduria*, [1981] 2 SCR 181.

<sup>71</sup> T Witelson. Retort: revisiting *Bhaduria* and the Supreme Court's rejection of a tort of discrimination. *National Journal of Constitutional Law* 1999; 10: 149 at 159.

<sup>72</sup> T de Bruyn. *A plan of action for Canada to reduce HIV/AIDS-related stigma and discrimination*. Canadian HIV/AIDS Legal Network. Montréal: Legal Network, 2004, available via [www.aidslaw.ca](http://www.aidslaw.ca) (under "HIV/AIDS, Stigma, and Discrimination").

<sup>73</sup> Office of the UN High Commissioner for Human Rights and the Joint UN Programme on HIV/AIDS (UNAIDS). *HIV/AIDS and Human Rights: International Guidelines*. Geneva: OHCHR & UNAIDS, 1998, Guidelines 5, 7 and 9.

# 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. The articles for this section were written by David Garmaise, the editor of Canadian News, and Glenn Betteridge, Senior Policy Analyst at the Canadian HIV/AIDS Legal Network. Address correspondence to David Garmaise at [dgarmaise@rogers.com](mailto:dgarmaise@rogers.com). Glenn Betteridge can be reached at [gbetteridge@aidslaw.ca](mailto:gbetteridge@aidslaw.ca).

## Legal Network launches Plan of Action on HIV/AIDS-related stigma and discrimination

On 26 January 2005, the Canadian HIV/AIDS Legal Network launched *A Plan of Action for Canada to reduce HIV/AIDS-related stigma and discrimination*.<sup>1</sup> The kick-off included a national press conference on Parliament Hill, and local press conferences by six community-based organizations across Canada.

### Stigma and discrimination fuelling HIV/AIDS in Canada

A 2003 EKOS Research Associates survey cited in the Plan of Action found that one-quarter of respondents were uncomfortable associating with people with HIV/AIDS.<sup>2</sup> Another 40

percent had only a moderate level of comfort and almost half of the people agreed that people infected with HIV should not be allowed to serve the public working in jobs like dentists or cooks.

According to the Plan of Action, HIV/AIDS-related stigma and discrimination are fuelling the

HIV/AIDS epidemic and its negative impacts. People living with HIV/AIDS in Canada face stigma and discrimination within their own communities, and from outside those communities.

Using testimony from people living with HIV/AIDS, the report details how this stigma and discrimination

keeps many such people on the margins of society and prevents them from accessing the health-care and other services they need to stay healthy.

The report focuses not only on stigma and discrimination directed at people living with HIV/AIDS, but also on the stigma and discrimination faced by groups of people linked with HIV/AIDS in the public mind, including intravenous drug users, gay men, sex workers, and people who come from countries where HIV/AIDS is widespread.

The report says that HIV/AIDS-related stigma and discrimination stand in the way of accessing the health and social services that people require, and is also a barrier to educational and other efforts aimed at preventing the transmission of HIV.

## The Plan of Action

The Plan of Action was developed by the Legal Network in conjunction with communities and people living with and vulnerable to HIV/AIDS in Canada. The Health Canada-funded project was guided by an advisory committee of community members.

The input of people living with HIV/AIDS, AIDS service organizations, organizations guided by people who inject drugs, lesbians/gays/transgender and Two-Spirited people, labour unions, prisoner organizations, health-care workers, and people from ethnocultural communities was solicited at a two-day in-person workshop, and via feedback on the draft report. The report was authored by Theodore de Bruyn, who also wrote the Legal Network's 1998 report on HIV/AIDS and discrimination in Canada.<sup>3</sup>

The Plan of Action explains the negative impacts of stigma and dis-

crimination on people living with and vulnerable to HIV/AIDS in Canada. It explores the connection between the right to health and the need for human rights protection. It is composed of 18 goals and the actions needed to achieve these goals, and was developed with input from people and organizations from across Canada.

**Responsibility for taking action against stigma and discrimination rests with governments, service providers, employers, and other agents who have an obligation to respect, protect, and fulfill human rights.**

The 18 goals are organized into five broad areas: participation of people living with HIV/AIDS and vulnerable to HIV; tackling stigmatizing attitudes; advocating for rights; improving services; and strengthening research and evaluation. The Plan of Action places primary responsibility for taking action against stigma and discrimination on those agents (such as governments, service providers, and employers) that, according to human rights and anti-discrimination law, have an obligation to respect, protect, and fulfill human rights.

According to the Plan of Action, government commitment in one form or another is needed to achieve all 18 goals and the actions listed under those goals. For some of the actions, governments must play the leading role, putting in place laws, policies,

and programs. For other actions governments are called on to provide groups and organizations, especially those working at the community level, with funding to design and deliver programs aimed at reducing HIV/AIDS-related stigma and discrimination.

The Plan of Action's goals and actions are comprehensive and ambitious, cutting across many facets of Canadian society, including institutions such as churches, schools, health services, human rights commissions, and government departments. The Plan sets out goals in each of the following areas:

1. Participation of people living with HIV/AIDS and vulnerable to HIV
2. Changing public attitudes
3. Informing media coverage
4. Supporting people living with HIV/AIDS and people vulnerable to HIV
5. Strengthening community-based education and advocacy
6. Greater awareness of human rights
7. Increase access to legal information and advice
8. Working with human rights commissions
9. More targeted community HIV/AIDS education and prevention
10. Client-centred health services
11. Affordable, accessible & adequate housing
12. Protecting people in employment
13. Education for youth that is accurate, appropriate to their age and not judgmental
14. Fair treatment for immigrants and refugees
15. Best practices in HIV testing for

- immigrants and refugees
16. International cooperation based on human rights
  17. Participatory and inclusive research
  18. Evaluation of programs to reduce stigma and discrimination

### **Other resources, the role of the community, and next steps**

In addition to the full-length report, the Legal Network, in partnership with the Canadian HIV/AIDS Information Centre, has published a concise, easy-to-read booklet. The booklet defines the basic concepts of stigma and discrimination; explains the legal obligations of government and other actors to take action to reduce HIV/AIDS-related stigma and discrimination; and lists the Plan of Action's 18 goals, along with examples of stigma and discrimination and programs that community-based organizations have implemented to reduce HIV/AIDS-related stigma and discrimination in their community.

As part of the campaign to reduce HIV/AIDS-related stigma and discrimination, the Legal Network is urging people in Canada to complete and mail a postcard to the Prime Minister urging that he and his government take a leadership role in the fight against stigma and discrimination.

In addition to the commitment and leadership required from government, communities and community organizations have a key role in ensuring that the Plan of Action, and its primary goal of reducing HIV/AIDS-related stigma and discrimination, is acted upon in Canada. Under the Plan, communities should ensure the involvement of people living with HIV/AIDS and vulnerable to HIV in action taken against stigma and discrimination. Additionally, they must work to change attitudes and behaviours in their organization and in their community, undertake human rights education and advocacy, and hold government agents accountable for taking action required to reduce stigma and discrimination.

The Campaign resources will be sent to a broad range of individuals and organizations responsible for public policy, decision-making, program development and delivery, and enforcement of human right law – including politicians, government officials, religious and other community leaders, AIDS service organizations, media, medical professional associations, human rights commissions, organized labour, teachers' associations, and researchers. All have important roles to play in reducing HIV/AIDS-related stigma and discrimination. The Legal Network will also be undertaking sustained follow up in an area in which it can make a significant contribution, namely advo-

cating for rights (Goals #6 to #8 in the Plan).

In related news, federal Minister of Health Ujjal Dosanjh and Minister of State for Public Health Carolyn Bennett, spoke out against stigma and discrimination on World AIDS Day (1 December 2004). (Goal 2 of the Plan highlights the need for leadership, including public statements in support of people living with and affected by HIV/AIDS, from federal and provincial ministers in the fight against HIV/AIDS-related stigma and discrimination.)

– Glenn Betteridge

For more information about the report or the Network's activities to reduce HIV/AIDS-related stigma and discrimination, please contact Glenn Betteridge, Senior Policy Analyst with the Canadian HIV/AIDS Legal Network, at (416) 595-9976 or [gbetteridge@aidslaw.ca](mailto:gbetteridge@aidslaw.ca).

<sup>1</sup> More information on the Plan of Action campaign, including the press release, the Plan of Action itself, a booklet, and a postcard, is available at [www.aidslaw.ca](http://www.aidslaw.ca).

<sup>2</sup> Ekos Research Associates. *HIV/AIDS – An Attitudinal Survey* (2003).

<sup>3</sup> T de Bruyn. *HIV/AIDS and Discrimination: A Discussion Paper*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1998.

# Alberta review panel recommendations threaten privacy of personal health information

**In a report released in October 2004, the Alberta Select Special Health Information Act Review Committee has recommended increasing the situations under which custodians of health information can release such information.<sup>1</sup> If these recommendations become law, people living with HIV/AIDS would have less control over the disclosure of their health information, including their HIV status.**

The Alberta legislature is not currently sitting, and it is unclear whether the new Alberta government will put in place a process to consider the proposed amendments and further issues identified by the Review Committee.

The Review Committee was established pursuant to the Alberta Health Information Act (HIA). The Act, which came into force on 25 April 2001, required that a legislative committee begin a comprehensive review of the Act three years after the date it came into force.

On 2 April 2004 the Legislative Assembly of Alberta appointed an all-party committee to undertake the review. The Review Committee conducted public consultations by seeking written feedback and by holding oral hearings. Only three out of a total of 87 submissions to the Review Committee were by advocacy or faith-based organizations.

## Scope of application of the Act

Under the existing scheme, employers are not bound by the HIA.<sup>2</sup> One of the questions for consultation put forward by the Review Committee was whether health information contained in employee files should fall under the Act. The Review Committee recom-

mended that it should not. It made this recommendation based on “considerable consensus that adequate privacy and access protections are in place” through existing legislation, and on objections from employers about the potential costs of keeping health information separate from other employee information.

Front-line workers in AIDS service organizations report that the confidentiality of health information of people living with HIV/AIDS is often breached in the workplace.<sup>3</sup> Many people living with HIV frequently access their employer’s prescription drug benefit programs, and may require leave or other accommodation to address health issues.

As a result, an employer may become aware of an employee’s HIV status, or pressure an employee into revealing her status, and may not have proper safeguards in place to adequately maintain the confidentiality of the information. The Review Committee also recommended that the workers compensation board and Alberta Blue Cross not be covered under the Act.

The Review Committee recommended extending the scope of the HIA to include ambulance operators and ambulance services. It also rec-

ommended that a committee of the legislature be established to consider whether to include other regulated health professionals and health-service providers under the HIA.

## Additional discretionary disclosure clauses recommended

The HIA permits discretionary disclosure of personal health information without consent in a number of circumstances. These circumstances include disclosures to family members or others with a close personal relationship, to any person to avert or minimize imminent danger, to anyone to whom the disclosure is authorized or required by an enactment of Alberta or Canada, and to comply with a court or tribunal order. A number of organizations submitted to the Review Committee that new discretionary disclosure clauses should be added.

A significant recommended amendment would permit people who hold health records to release information to health departments of provincial, territorial, and federal governments where a person is under their jurisdiction. This would permit, for example, an Alberta regional health authority or an Alberta physi-

cian to disclose a person's health information without consent to an out-of-province public health department or physician if that person was being treated in a jurisdiction other than Alberta.

The Review Committee recommended against requiring that people be notified before their personal health information is disclosed without their consent.

Unfortunately, the Review Committee also recommended that the HIA not be amended to require that people be notified before their personal health information is disclosed without their consent.

### Disclosure to police

Under the HIA, custodians of health information have the discretion to disclose diagnostic, treatment and health information to police without consent in three circumstances: pursuant to a warrant, subpoena, or court order; to investigate a life-threatening offence committed against a person, unless that person objects; and to minimize imminent danger.

The Calgary and Edmonton police services each made oral and written

submissions to the Review Committee, and the Lethbridge police service made written submissions. The police requested that information custodians be given the power to release to police diagnostic, treatment, and health information, registration information (ie, personal information, including name, address, home address), and information about treating health-service professionals. They requested that this information be made available for the purpose of assisting in the investigation of a criminal or provincial offence.

The Review Committee did not recommend the broad powers sought by police for custodians of health information. However, it did recommend that the HIA be amended to mandate custodians to release specific patient information (patient name, address/location in facility, date of admission, name of physician, and nature of injury) to police so that police could apply for a subpoena or warrant to seek the patient's health information.

Even in the absence of a request for information by police, custodians would have a duty to provide police with patient information where a custodian has reasonable grounds to suspect that the person seeking health services has been involved in some form of criminal activity. Under the proposed amendment, it would rest with an independent authority such as a justice of the peace to determine whether a subpoena or warrant should be issued.

In light of the criminalization of HIV exposure since the Supreme Court of Canada's decision in the *Cuerrier* case, HIV-positive people who fear criminal charges as a result of placing others at risk of HIV infection may be reluctant to seek medical care. Health-care custodians will also potentially be put in the position of informing on people living with HIV/AIDS who seek counselling to reduce behaviours that risk transmitting HIV. The Review Committee recognized that an expansion of mandatory or discretionary disclosure of health information to the police could result in challenges under the Canadian Charter of Rights and Freedoms.

– Glenn Betteridge

<sup>1</sup> Select Special Health Information Act Review Committee. *Final Report*. October 2004, and other information and documentation relating to the Committee's work is available at [www.hiareview.assembly.ab.ca](http://www.hiareview.assembly.ab.ca).

<sup>2</sup> For a more thorough examination of the HIA and other privacy protections for health information in Canada, see *Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada*. Montréal: Canadian HIV/AIDS Legal Network, 2002-2004.

<sup>3</sup> The author was a staff lawyer at the HIV & AIDS Legal Clinic (Ontario) from 2000 to 2002, during which time he provided advice to people living with HIV/AIDS and their service providers regarding confidentiality of medical information in the employment setting, and discrimination in employment on the basis of HIV status.

# Medical marijuana developments

## Politicians call for audit and legislative reform of federal program

MP Libby Davies and Senator Pierre Claude Nolan have called for an investigation into Health Canada's medical marijuana program. Davies also called for reforms to the Marihuana Medical Access Regulations. The calls were contained in letters addressed to the Auditor General of Canada and Minister of Health Ujjal Dosanjh, respectively.<sup>1</sup>

In their letter to the Auditor General, Davies and Nolan assert that the Office of Cannabis Medical Access, the federal bureaucracy established to administer the medical marijuana program formed under the Marihuana Medical Access Regulations (MMAR)<sup>2</sup> has "failed to meet their own mandate on a number of fronts."<sup>3</sup>

The politicians cite the low number of medical marijuana users registered by the office (753) in its five-year existence. They also take to task the medical marijuana research program and the production arrangements. The politicians state that very few research projects have been approved, and that those that have are not moving forward.

Regarding the sole government-authorized production facility, operated by Prairie Plant Systems (PPS), the letter's authors estimate that it has cost the government approximately \$65,000 per person receiving marijuana from the government-licensed facility. They also cite concerns with

the quality of the PPS product. Davies and Nolan call on the Auditor General to investigate the Office of Cannabis Medical Access, the Medical Marihuana Research Plan, and the PPS production contract.

Davies's letter addressed to Minister Dosanjh concerns the proposed amendments to the MMAR.<sup>4</sup> It urges the Minister and his Health Canada officials to improve the medical marijuana programs by taking into account the recommendation for regulatory changes made by certain groups and individuals, including the Canadian AIDS Society.<sup>5</sup> The letter also cites the need to "find constructive ways to support the important work of compassion clubs," many of which "do invaluable work by making available safe medical marijuana."

## Hospice struggles with marijuana regulations

A Toronto hospice for people living with HIV/AIDS is struggling with whether or not to permit hospice patients to smoke medical marijuana on its property.<sup>6</sup> Under the MMAR, people who use marijuana for medical purposes can obtain an authorization to possess dried marijuana and a licence to produce marijuana without threat of criminal penalties. The MMAR are silent on the issue of where authorization holders can or cannot smoke marijuana.

However, the regulatory impact analysis statement that accompanied the original MMAR recognizes that

"how and where a patient may use a drug for medical use is not subject to federal regulation but may be subject to the laws and policies of other levels of government.... Hospitals and correctional institutions have their own regulations and policies governing the use of or access to drugs for medical use; these will determine whether marijuana may be used and under what conditions."<sup>7</sup>

A resident at the hospice said that he was told that he would not be allowed to smoke marijuana on the hospice property despite the fact he held a valid authorization to possess marijuana. Despite the hospice policy, the resident reported that employees were looking the other way.

– Glenn Betteridge

<sup>1</sup> Email from Libby Davies, MP for Vancouver East.

<sup>2</sup> SOR/2001-227; amended by SOR/2003-387.

<sup>3</sup> The Office of Cannabis Medical Access maintains a website at [www.hc-sc.gc.ca/hecs-sesc/ocma/](http://www.hc-sc.gc.ca/hecs-sesc/ocma/).

<sup>4</sup> For more information on the proposed amendments, see G Betteridge. Proposed amendments to medical marijuana regulations released for comment. *Canadian HIV/AIDS Policy & Law Review* 2004; 9(3): 28-29.

<sup>5</sup> The Canadian AIDS Society submissions are available at [www.cdnaids.ca/web/repguide.nsf/24157c30539cee20852566360044448c/4f80c1656d82605e85256f54005bac45!OpenDocument](http://www.cdnaids.ca/web/repguide.nsf/24157c30539cee20852566360044448c/4f80c1656d82605e85256f54005bac45!OpenDocument).

<sup>6</sup> P Henderson. No med-pot at Casey House (16 November 2004), available at <http://cannabisculture.com/articles/4066.html>.

<sup>7</sup> *Canada Gazette Part II*, Vol 135, No 14 (4 July 2001) at 1370.

# New Brunswick: New sex education curriculum stirs debate

**Controversy has surrounded the sex education component of the New Brunswick Department of Education's new health curriculum for grades six, seven, and eight<sup>1</sup>.**

Introduced in September 2004, the curriculum was developed based on a survey of parents, students, and teachers. It covers sexuality, relationships, and reproductive health, and refers to topics such as homosexuality, birth control, masturbation, sexual pleasure, orgasm, and oral sex.

Parents opposed to the curriculum have charged that it will promote a sexually permissive, anything-goes society, and have called for a curriculum that focuses on abstinence based on a model from Texas.<sup>2</sup> Parents have also charged that resources for teachers included links to pornographic websites.<sup>3</sup>

In light of parental concerns, the Minister of Education, Madeleine Dubé, has dropped the list of resources for teachers and has established an advisory committee to review the curriculum materials. The Planned Parenthood Federation of Canada, a group of 46 Fredericton-area physicians, AIDS Saint John, SIDA/AIDS Moncton, and AIDS New Brunswick are among those who

support the current curriculum. The government caucus had heard representations from people and organizations on both sides of the issue.<sup>4</sup>

In a related development, a recently-released report by the Canadian HIV/AIDS Legal Network calls upon provincial and territorial departments of education to ensure that school-based curricula include culturally sensitive, age-appropriate, accurate, and non-judgmental education about sexuality, sexual activity and the skills to practise sex safely, as well as HIV/AIDS and other sexually transmitted diseases.<sup>5</sup>

According to *A Plan of Action for Canada to reduce HIV/AIDS-related stigma and discrimination*, youth require alternatives to abstinence-based approaches to sexual health in order to protect youth who are sexually experimenting.

(The release of the Plan of Action is covered in an article elsewhere in this section.)

A 2003 study by the Council of Ministers of Education, Canada con-

cluded that the sexual knowledge of Canadian students was lower in 2002 than in 1989, and called for greater focus on students' sexual health.<sup>6</sup>

— Glenn Betteridge

<sup>1</sup> See for example: NB education minister responds to calls for review of sex ed curriculum. Canadian Press, 17 November 2004; New education program in NB raises questions about modern sex-ed. Canadian Press, 2 December 2004.

<sup>2</sup> NB parents send Christmas cards about sex-ed to Premier Bernard Lord. Canadian Press, 21 December 2004; NB parents ask government to adopt abstinence-based sex-ed curriculum. Canadian Press, 19 January 2005.

<sup>3</sup> Opponents of NB sex-ed course say program material links to porn sites. Canadian Press, 7 December 2004.

<sup>4</sup> Supporters of proposed sex education program to lobby NB Tories. Canadian Press, 7 February 2005.

<sup>5</sup> See Goal 13 of T de Bruyn. *A Plan of Action for Canada to reduce HIV/AIDS-related stigma and discrimination*. Montréal: Canadian HIV/AIDS Legal Network, 2004.

<sup>6</sup> D Garmaise. National school survey reveals gaps in knowledge of HIV/AIDS. *Canadian HIV/AIDS Policy & Law Review* 2003; 8(3): 32-33.

# Standing Committee on Justice re-establishes Subcommittee on Solicitation Laws

On 24 November 2004, the House of Commons Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness established a Subcommittee on Solicitation Laws to review the Criminal Code provisions relating to prostitution.<sup>1</sup> A previous subcommittee with a similar mandate was disbanded when Parliament was prorogued in 2003.

The motion to establish the subcommittee was brought by Joe Comartin, the New Democratic Party (NDP) member from Windsor-Tecumseh. The Subcommittee is made up of five members, including a Chair from the governing Liberal Party, and one member from each party represented in the House of Commons.

## Background

In February 2003, Parliament passed the following motion:

That the Standing Committee on Justice and Human Rights be ordered to review the solicitation laws in order to improve the safety of sex-trade workers and communities overall, and to recommend changes that will reduce the exploitation of violence against sex-trade workers.<sup>2</sup>

The motion was presented to Parliament by Libby Davies, the NDP Member of Parliament from Vancouver East, whose riding is home to an open and active drug and sex trade. Many of the sex trade workers who are missing or were murdered in

recent years in Vancouver lived or worked in the Downtown Eastside.

The Subcommittee held five hearings in October and November of 2003, during which it heard evidence from the Department of Justice, university researchers, and individuals. In mid November 2003 the Parliamentary session ended, and with it the mandate of the Subcommittee. The Subcommittee had been in the process of drawing up a list of twenty additional witnesses, including groups that work with sex trade workers.<sup>3</sup>

## New subcommittee

The Subcommittee will continue the work begun during the previous Parliament. The Subcommittee held its first meeting on 9 December 2004, and will hear evidence from witnesses during the current parliamentary session. Among the witnesses scheduled to appear are the Montreal-based sex worker rights organization STELLA, sex work researchers Professors Fran Shaver and Deborah Brock, and John Fraser, the lawyer who chaired the

ground-breaking Fraser Commission established by the federal government in the 1980s to examine the issue of street prostitution.

The Subcommittee has also applied for a budget to allow it to travel to a jurisdiction where sex work law reforms have been enacted.

– Glenn Betteridge

<sup>1</sup> Information on the Subcommittee on Solicitation Laws (including notice of meetings, minutes from meetings, testimony before the committee, etc) is available via [www.parl.gc.ca/committee/](http://www.parl.gc.ca/committee/).

<sup>2</sup> Information on the Subcommittee on Solicitation Laws under the 37<sup>th</sup> Parliament, 2<sup>nd</sup> Session, is available on the House of Commons Committee home page via the Parliamentary web site [www.parl.gc.ca](http://www.parl.gc.ca).

<sup>3</sup> The Canadian HIV/AIDS Legal Network will be completing a report on sex work, Canadian criminal law, and HIV/AIDS. The Network will seek an opportunity to present the report to the Subcommittee on Solicitation Laws.

## In brief

### Quebec activists draw attention to lypodistrophy

On 28 November 2004, a group of Québec AIDS activist called on the Québec Minister of Health to cover the costs of treatments for people living with HIV/AIDS suffering from the body-altering side effects of medications.

The Comité Lipo-Action was formed on 1 December 2003 by people living with HIV/AIDS, their families, friends, and allies.<sup>1</sup> The goal of the committee is to advocate for treatment for people suffering from lypodistrophy.

Preliminary results from a survey of 143 people living with HIV/AIDS conducted by the committee in February and March of 2004 indicate that 93 percent of respondents suffered from atrophy of fat tissue, and 58 percent suffered from an accumulation of fat tissue. Sixty-nine percent of respondents reported depression, 36 percent avoided leaving home, and 56 percent felt ill at ease in public all as a result of the body changes they experienced.

Lyse Pinault, Executive Director of COCQ-Sida (the Québec coalition of community-based organizations fighting AIDS) said that some patients resort to expensive liposuction to remove the fat, and that there have been reports of people who have sold their homes to pay for treatments. Pineault also said that some patients have lost their jobs because of their appearance.<sup>2</sup>

– Glenn Betteridge

### Another call for needle exchange programs in prisons

The federal prisons ombudsman has recommended that needle exchange programs be established in Canadian penitentiaries.<sup>3</sup> The recommendation was contained in the annual report released by Howard Sapers, the Correctional Investigator of Canada. Sapers said that such a program would help reduce the rate of HIV, which is at least 10 times higher in prison than in the general population.

The recommendation from the prisons ombudsman came shortly after the Ontario Medical Association issued a position paper calling for NEPs in prisons, and the Canadian HIV/AIDS Legal Network released a report supporting NEPs.<sup>4</sup>

– David Garmaise

### Saskatchewan: New regulations designed to reduce needle-stick injuries

Saskatchewan will introduce regulations calling for the mandatory use of safety-engineered needles, the Canadian Press reported in October 2004.<sup>5</sup> The needles are designed to reduce the risk of needle-stick accidents, possibly by as much as 90 percent.

At least 2000 needle-stick accidents occur yearly in Saskatchewan, and it is estimated that many more go unreported. The spring-loaded safety needles retract into the barrel after each use, virtually eliminating the risk of workers accidentally being stuck

and becoming infected with blood-borne diseases like HIV and hepatitis.

The news was announced by Labour Minister Deb Higgins at the annual convention of the Saskatchewan Federation of Labour. Many labour organizations had been actively campaigning for safe needles.

According to Barbara Cape, president of Local 299 of the Service Employees International Union, mandatory use of safety-engineered needles will dramatically impact paramedics, police and firefighters, and health-care, education, and corrections employees. Getting stuck with a dirty needle is an acutely stressful experience for workers, who then must undergo testing for two years to ensure they have not contracted HIV or hepatitis B or C, Cape said.

Higgins said that her department would consult with health authorities, unions, and other stakeholders on the wording of the regulations.

The introduction of safety-engineered needles will promote the right of workers to a safer workplace, and is good HIV prevention policy. This is a good example of how respecting, protecting, and promoting human rights makes good public health sense.

– David Garmaise

<sup>1</sup> More information on the Comité Lipo-Action, including preliminary results of a survey of people living with HIV/AIDS, is available in French at [http://cpaviv.qc.ca/lipo/index\\_html/](http://cpaviv.qc.ca/lipo/index_html/).

<sup>2</sup> Sufferers want treatment for deforming antiretroviral side effects. Canadian Press, 29 November 2004.

<sup>3</sup> Prison ombudsman calls for needle exchange program. CBC (online), 18 November 2004.

<sup>4</sup> See R Jürgens. Prison needle exchange programs work. *HIV/AIDS Policy & Law Review* 2004; 9(3): 41-42.

<sup>5</sup> Saskatchewan plans to make safety-engineered needles mandatory; labour groups happy. Canadian Press, 28 October 2004.

# INTERNATIONAL DEVELOPMENTS

This section provides brief reports on developments in HIV/AIDS-related law and policy outside Canada. We welcome information about new developments for future issues of the Review. Address correspondence to David Garmaise, Managing Editor of the Review, at [dgarmaise@rogers.com](mailto:dgarmaise@rogers.com).

## Breaking new ground on HIV/AIDS and human rights in China

**A ground-breaking meeting of HIV/AIDS NGOs and community-based activists in China, focusing largely on legal and human rights issues related to HIV/AIDS, was held in Shanghai in December 2004. This was one of the first meetings in China where people living with HIV/AIDS from diverse communities were able to share openly their experiences and to discuss in detail the human rights, legal, and policy measures that are needed to protect people living with HIV/AIDS in China and to enable civil society organizations to contribute to China's fight against HIV/AIDS.**

The meeting was organized by the Aizhixing Institute of Beijing. Participants included persons living with HIV/AIDS who were infected through government-run blood sales, persons living with HIV/AIDS representing regions where drug use is the predominant means of HIV transmis-

sion, and gay rights activists.

Participants drew up a wide-ranging list of recommendations covering such topics as the complex regulations governing the functioning of NGOs (and their websites) in China; the frequent practice of compulsory HIV testing in the Chinese health system;

the high cost and inaccessibility of legal assistance for people living with, or affected by, HIV/AIDS; the need for training of health professionals to reduce discrimination faced by people living with HIV/AIDS in the health system; the urgent need for greater transparency and for better quality

medications in the government's medical treatment for people living with HIV/AIDS; and comprehensive efforts, including public education, to reduce discrimination and other human rights abuses regularly faced by vulnerable populations and by people living with HIV/AIDS.

The day after their important meeting, the community activists presented their recommendations to legal experts at a meeting co-organized by Aizhixing Institute and the Shanghai University Law School. There were lively exchanges of views on legal and human rights questions related to HIV/AIDS.

These two meetings were convened immediately prior to, and in preparation for, a third gathering in Shanghai, one of first international conferences of government, academic experts, and civil society representatives in China on AIDS and the law. This official conference was convened under the auspices of the Shanghai Academy of Social Sciences, the Shanghai Law Society, and Temple University (Philadelphia, USA). Participants included high-level representatives from the Shanghai municipal government as well as government officials specializing in public health policy and the law.

Discussions at the government conference were not always easy. A number of the legal experts from the

government and from several of China's law schools appeared to be most concerned about the need for laws to protect the public from HIV transmission through such means as exposure to saliva, assaults on the part of HIV-positive individuals involving biting or attacks with contaminated needles, and the like. Prof Scott Burris of Temple University presented his extensive research demonstrating the ineffectiveness of such laws in countries that passed them in the early years of the AIDS epidemic in North America and elsewhere, but some of the local legal experts kept coming back to the need for criminalizing these unlikely means of HIV transmission.

International experts at the conference and some academic experts emphasized the importance of civil society in helping to lead the fight against HIV/AIDS, especially in reaching out to marginalized persons who may be at high risk of contracting HIV. The onerous restrictions on NGOs in China, and the government's practice in the past of working only with government-organized NGOs, were cited as important challenges. It was also noted that the Global Fund to Fight AIDS, Tuberculosis and Malaria has adopted new regulations requiring country coordination mechanisms that submit proposals to the Global Fund to include NGO representatives who are chosen by the

communities they represent rather than by the government.

Shanghai officials are expected to draft HIV/AIDS-related legislation in the coming months. It was noted by several government officials at the meeting that the Shanghai legislation will be looked to as a potential model by officials elsewhere in China.

In addition to Prof Burris, international invitees to the government conference and the NGO meeting included Bebe Loff of Monash University (Melbourne, Australia), Tim Westmoreland of Georgetown University (Washington, DC, USA) and Joanne Csete of the Canadian HIV/AIDS Legal Network.

— Joanne Csete and Wan Yan Hai

Joanne Csete is Executive Director of the Canadian HIV/AIDS Legal Network and can be reached at [jcsete@aidslaw.ca](mailto:jcsete@aidslaw.ca). Wan Yan Hai is director of the Aizhixing Institute of Health Education in Beijing, and a recipient of the Award for Action on HIV/AIDS and Human Rights. He can be reached at [wanyanhai@hotmail.com](mailto:wanyanhai@hotmail.com).

# Caribbean: Birth of a regional network responding to HIV/AIDS and vulnerability

**In December 2004, representatives from 30 Caribbean NGOs met in Kingston, Jamaica to form a regional network of organizations working with populations most vulnerable to HIV/AIDS – the Caribbean Vulnerable Communities (CVC) Network. In this article, two Caribbean researchers and activists situate this vulnerability and the civil society response in their specific socio-historical context.**

The CVC Network was formed in response to the lack of coordinated and supported community work for vulnerable populations as identified in the Caribbean Regional Strategic Framework for HIV/AIDS.<sup>1</sup> It includes those organizations representing populations with whom little or no regional collaboration has so far occurred – sex workers, men who have sex with men, substance abusers, prisoners, and migrant populations, and two other groups who have been left out altogether: women in particularly vulnerable socio-economic situations, and orphans and other children made vulnerable by HIV and AIDS.<sup>2</sup>

The purpose of the meeting in Kingston was to introduce the idea of the network to NGOs working directly with one or more of the vulnerable populations identified. All four language groups in the region were represented, as were all of the target groups. In addition, there was a smaller meeting in Montego Bay to develop a workplan and to solicit support from key regional agencies such as the Caribbean Epidemiology Centre, the Pan-Caribbean Partnership on HIV/AIDS, and UNAIDS. Support for the network from the donor agencies responsible for implementing the Regional Framework has been enthusiastic.

## Construction of rights in the Commonwealth Caribbean

Commonwealth Caribbean societies today feature pervasive structures of domination and exclusion. These were inherited from the foundational paradigm of the plantation as the centre of law and authority. Under slavery and indentureship, order and justice were constructed as the protection of the rights of the minority master class, with the law and its enforcement based on the social exclusion of the majority. The will to exclude also pervaded the subject population, taking forms such as house slave vs field slave, and African vs “coolie.”

After Emancipation, Christianity was deployed as an ideology of control among the African population. European missionaries brought the Bible from which they taught some ex-slaves to read, creating the phenomenon of the “black preacher,” whose ability to read became a marker of power over his illiterate congregation. Literacy thus became a tool through which dominated Afro-Caribbeans were inserted into the European power logic.

As the colonial masters receded from the forefront of political life, the system of rights they had devised was taken over by local elites. Yet,

because political rights were accorded to the majority, the elite were left in need of mechanisms of social control outside the process by which laws were made. Consequently, today, even where social exclusion is not formally encoded in law, as a value, it permeates everyday customs and relationships.

## Vulnerability in the socio-political and cultural context of the Commonwealth Caribbean

As post-colonial Caribbean societies matured, they attempted to address important questions of social justice that the colonial administration had largely ignored. The poor state of key social institutions in the context of export-driven, import-dependent economies meant that the state had minimal resources to address social inequities. What little support there was came from the family, the community, or religious organizations. Issues affecting the destitute, the illiterate, and prisoners (among others), whose rights to social services had generally not been conceded by the colonial administration, remained largely unaddressed.

The poverty of post-colonial states coupled with the sluggishness of

social reform has meant that the socially and economically marginalized have found only limited escape from poverty through education and engagement in a range of low-skill jobs. Additionally, attempts to address larger issues of social justice have often been stymied by nationalist-religious conservatives. Nationalism, with its construction of the “barefoot man,” created its own set of exclusions, by making its subject male, heterosexual, Christian, and black. The rights of persons outside that construct were not assured.

**Attempts to address larger issues of social justice have often been stymied by nationalist-religious conservatives.**

So ingrained are patterns of exclusion in the Caribbean consciousness that attempts at transforming the social system end up entrenching exclusion based on specific characteristics. The Trinidad and Tobago Equal Opportunities Act (2000), for example, proclaims the equality of all Trinbagonians regardless of socio-cultural or birth category but ignores sexual orientation. In fact, the 1986 Sexual Offences Act explicitly criminalizes homosexual sex between both men and women.

Similarly, the conditions of the imprisoned in the Commonwealth Caribbean, especially in Jamaica, which has the largest population of inmates, remain brutal. Sex work is ubiquitous because of its inextricable links with tourism, the lifeblood of

many Caribbean economies. Yet sex workers, including those who migrate illegally to sell sex in other territories, are left without human rights redress because of the laws addressing immigration and sex work.

### **Attempts at redress**

A strong civil society has not yet emerged in the Commonwealth Caribbean. The post-Independence civil society movement has been dominated by the church, preventing the groups under focus here from being given attention because of value-laden Christian concerns. As emphasis in the Caribbean has shifted away from political support as a means of escaping vulnerability toward work in the drug, sex, and other such economies, there is a new kind of penetration of the Caribbean which, while helping some to emerge from poverty, has reinforced the vulnerability of others.

In the last decade, civil society in the Caribbean has become increasingly responsive to the vulnerability created by factors such as the HIV epidemic, the increased migration of peoples seeking economic opportunities, and the creation of drug-addicted populations. Moreover, globalization has brought with it increased familiarity with the idea of rights and social justice. This has led to the formation of organizations such as Jamaica AIDS Support, which focuses on services and advocacy for sex workers, children infected and affected by HIV and AIDS, men who have sex with men, and prisoners and, more recently, the United Gays and Lesbians Against AIDS in Barbados, and Friends for Life, a gay rights and HIV education group in Trinidad.

The emergence of these groups and the fact that they embody symbols of

a Pan-Caribbean nation is a sign of the maturation of Caribbean society. The formation of the CVC can be seen as a high-point of this maturation. At the start of a new century, it represents the beginning of a conversation about those marginalized by the dominant discourse on what it means to be Caribbean.

In responding to the AIDS pandemic within the context of globalization, there are now important opportunities for those who have been left out of the prevailing ideologies of nationalism to find a place where their humanity is recognized. For many in civil society, the ineluctable interconnections between marginalized groups and the wider society have always been clear; the AIDS pandemic has only made these interconnections undeniably so.

— Robert Carr and R Anthony Lewis

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<sup>1</sup> Pan-Caribbean Partnership on HIV/AIDS. The Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006. Available via [www.caricom.org](http://www.caricom.org).

<sup>2</sup> See also the vulnerable populations identified in the Caribbean Regional Strategic Framework on HIV/AIDS. Available via [www.caricom.org](http://www.caricom.org).

## Jamaica: Report documents homophobia and violence

**In November 2004, Human Rights Watch (HRW) released a report documenting widespread violence and discrimination against people living with, and at high risk of, HIV/AIDS in Jamaica.<sup>1</sup> The report alleges police use Jamaica's Victorian-era sodomy laws, which criminalize consensual sex between adult men, as a basis to harass and persecute people suspected of homosexual conduct and peer educators who provide HIV/AIDS information and condoms to them.**

The report found that gay men and people living with HIV/AIDS face serious violence and are often forced to abandon their homes and communities, and that health workers provide inadequate treatment, deny services altogether, and release confidential information about HIV/AIDS and sexual orientation. The report suggests that these abuses are undermining Jamaican government efforts to combat the country's fast-growing epidemic.

Discrimination and abusive treatment by health workers spreads HIV/AIDS by discouraging at-risk Jamaicans from seeking HIV-related information or health care. The widespread misperception in Jamaica that HIV/AIDS is a gay disease, coupled with deep stigma associated with HIV/AIDS, compounds this problem. Many at highest risk of the disease – including people who don't engage in homosexual sex – shun HIV/AIDS information and health services because they are terrified of stigma, or because they do not believe that they are vulnerable to HIV.

The HRW issued a call to repeal the sodomy law, and to enact legislation to protect people living with HIV/AIDS against discrimination. These recommendations reflect the similar findings of a legal review undertaken in 2001 by the Jamaican

National AIDS Committee,<sup>2</sup> international law, and best practice – including the International Guidelines on HIV/AIDS and Human Rights and the United Nations Declaration of Commitment on HIV/AIDS – and recent Caribbean regional consultations that Jamaica hosted or in which Jamaica played a leading role.<sup>3</sup>

The HRW also called on Jamaica to cease and publicly repudiate police violence against gay men, lesbians, sex workers, and people living with HIV/AIDS; and to reform the criminal justice system to ensure protection for all citizens from torture and abuse.

The report provoked both threats and blanket denials from sectors of the government and from the police. Jamaican government representatives repeatedly cited Jamaica's "sovereignty" as a reason to oppose the repeal of sodomy laws and to dismiss the report's other recommendations.<sup>4</sup> The health ministry dismissed the report as "exaggerated, misleading, and unacceptable," rejecting its first-hand witness accounts as "unfounded," and accusing the HRW of undermining the government's national HIV/AIDS program by publishing its findings.<sup>5</sup>

Five Jamaican human rights organizations supported the launch of the report in Kingston – an unprecedented show of public support recognizing

violence and discrimination based on sexual orientation and HIV status as important human rights issues. For this courageous act, a representative of Jamaica's Police Federation (the union for rank-and-file police) accused these organizations of joining the HRW to "spread lies and deliberately malign and slander the police force and the government."

To meet the challenges of this public health and human rights crisis, Jamaica must reverse current attitudes toward sexual orientation, HIV/AIDS, and human rights.

In a letter published in a major Jamaican newspaper, the representative called for their arrest, and demanded that the government "slap on sedition charges where necessary to both foreign and local agents of provocation." The letter states that "the police cannot be held responsible for either the careless liaisons by homosexuals or the cultural responses of the population towards gays."<sup>6</sup>

The Federation representative's letter – which endorses homophobia as “good moral values” and blames the victims of homophobic violence – illustrates attitudes toward sexual orientation, HIV/AIDS, and human rights that Jamaica must reverse to meet the challenges of this public health and human rights crisis.

The government of Jamaica has failed to respond publicly to the Police Federation's letter, leaving the impression that they find these views to be acceptable. Meanwhile, Jamaican human rights groups continue to raise publicly their concern about the human rights violations against gay men and people living with HIV/AIDS documented in the HRW's report, including by holding public meetings to discuss these issues and the government's plans to address them.

As the HRW report acknowledges, Jamaica's Ministry of Health has taken steps to combat discrimination against people living with and at high-risk of HIV/AIDS, including men who have sex with men. Since the publication of the Police Federation letter, the Ministry has publicly acknowledged that the abuses documented in the HRW report do take place. It has also ramped up its efforts to address them.

The HIV/AIDS program is recruiting staff to coordinate the HIV/AIDS

program's outreach to men who have sex with men and to sex workers, and has enhanced its efforts to address HIV/AIDS-related stigma and discrimination in Jamaican public health hospitals. The national HIV/AIDS program coordinator has also actively engaged with Jamaican human rights groups and NGOs working with people living with HIV/AIDS and marginalized high-risk groups in public debate about the violence and discrimination based on sexual orientation and HIV status. He has enjoined these groups to work with the government to strengthen the government's response to these problems.

In 2004, Jamaica launched an ambitious project to provide antiretroviral drugs to people living with HIV/AIDS and to address underlying human rights violations that are driving the epidemic. These promising initiatives will be compromised, however, unless government leaders act quickly and forcefully to combat widely held prejudices that interfere with HIV/AIDS policy and undermine Jamaicans' right to health. Government leaders must also ensure protection for human rights defenders who work with marginalized high-risk groups. If Jamaica fails to take such steps, it could miss an opportunity to reverse the course of its epidemic.

– Rebecca Schleifer

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<sup>1</sup> Hated to Death: Homophobia, Violence, and Jamaica's HIV/AIDS Epidemic. Human Rights Watch. November 2004. Available at [www.hrw.org/reports/2004/jamaica1104/](http://www.hrw.org/reports/2004/jamaica1104/).

<sup>2</sup> HIV/AIDS, Legal, Ethical and Human Rights Issues in Jamaica. National AIDS Committee (Jamaica). August 2001. Available at [www.nacjamaica.com/subcom/legal\\_ethical/index.htm](http://www.nacjamaica.com/subcom/legal_ethical/index.htm).

<sup>3</sup> In November 2004 the Coordinator of the National AIDS Programme, Dr Peter Figueroa, chaired a Technical Meeting that preceded a high-level conference hosted by CARICOM in St Kitts, titled “Champions for Change.” The Conference Declaration called, inter alia, for law reform to eliminate discrimination against persons living with HIV/AIDS. In October 2004 the National AIDS Programme Coordinator chaired a regional expert meeting on HIV prevention and gender, which also recommended in a draft report “the decriminalization of sexual acts between men in private” and “legislation prohibiting discrimination on the grounds of sexual orientation.” See Strengthening the Caribbean Regional Response to the HIV Epidemic: Report of the Caribbean Technical Expert Group Meeting on HIV Prevention and Gender. October 2004.

<sup>4</sup> See, eg, D Rose. We won't be bullied: Gov't says it has no plan to repeal buggery law; denies anti-gay allegation. *Jamaica Gleaner*, 18 November 2004; and Gov't slaps down U.S. group. *Jamaica Observer*, 18 November 2004.

<sup>5</sup> Letter from Dr Yitades Gebre, Executive Director, National HIV/AIDS Program to Rebecca Schleifer, 22 November 2004; see also: U.S. group report misleading. Health Ministry says Human Rights Watch “survey” contains unfounded testimonials and hearsay. *Jamaica Observer*, 23 November 2004.

<sup>6</sup> “Charge those groups for sedition,” letter from Sergeant David White, Public Relations Officer, Jamaica Police Federation. *Jamaica Observer*, 25 November 2004.

## Hungary: Segregation of HIV-positive prisoners breaches national and international standards

**In October 2004 the Hungarian Civil Liberties Union (HCLU) filed a petition to the Hungarian Constitutional Court concerning segregation of HIV-positive inmates in correctional facilities in Hungary.**

According to article 43 of Ministry of Justice Decree No 5/1988 (III.6.),

Inmates infected with the virus of the acquired immune deficiency syndrome are to be placed, irrespective of the stage of their disease – for the purpose of their enhanced protection, for the protection of the community and with respect to their state of health –, in the penal institution which has been designated for their placement.

In practice, the application of this rule means not only that HIV-positive inmates are all kept in the same penal institution, no matter which part of the country they come from, but also that all of them have to stay in a separate unit of the institution.

All HIV-positive inmates in Hungary are kept in the Penal Institution for Juvenile Offenders of Tököl. They are kept in Unit K. They are completely isolated from other

inmates. They cannot use the common rooms of the institution. Nor do they have access to the canteen, the library, or the chapel. As well, they cannot take part in social or educational programs that are available for HIV-negative inmates.

The HCLU argued in its petition that the segregation is unconstitutional and violates the right to human dignity, the right to non-discrimination, the right to physical and mental health, the right to freedom of religion, the right to free movement, and the right to education. HCLU pointed out that the prison practice and its basis (article 43) not only violated the Hungarian Constitution, but also contravened international recommendations and guidelines, such as those issued by the World Health Organization, UNAIDS, the Office of the (UN) High Commissioner for Human Rights, and the Council of Europe.

In several reports issued in the last ten years, the Council of Europe's Committee for the Prevention of Torture and Inhumane Treatment or Punishment (CPT) has criticized the practice of segregating HIV-positive inmates in Hungarian penal institutions, but the Hungarian government has failed to modify the practice.

The next routine visit of the CPT to Hungary will take place in 2005. The Constitutional Court has no deadline for examining the petition. The HCLU has said that it will ask the CPT to again visit the Tököl prison. In the meantime, the HCLU has started a dialogue with the National Prison Administration.

– *Eszter Csernus*

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## Ukrainian survey of PLHA rights reveals widespread abuses

**A survey conducted in 2004 by the All-Ukrainian Network of People Living with HIV found that HIV-related rights violations are widespread in Ukrainian society, and that many people living with HIV/AIDS (PLHAs) are ignorant of the provisions of HIV/AIDS-related legislation.<sup>1</sup>**

The survey, which was supported by the International HIV/AIDS Alliance with funding from the Global Fund to Fight AIDS,

Tuberculosis and Malaria, had the following goals:

- to evaluate the accessibility of prevention and treatment of opportunistic infections, social and psychological support, and counselling for PLHAs in Ukraine;
- to assess PLHA awareness of their rights and benefits;
- to identify violations of the rights of people living with HIV; and
- to study how PLHAs perceive attitudes of different social groups toward them.

A total of 692 respondents were interviewed in 16 cities throughout Ukraine.

The survey found that more than two in five respondents living with HIV (41.5 percent) reported violations of their rights as a result of their HIV status. Given the low level of respondent awareness about their rights, this may underestimate the actual situation. Poor knowledge of rights also leads to low levels of enforcement of legal mechanisms to protect rights. More than one-quarter of respondents

(28.6 percent) reported violations of their right to confidentiality. Only four of the respondents had received any compensation for breaches of confidentiality relating to their HIV status.

The survey also showed a lack of awareness among respondents of the Law on Prevention of Acquired Immunodeficiency Syndrome (AIDS) and Social Protection of the Population.<sup>2</sup> Less than one-tenth of respondents (7.3 percent) were well aware of all or almost all provisions of this law. Just over one-quarter of respondents (28.9 percent) knew some of its provisions, while one in five knew nothing about the law. Members of PLHA organizations showed a much greater awareness of the law than other respondents.

Although few PLHAs currently benefit from the social services mandated by the law, the numbers are increasing, particularly regarding free medical drugs and psychological and social assistance. However, the majority of PLHAs surveyed were unaware of how to obtain invalid status, as well as associated payments and access to free legal, medical,

social, and psychological services.

While prejudice against PLHAs means that disclosure can result in substantial problems, hiding a positive HIV status makes it impossible for PLHAs to access legitimate benefits and assert their rights. While 6.7 percent of respondents had documented evidence of rights violations, only half of these (3.4 percent) expressed readiness to assert their violated rights in court.

– Tetanya Deshko

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See also “Ukraine: Dismissal on the basis of HIV status ruled unconstitutional” in the HIV/AIDS in the Courts – International section of this issue.

<sup>1</sup> International HIV/AIDS Alliance. Report on Survey of Access to Services and Rights of PLHA. Kiev, 2004. The full version of the report in English is available via [www.aidsalliance.kiev.ua](http://www.aidsalliance.kiev.ua).

<sup>2</sup> VM Rudyi. Ukrainian Anti-HIV/AIDS Legislation: Current State and Ways of Improvement. Ukrainian Harm Reduction Association. Kiev, 2004.

## Nepal: Legal system HIV/AIDS audit conducted

**An HIV/AIDS audit of the legal system of Nepal, carried out in 2004 by the Forum for Women, Law and Development (FWLD), found that Nepal has poor public health legislation, but good regulation of health-care professionals and research.**

The audit was carried out using methodology developed by Dr Helen Watchirs for assessing legal systems against the standards contained in the International Guidelines on

HIV/AIDS and Human Rights. The audit methodology was expanded to include government policies affecting the epidemic. However, the assessment of policies was included in the

commentary, not the scoring of results under each indicator.

Legal research for the audit involved examination of the Constitution of the Kingdom of

Nepal, 1990, 280 Acts, 210 Regulations, three Executive Orders, seven Policies, three Guidelines, and two Bills. Consultations were held to gather information both on the accuracy of the legal research, and on gaps between the formal content of laws and the operation of the legal system in practice.

The Nepal audit scored laws against 10 indicators, with a possible score of 10 for each indicator, and hence a maximum possible score of 100. The ten indicators were: public health; criminal laws and transmission offences; anti-discrimination; privacy and confidentiality; sexual offences; prisons and correctional laws; employment; equality of status of vulnerable populations; regulation of health-care professionals and ethical research; and treatment, therapeutic goods, testing, and other issues.

The lowest scoring indicator was public health. This area of the legal system lacked:

- a legal requirement to implement universal infection-control procedures;
- a prohibition against the segregation of people with HIV/AIDS on the basis of their HIV status;
- a legal framework for epidemiological monitoring;
- a prohibition on mandatory or compulsory HIV testing; and
- a requirement to provide pre-test and post-test counselling.

The highest-scoring indicator was regulation of health-care professionals and ethical research. The audit found that in Nepal there were:

- provisions regulating professional standards of health-care workers;
- independent monitoring of the scientific validity and ethical conduct of research involving human subjects;
- a requirement of informed consent by research participants;

- the maintenance of participants' confidentiality; and
- compensation for harm to research subjects resulting from participation in research.

The overall score for the audit was 40 (out of 100), indicating the need for significant reforms.

The audit and associated activities were funded by the United States Agency for International Development through a subcontract with the POLICY Project Nepal.

*– Sapana Pradhan-Malla,  
Purna Shrestha, and Chris Ward*

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## **Mexico: General Recommendation issued on school-based discrimination against HIV-positive children**

**In September 2004, Mexico's National Human Rights Commission (NHRC) issued a General Recommendation responding to various discriminatory practices by federal and local education officials against children living with HIV/AIDS.<sup>1</sup> The Recommendation reflects the general guidance provided by the Committee on the Rights of the Child in its 2003 General Comments on HIV/AIDS and the Rights of the Child, and Adolescent Health.<sup>2</sup>**

The NHRC's involvement was prompted by media coverage of the issue and by the work of MEXSIDA, a coalition

of HIV/AIDS NGOS in Mexico, which presented a written complaint to the NHRC in March 2004. The MEXSIDA

complaint highlighted a number of cases in which children had been excluded or expelled from public and

private schools because of their HIV status or that of their parents. The MEXSIDA complaint also lamented that federal education officials had done nothing to prevent these ongoing human rights abuses.

General Recommendation 8 was issued following an investigation by the NHRC into discriminatory practices and human rights violations against children living with HIV/AIDS within the education system. The investigation registered 47 cases of discrimination against HIV-positive children in schools. However, the Commission recognized that reporting of such violations was diminished by the victims' fear of further stigma and discrimination.

The children were between four and 12 years of age; the majority were six years old. Although human rights violations were reported throughout the education system, the vast majority of acts of discrimination took place in public pre-schools and primary schools.

The Recommendation denounced a significant number of cases in which education authorities either refused to enrol children living with HIV/AIDS, or expelled them from school once their HIV status became known.

The Recommendation identified cases in which school authorities demanded that children undergo HIV testing or that health authorities release the results of children's HIV tests. By doing this, education authorities made the HIV status of children known within school communities, which generated further stigma and discrimination against the children

and their parents. The Recommendation also found that insults and other forms of abuse as a result of the HIV status of children or parents were frequent in schools.

The Recommendation stated that

the actions of the education authorities have caused minors and their families to be stigmatised and discriminated against by members of the school communities and society in general; in addition, by these attitudes the [education] authority has strengthened the misinformation that unfortunately exists in our society regarding this illness; particularly with respect to the mistaken social belief in the possibility or risk of infection with HIV/AIDS through casual contact.

The Recommendation noted that education authorities violated a number of specific rights found within national laws and in international human rights treaties) – namely the right to equality (which prohibits discriminatory conduct), the right to receive an education, the prohibition on arbitrary interference, the right to be treated with dignity, the right to receive the protections due to children, and the right to privacy.

The Recommendation requested that State governors, the Chief of Government of Mexico City, and the Secretary of the federal Public Education Ministry:

- issue instructions that children living with HIV/AIDS should not be expelled from school, impeded in their enrollment, or separated from their studies;

- issue instructions that education authorities respect the privacy of children living with HIV/AIDS, and give them the support necessary to continue their studies;
- implement training and education programs regarding HIV/AIDS for public servants in the education sector; and
- undertake HIV prevention and education campaigns for children, adolescents, parents, and teachers that promote the rights of people living with HIV/AIDS.

The General Recommendation is not legally binding. However, according to the NHRC, the authorities involved have indicated their willingness to comply with it.

– Richard Pearshouse

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In a related case, the NHRC also issued a separate Recommendation (Recommendation 74/2004) in November 2004 to the Governor of the state of Chiapas with respect to a case in which a child living with HIV/AIDS was denied enrollment in the first grade of primary school.

<sup>1</sup> The full text (in Spanish) of General Recommendation 8 is available at [www.cndh.org.mx/Principal/document/recomen/gen\\_2001/fr\\_generales.htm](http://www.cndh.org.mx/Principal/document/recomen/gen_2001/fr_generales.htm).

<sup>2</sup> Available at [www.ohchr.org/english/bodies/crc/comments.htm](http://www.ohchr.org/english/bodies/crc/comments.htm).

## In brief

### Botswana: National Policy on HIV/AIDS and the World of Work

In 2004 the Botswana government, in consultation with employers' and workers' organizations and with the assistance of the International Labour Organization (ILO) and the US Department of Labour (USDOL), commenced the development of a National Policy on HIV/AIDS and the World of Work.

The policy is intended to complement the existing National Policy on HIV/AIDS, and provide the government, employers' and workers' organizations with specific guidelines in areas such as the promotion of education and awareness for the prevention of HIV infection; the provision of care and support and the establishment of referral networks for workers infected and affected by HIV/AIDS; and the elimination of discrimination based on HIV status in the workplace.

A draft policy was developed by a task force comprising employers' organizations (through the Botswana Business Coalition Against AIDS), workers' organization (through the Botswana Confederation of Trade Unions), the Botswana Network on Ethics, Law and HIV/AIDS, the Botswana Network for People Living with HIV/AIDS, and the Ministry of Labour and Home Affairs. The policy was to be discussed and finalized at a national consultation workshop in Gaborone in January 2005.

– Mareanyana Selelo and  
Marie-Claude Chartier

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### Nigeria: HIV-positive journalism student reinstated after mobilization and threat of legal action

In mid-2004 an HIV-positive journalism student who needed time off to attend a government-supported anti-retroviral clinic was reported to have been expelled from his school, the Nigerian Institute of Journalism in Lagos, on the grounds of his HIV status. The Center for the Right to Health took up the issue and issued a press release, describing the expulsion as an act of unfair discrimination and inhuman and degrading treatment forbidden by the Nigerian Constitution and other international and regional human rights instruments ratified by Nigeria. The Center then issued a seven-day warning for the Institute to reverse its decision or face legal action.

The Center and other non-governmental organizations – including Journalists Against AIDS, the Positive Life Association of Nigeria, and the National Network of People Living with HIV/AIDS in Nigeria – then mobilized about 300 people, including people living with HIV/AIDS, journalists, and human rights activists, to stage a demonstration in front of the Institute to protest against the discrimination. The demonstration attracted widespread publicity, and the Institute agreed to reinstate the student.

The incident is particularly significant because it was reportedly the first time civil society groups had publicly mobilized around the violation of rights of persons living with HIV/AIDS in

Nigeria, and because it demonstrates the importance of both legal mechanisms and social mobilization in protecting and promoting human rights in the context of HIV/AIDS.

– Ebenezer Durojaye

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### Nigeria: Public lecture series highlights deficiencies in national law and policy

In 2004, as part of its Law and HIV/AIDS Project, the Development Initiatives Network organized a series of public lectures to promote public debate about the role of the law in HIV and AIDS policy in Nigeria. Topics covered included discrimination and stigma, reproductive rights, privacy and confidentiality, labour and employment, occupational health and safety, insurance, and criminal law and policy. Participants came from the governmental, private, and non-governmental sectors, as well as the international donor community.

The Nigerian National Policy on HIV/AIDS, which was adopted in June 2003, commits the government to reviewing and introducing legislation to protect persons living with, or affected by, HIV/AIDS. However, the National Policy gives little specific direction on law reform, and is not legally binding.

Participants in the lecture series agreed that Nigeria's human rights framework should be reformed urgently, especially with respect to dealing with HIV and AIDS. Issues highlighted included the following:

- the anti-discrimination protections in Nigeria's 1999 Constitution do not extend to discrimination based on HIV status (let alone disability more generally, or sexual orientation);
- constitutional protections such as those in connection with privacy, freedom of movement and even freedom from discrimination, which should be of universal application, apply only to Nigerian citizens; and
- although the African Charter on Human and Peoples' Rights<sup>1</sup> may provide recourse in some cases, it is not comprehensive.

Participants agreed that law reform based on the provisions of the Protocol to the above-mentioned charter dealing with the rights of women in Africa<sup>2</sup> could offer additional protection.

– Bola Fajemirokun

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### Kenya: Law students assist with HIV/AIDS legal clinics

To commemorate World AIDS Day, in late 2004 the Kenya Ethical and Legal Issues Network (KELIN), in collaboration with the Kenya AIDS NGOs Consortium, held free legal aid clinics in four provinces on legal, ethical, and human rights matters relating to HIV and AIDS.

The clinics were facilitated by a team of KELIN legal experts accompanied by law students from the

University of Nairobi. The clinics provided services to hundreds of clients with diverse legal needs.

In 2004 KELIN also held training workshops for law students from the University of Nairobi to enable them to support the clinics; provided advice and referred clients to existing legal institutions and other organizations for services; collaborated with national programs on priority HIV/AIDS issues (eg, through workshops for judges and other government officials); and joined with other groups to advocate for law reform (eg, the HIV and AIDS Prevention and Control Bill, 2004) and other measures.

Technical and financial support for KELIN is provided in part by the Canadian HIV/AIDS Legal Network with funding from the Canadian International Development Agency.<sup>3</sup>

– Victor Arika

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### Ukraine: Advocacy workshops support PLWA rights and advance HIV prevention

In October 2004 the International HIV/AIDS Alliance held an advocacy training workshop for participants from organizations identified as recipients of Global Fund grants for regional resource centres.

Advocacy skills are often weak in emerging democracies because people living with and vulnerable to HIV/AIDS and their advocates have little experience in strategies for change in societies largely governed by the rule of law. The Alliance has developed training materials to respond to the need to enhance advocacy skills.<sup>4</sup>

All organizations participating in the workshop were already undertaking some activities relating to HIV/AIDS, varying from information distribution to outreach and advocacy. Participants shared their advocacy experiences, identifying successful strategies as well as pitfalls, and developed advocacy plans to address key issues.

One participant, representing Blahodyinist, a Mykolaiv NGO, reported on an advocacy campaign that followed that organization's participation in a similar Alliance workshop in 2002. At that time, local police hostility to needle and syringe programs (NSPs) was identified as an obstacle to effective HIV prevention among injecting drug users in the city. Following the 2002 training workshop, Blahodyinist undertook a targeted advocacy campaign that resulted in a decree, issued by the Head of the Mykolaiv City Department of Interior, about the conduct of personal examinations of injecting drug users.

As a result, the local NSP now operates effectively with the cooperation of local police. This experience demonstrated the concrete impact of the advocacy workshops, and also the importance of monitoring and evaluating advocacy activities. Such monitoring and evaluation are now an integral part of the work of the regional resource centres.

– Tetanya Deshko

<sup>1</sup> African [Banjul] Charter on Human and Peoples' Rights. Adopted 27 June 1981. Available via [www.africa-union.org](http://www.africa-union.org).

<sup>2</sup> Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Adopted 11 July 2003. Available via [www.africa-union.org](http://www.africa-union.org).

<sup>3</sup> See [www.aidslaw.ca/Maincontent/issues/discrimination/rights\\_approach/international.htm](http://www.aidslaw.ca/Maincontent/issues/discrimination/rights_approach/international.htm).

<sup>4</sup> See *Advocacy in Action: A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS* (Brighton: International HIV/AIDS Alliance, 2002). Available via [www.aidsalliance.org](http://www.aidsalliance.org).

# 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](mailto:gbetteridge@aidslaw.ca). All the articles in this section were written by Barbara Mysko, a student at the Faculty of Law, McGill University.

## Canadian AIDS Society granted intervener status in blood donor case

The Canadian AIDS Society (CAS) was recently denied leave to intervene as an added party in a case related to screening criteria for blood donations.<sup>1</sup> The court did however grant CAS the right to intervene as a friend of the court, which is a more restricted status.

The facts of the case are as follows. Kyle Freeman falsely answered “no” to the Canadian Blood Services’ (CBS) screening question that asks male donors whether they have had sex with another male even once since 1977. Freeman later contacted the CBS anonymously, advised it of his false statement, and took the position that the screening criteria discriminat-

ed against him on the basis of sexual orientation.

After determining Freeman’s identity, the CBS initiated a civil action against him seeking \$100,000 in damages for negligent misrepresentation based on his false response on the questionnaire. In a counterclaim, Freeman alleges that the screening criteria infringe Freeman’s section 15

Charter equality rights on the basis that the criteria discriminate against blood donors based on sexual orientation and are not rationally connected to the purpose of collecting blood. He also claimed that the question violated his right to be free from discrimination on the basis of sexual orientation under the Canadian Human Rights Act.

The court has the discretion to grant an applicant status to intervene as an added party if a person has an interest in the proceeding.<sup>2</sup> Counsel for CAS emphasized that the organization had extensive knowledge of the documents listed in the trial affidavit and that it would be able to provide assistance that no other party would be able to provide. Master Beaudoin of the Ontario Superior Court of Justice decided that while CAS has an interest in the proceeding, the organization would not make a “useful contribution” as an added party.

More specifically, CAS could not show that it would enhance the court’s ability to determine the constitutional question in issue. Master Beaudoin pointed out that CAS did not identify any experts it intended to call at trial, did not indicate that it would submit any additional documents, and proposed to deal only with the same questions involving discrimination and policy that Freeman had raised in his statement of defence.

Nonetheless, Master Beaudoin granted CAS the right to intervene as a friend of the court. In its capacity as

a friend of the court, CAS may not adduce evidence in the case, must avoid duplication of written arguments, will only be granted a limited time allocation for oral submissions, and is not allowed to seek or be subject to an award of costs.

<sup>1</sup> *Canadian Blood Services v Freeman*, [2004] OJ No 4519 (SCJ) (QL).

<sup>2</sup> Ontario Rules of Civil Procedure, RRO 1990, Reg 194 at rule 13.

## Criminal law and HIV transmission/exposure: two new cases

### Court of Appeal affirms 42-month sentence

The British Columbia Court of Appeal has affirmed the sentence of a man convicted of aggravated assault for having unprotected sex with a woman without disclosing his HIV-positive status.<sup>1</sup> Rene Bradley Smith was sentenced to 42 months’ incarceration after pleading guilty to aggravated assault.<sup>2</sup> At the time of sentencing, the woman had not contracted the virus.

On appeal, defence counsel argued that there had been a “consensual arrangement” under which Crown and defence counsel had agreed to a shorter sentence.<sup>3</sup> Newbury JA of the Court of Appeal found that there was

no reason for the sentencing judge to infer that such an arrangement existed. Smith’s sentence was based on his criminal record, the need to protect the public, the guilty plea, and his remorsefulness. In upholding the sentence, Newbury JA stated that the sentence was not unfit and that no miscarriage of justice had occurred.

### Williams reasoning to feature in trial for aggravated assault

At the conclusion of a pre-trial hearing, an Ontario man has been committed to stand trial on various charges for engaging in sexual contact with his five-year-old daughter.<sup>4</sup> In July of 2001 both the man and his daughter

were diagnosed with the same strain of gonorrhoea. The daughter may have been exposed to HIV as a result of the alleged sexual assault, since the man had been in a relationship involving unprotected intercourse with the child’s HIV-positive mother both before and after her HIV diagnosis. At the time of the pre-trial, there was no conclusive medical evidence that the man was HIV-positive

At a pre-trial hearing, the court must determine if “there is admissible evidence which could, if it were believed, result in a conviction.”<sup>5</sup> The accused was charged with sexual interference, aggravated sexual assault, criminal negligence causing bodily harm, and failing to provide the necessaries of life. The Ontario

Court of Justice found sufficient evidence to commit the accused to trial on the first three counts but not the fourth. It is open to the judge or jury at trial to determine whether the accused is actually guilty of the first three charges, based on all the evidence.

To be found guilty of the charge of aggravated sexual assault, the Crown must prove that an accused “wounds, maims, disfigures or endangers the life of the complainant” through his actions.<sup>6</sup> Because gonorrhea is readily treatable and can be cured with appropriate treatment, the court found that infecting a child with gonorrhea cannot constitute endangering her life. However, regarding the issue of HIV exposure, the court followed the decision of the Supreme Court of Canada in *Cuerrier*, which found that exposing another person to HIV through unprotected sex does constitute endangering life.<sup>7</sup>

The court then addressed the issue of the man’s intent to expose his daughter to HIV, thereby endangering her life. For the purposes of the offence of aggravated assault, the Crown must prove that the accused applied force intentionally or recklessly with the objective foresight of the risk of bodily harm to another.<sup>8</sup> In the context of HIV, according to the Supreme Court’s decision in *Williams*: “Once an individual becomes aware of a risk that he or she has contracted HIV... but nevertheless persists in unprotected sex that creates a risk of

further HIV transmission without disclosure to his or her partner, recklessness is established.”<sup>9</sup>

In the present case, Fairgrieve J stated that it is not necessary for the accused to have HIV to require that he be alert to the risk of spreading it.<sup>10</sup> It is sufficient to engage in risky behaviour and then expose another person to the danger of contracting HIV. Although the risk to the other person is less if the accused is not HIV-positive, there is sufficient risk of endangering another’s life.

Fairgrieve J left it open to a jury to conclude that the accused was both the likely source of the child’s gonorrhea and likely HIV-positive when the alleged incidents occurred.<sup>11</sup> The child’s mother testified that she had no other intimate partners for many years before her diagnosis and she had never used drugs intravenously or had a blood transfusion.

Based on this evidence, it is open to the jury to conclude that it was improbable that any source other than the accused caused the child’s mother’s HIV infection. Although the accused used a condom after finding out about the mother’s infection, it is still to be determined whether he knew that he was the likely source of the woman’s infection or whether he realized that he continued to put himself at risk of contracting HIV.

On the charge criminal negligence causing bodily harm, Fairgrieve J stated that there must be sufficient evidence that the accused showed

wanton or reckless disregard for the safety of the child.<sup>12</sup> The court found that there was sufficient evidence in this case, if believed, to find that the transmission of gonorrhea caused the child bodily harm.

The court stated that it was possible to foresee risk of harm in having sexual contact with a child while suffering from a sexually transmitted disease that can cause serious pain and physical suffering.<sup>13</sup> The court cited evidence that the accused had suffered from related symptoms at the relevant time. Thus, it was open to the jury to decide that he had sufficient knowledge that he had an infectious venereal disease at the time he transmitted it to his daughter.

The court did not find sufficient evidence to commit the accused to trial on the charge of failing to provide the necessities of life.

<sup>1</sup> *R v Smith*, [2004] BCCA 657 (CanLII).

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid* at para 10.

<sup>4</sup> *R v FS*, [2004] OJ No 4170 (OCJ) (QL).

<sup>5</sup> *Ibid* at para 10.

<sup>6</sup> Criminal Code, RSC 1985, c C 46, s 268(1).

<sup>7</sup> *R v Cuerrier*, [1998] 2 SCR 371.

<sup>8</sup> *R v FS*, *supra*, note 4 at para 42.

<sup>9</sup> *R v Williams*, [2003] 2 SCR 134 at paras 27-28.

<sup>10</sup> *R v FS*, *supra*, note 4 at para 44.

<sup>11</sup> *Ibid* at para 48.

<sup>12</sup> *Ibid* at para 62.

<sup>13</sup> *Ibid* at para 52.

## In brief

### Court takes HIV status into account in robbery sentencing

The British Columbia Provincial Court recently sentenced a man to five years' imprisonment after he pleaded guilty to three charges of robbery.<sup>1</sup> The Court took the man's HIV-positive status into consideration when deciding on the sentence.

Bruce J stated that the man's HIV status and the fact that his health would continue to deteriorate were a concern for the court. Other mitigating factors included the gap in his criminal record, the fact that the rob-

beries could be regarded as a spree, the lapse since the last robbery conviction, and the guilty plea.

### Crown stays assault charge in spitting case

On 4 October 2004, a Manitoba woman was sentenced to three days in jail for resisting arrest.<sup>2</sup> She had also been charged with assault because she spat on the chest and face of a police officer and stated that she had "HIV disease."<sup>3</sup>

The Crown had no evidence to refute or confirm that Boras was HIV-

positive. The charge of assault was stayed by the Crown. The woman will serve an additional one-year probation after she completes her jail sentence. While on probation, she will have to undertake an addictions assessment and submit to any counselling that is recommended.

<sup>1</sup> *R v JHO*, [2004] BCJ No 1942 (Prov Ct) (QL).

<sup>2</sup> I Hitchen. No more jail time for woman who spat at cops. *The Daily Graphic* (Portage La Prairie), 5 October 2004.

<sup>3</sup> Personal correspondence with Larry Hodgson, Senior Crown Attorney, 1 February 2005.

# 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 US cases is very selective, as reports of US cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of Glenn Betteridge, editor of this section, at [gbetteridge@aidslaw.ca](mailto:gbetteridge@aidslaw.ca).

## Colombia: Constitutional Court grants interim order reinstating HIV-positive woman in her job

In late 2004 the Constitutional Court of Colombia ordered that a woman living with HIV be reinstated in her job at a health clinic in order to respect her rights under the national constitution, pending a final determination of the merits of her claim of discrimination and other infringement of human rights.<sup>1</sup>

The complainant began employment for a fixed period of three months in December 1997, her contract being automatically renewed over time. In February 2000 she was diagnosed with HIV. In November 2002 she was informed by her employer, with the

month's notice required by law, that her contract would not be extended past December 2002.

The complainant initiated a legal proceeding (*acción de tutela*) that permits a court to intervene to enjoin a breach of fundamental rights under the

constitution. She claimed that the decision not to renew her contract was based on her diagnosis and argued that this infringed her rights to life, equality, dignity, work, and social security. The complainant sought an order that she be reinstated on the same terms

and conditions, including her affiliation with the social security system to which she was contributing, and from which she was entitled to benefits, as a result of her employment.

The company contested her motion, claiming that her application was improper and could not proceed, and that the complainant should proceed with her case before a labour court judge. The court of first instance agreed with the employer. The complainant appealed, pointing to the grave and imminent harms to both her life and physical integrity, and that of her daughter, given her inability to pay for medicines, food, and education as a result of loss of employment.

The complainant argued that the ordinary procedures of the labour court are ineffective to prevent this irreparable harm, meaning that she should be entitled to the recourse of a *tutela* action seeking measures that would provide immediate protection of her fundamental rights. The appeal court, however, dismissed her appeal on the basis that it was not established that her employer had dismissed her because of her HIV status.

On further appeal, the Constitutional Court invited representations from two non-governmental organizations, the Fundación EUDES and the Liga Colombiana de Lucha contra el SIDA (Colombian Alliance Against AIDS), regarding employment discrimination against people living with HIV/AIDS, and relevant legislation and initiatives. The court also posed the question of whether the non-renewal of a fixed-term employment contract of a worker with asymptomatic HIV infection infringes the rights to work, equality, social security, and life.

On the procedural question of whether the complainant's *tutela*

application could proceed, the Constitutional Court ruled that a court must assess whether any alternative legal mechanisms would be effective in protecting fundamental rights facing irreparable harm. While the complainant did have a pending case under the *Código Procesal del Trabajo y de la Seguridad Social* (Labour and Social Security Code), the serious circumstances of this case mean that the residual remedy of a *tutela* application was available. These circumstances included the applicant living with an illness that is costly for her to treat, the fact that treatment could not be suspended without negative medical consequences, the employer's knowledge of her situation, the lack of any additional source of income, her situation as a single mother, and the impossibility of the court ignoring the right to life of a litigant.

On the merits of her claim, the court found that the constitutional principle of "stability of employment" did not permit the company to release a person based solely on the completion of the contract period. As the employee had complied with the contract and as the conditions that gave rise to the contract were still in force, she had the right to have the contract renewed. However, the court said, this stability of employment is not absolute: a termination of the contractual relationship would be legitimate if based on objective criteria, the burden of proving which is on the employer. The court noted that Colombian law has recognized the guarantee of stability of employment in cases such as those of pregnant women or people with disabilities; and that based on the principle of social solidarity, constitutional jurisprudence has applied this guaran-

tee to include those who are in a condition of "obvious weakness."

Furthermore, the court said, not only the state but also the private sector must fulfill its public obligations to promote the progressive improvement in quality of life for marginalized groups. This principle of solidarity applies to employment relationships, including cases of fixed-term work contracts of people who are in a condition of obvious weakness yet still fulfill their contractual work obligations, as long as the original reasons that necessitated the work still exist. When those conditions no longer exist, the court said, it should be possible to transfer workers to another posting or to relocate them inside or outside the company's office. As a matter of humanitarianism and solidarity, the court noted, there is a general constitutional obligation to assist those who need help.

In light of the above analysis, the Constitutional Court granted the application on an interim basis, pending the ruling of the labour court on the full merits of the worker's case. This was deemed necessary to protect the complainant's rights to work, life, social security, and dignity. The court ordered the company to reinstate the complainant to her job within 48 hours.

– Germán Humberto Rincón Perfetti

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<sup>1</sup> Yudis Luz Mercado Herrera v Sociedad Médica de Santa Marta Ltda (SOMESA – Clínica El Prado), Constitutional Court of Colombia, Decision No T-469, 17 May 2004, on file.

## Australia: Appeal court upholds compensation for occupational exposure

**On 5 August 2004, the New South Wales Court of Appeal upheld a decision ordering a medical centre to pay workers' compensation to a physician infected with HIV during the course of his employment.<sup>1</sup>**

It was accepted at trial in the Compensation Court that Dr Vozzo was infected with the virus in the course of his employment. There was no suggestion that Dr Vozzo was infected otherwise than by the virus being transmitted to him through his treatment of an infected patient. Dr Vozzo gave evidence that he had suffered cutaneous and mucosal exposure to blood or other body fluids on numerous occasions over the years.

The Compensation Court was called upon to determine which employer would bear the costs of compensation, given that Dr Vozzo had worked for a number of employers during his medical career. In reaching its decision, the court took into account the following evidence:

- first, the length of time that Dr Vozzo worked for the centre in comparison with the time he worked for the other hospitals;
- second, the risk of injury he incurred while working for the appellants;
- third, the means whereby, while working for the centre, he might have been infected; and

- fourth, expert evidence about the course of HIV infection in the population of HIV-infected individuals and expert opinion about the period of time when Dr Vozzo may have been infected.

The court found that it was “satisfied on the balance of probabilities the infection more likely than not occurred during the period” Dr Vozzo was employed by the Family Medical Centre.<sup>2</sup>

The Family Medical Centre appealed this finding on a number of grounds. The centre argued that Dr Vozzo had worked at other hospitals where he could have contracted HIV, and contended that the evidence was circumstantial and could not show that Dr Vozzo was infected while in its employ.

The centre challenged the relevance of evidence showing that HIV had increased in prevalence over the years and that Dr Vozzo had worked longer for the medical centre than any other hospital.<sup>3</sup> The relevance of workplace factors that could have put Dr Vozzo at risk of contracting the virus was also put in issue. Finally,

the appellant centre questioned the evidence of expert witnesses providing estimates as to when Dr Vozzo likely contracted the HIV virus, based on his medical history and the course of HIV infection.

The Court of Appeal dismissed the appeal. It upheld the Compensation Court's finding that the evidence that the physician was more likely than not infected at the centre was sufficient to show causation.<sup>4</sup> The court said that although the evidence was circumstantial, taken as a whole it demonstrated that the infection probably occurred while Dr Vozzo was employed at the centre.

– Barbara Mysko

Barbara Mysko is a student at the Faculty of Law, McGill University.

<sup>1</sup> *A Mazzaferro & Riverstone Pty Ltd (t/as Family Medical Centre) v Vozzo*, [2004] NSWCA 271 (5 August 2004). Available via [www.austlii.edu.au](http://www.austlii.edu.au).

<sup>2</sup> *Ibid* at para 3.

<sup>3</sup> *Ibid* at para 47.

<sup>4</sup> *Ibid* at para 57.

## Ukraine: Dismissal on the basis of HIV status ruled unconstitutional

**On 18 October 2004 the Novosanzhary District Court in Poltava oblast ruled in favour of Olexiy Voloshyn, who had been harassed and fired by his employer on the basis of his HIV status. The court held that Voloshyn's constitutional rights to equality in choice of profession and labour activity, and respect for human honour and dignity, had been violated by Viktoriya Dev'yatko, editor-in-chief of the Novosanzhary district newspaper.**

After finding out Voloshyn's HIV-status in early 2003, Dev'yatko harassed him in an effort to have him resign. When Voloshyn refused to do so, Dev'yatko forced him to attend the laboratory of the Central District Hospital for an HIV-antibody test, and demanded the test results. Her demand was refused by the laboratory. Dev'yatko admitted in evidence that she had harassed and terminated Voloshyn due to his HIV status.

Under article 17 of the Law of Ukraine on AIDS Prevention and Social Protection of Population, Ukrainian citizens living with HIV

and AIDS enjoy all the rights provided by the Constitution of Ukraine. Article 3 of the Constitution provides that the human being, his or her life and health, honour and dignity, inviolability and security are recognized as the highest social value. Moreover, the Constitution guarantees every one the right to labour, and equal opportunities in the choice of profession and of types of labour activity. Finally, article 43 protects citizens from unlawful dismissal.

The court ordered Dev'yatko to compensate Voloshyn for the moral (non-property) damage he suffered.

Voloshyn was represented and supported by the All-Ukrainian Network of People Living with HIV.

– Tetyana Bordunis

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## South Africa: "HIV-positive" T-shirt leads to dismissal?

**In October 2004 a South African Labour Court dismissed a worker's application for unfair dismissal based on "an arbitrary ground including but not limited to the applicant's actual or perceived HIV-positive status."<sup>1</sup>**

The judge in this case ordered that the names be withheld. A was employed by X, a company that makes measuring instruments. While at work A was

exposed to chemical fumes, fainted, and was brought to a medical clinic by a manager. At the clinic, when A undressed for the examination, the

manager noticed that he was wearing a T-shirt that said "HIV positive."

Following the accident, A was given a sick-leave certificate and was

scheduled to be off work for three days. However, A chose to return to work the day after the accident.

The manager asked A whether he was HIV-positive; A stated that he was not. The manager then told A that he could detect that A had HIV symptoms, and that A should go for HIV and tuberculosis testing. A became upset and informed the manager that he was going home, as he was not supposed to be at work in any event. The manager responded that A would be dismissed if he left.

A returned home. After the three-day sick leave, A returned to work and was promptly instructed to sign a

letter of resignation, failing which he would not receive his wages. A refused, was instructed to leave the premises and was not paid the wages owed to him.

A approached the Council for Conciliation, Mediation and Arbitration for assistance in regaining his employment, but the manager of X stated that he did not want A back in his employ since he “could see that he was HIV positive.”

The matter was then sent to the Metal and Engineering Industries Bargaining Council, but the dispute remained unresolved. A then made an application to the Labour Court for

unfair dismissal. The Labour Court found that A had not shown on a balance of probabilities that he was actually formally dismissed from his employment. The court determined that A’s evidence was less reliable than that of X, and dismissed the case.

– Arryn Ketter

Arryn Ketter is a student at the Faculty of Law, McGill University.

<sup>1</sup> *A v X (Pty) Ltd*, Case No JS 597/02, Labour Court of South Africa, Johannesburg.

## Criminal law and HIV transmission/exposure: three new cases

### New Zealand<sup>1</sup>

In October 2004 a New Zealand man pleaded guilty in a Wellington district court to a charge of criminal nuisance brought because he had unprotected sex with his partner without telling her that he had HIV, and knowing that it could endanger her health. The woman learned that her partner was HIV-positive when a friend of the man informed her in a letter.

In September 2004 an HIV-positive Zimbabwean refugee in New Zealand was jailed for three years on multiple charges of assault and criminal nui-

sance for failing to inform several women of his HIV status.

### Australia

An Australian, Ronald Houghton, who has been twice convicted of unlawfully causing grievous bodily harm to his girlfriend for having unprotected vaginal and anal intercourse with her, and for failing to disclose his HIV-positive status,<sup>2</sup> was sentenced in November 2004 for the second conviction.

Defence counsel argued that Houghton took reasonable precautions by allegedly not ejaculating. The pros-

ecution countered that engaging in a high-risk activity without a condom was not reasonable.

Houghton was sentenced to four years and eight months’ imprisonment; the maximum for this offence is 10 years’ imprisonment. Houghton intends to appeal the conviction.

– Arryn Ketter

<sup>1</sup> HIV-positive man did not tell partner of infection. *Dominion Post*, 30 October 2004.

<sup>2</sup> See B Mysko. Australia: Man convicted on retrial. *HIV/AIDS Policy & Law Review* 2004; 9(3): 64.

## In brief

### UK: Court orders reconsideration of asylum case

A Ugandan refugee applied for asylum in the United Kingdom. He had a very unusual combination of medical conditions: life-threatening pulmonary tuberculosis, leprosy, and HIV. The medical examiner found that a drug regime adequate to treat his conditions would be unavailable in Uganda.

The refugee's asylum application was based in part on the claim that a return to Uganda would breach his rights under articles 2 and 3 of the European Convention on Human Rights, dealing with the right to life and the prohibition of torture, respectively. His claim was dismissed, as was his appeal to the Immigration Appeal Tribunal.

In an application for judicial review of the Immigration Tribunal's decision, Mitting J of the High Court quashed the decision and ordered the tribunal to reconsider the case on the grounds that it was "settled law that the removal of a seriously ill asylum seeker to a country with inferior medical resources could amount to inhuman and degrading treatment in exceptional and extreme circumstances."<sup>1</sup>

The claimant's combination of medical conditions led the judge to conclude that "there was clear medical evidence that not only would the claimant have suffered more and died sooner had he been returned to Uganda, but also that he would have done so in circumstances of extreme degradation."

– Arryn Ketter

### Malaysia: Judge refuses to reduce sentence on account of HIV

In July 2004 a 49-year-old man's appeal against a 36-month jail sentence for drug possession was dismissed by the Malay High Court.<sup>2</sup> The court held that being HIV-positive was an insufficient ground for an appeal against a jail sentence.

Despite the offender's guilty plea, the court did not feel that the offender showed remorse. It stated that the appellant had failed to convince the court that he would "change his lifestyle," adding that he had brought it upon himself. The court concluded that "having HIV itself is not a condition to reduce the sentence."

– Arryn Ketter

### New Zealand: Man jailed for lying about HIV status on residency application

In December 2004 a Ghanaian national with HIV was jailed in New Zealand for six months for lying in his application for residency.<sup>3</sup> He was found guilty of fraudulently ticking "no" to a question on a medical form in 2000 on whether he was HIV-positive.

The man learned of his HIV status in 1998. The judge rejected defence counsel's argument that he ticked the "no" box as a "basic instinct for survival" since, on the facts, the man had been receiving treatment in Australia before settling in New Zealand. The judge found that the man could have remained in Australia and that there

was no evidence that he was facing deportation to Ghana where he might not have access to treatment. The judge decided upon a six-month jail term to deter others from giving false information on residency applications.

– Arryn Ketter

### Scotland: Court orders damages and reinstatement for unjust dismissal

An employment tribunal in Edinburgh awarded a man £40,000 for lost wages and ordered the restaurant that unfairly dismissed him to reinstate him.<sup>4</sup>

The tribunal concluded that the employee was fired because the general manager disapproved of the employee's personal relationship with a woman who was being tested for HIV.

– Arryn Ketter

### Indian High Court refuses to review challenge to criminalization of homosexuality

The Naz Foundation filed a petition requesting the High Court review its September 2004 dismissal of a petition challenging the constitutional validity of section 377 of the Indian Penal Code, which makes homosexuality a punishable offence.<sup>5</sup>

Counsel for the Naz Foundation argued that the court hearing the challenge had failed to consider recent judgments with respect to the issue of

litigation “standing.”<sup>6</sup> He also asked the court to consider that laws regarding homosexuality have changed dramatically in other countries in recent years.

In dismissing the petition for review, the High Court stated that a petition cannot be filed only for the purpose of testing the validity of legislation. In response to the dismissal, the Naz Foundation has publicly stated that the High Court failed to properly consider the threat to public health posed by the further marginalization of homosexuals, including those suffering from HIV/AIDS.

– Barbara Mysko

### South Africa: Court upholds disciplinary measures against outspoken physician

In October 2004 a South African High Court dismissed an application by a physician to have a magistrate’s decision finding him guilty of misconduct, as well as the sentence that resulted from the decision, set aside.<sup>7</sup> The misconduct resulted from an incident in April 1999 when Dr Gazidis, in his capacity as medical doctor and secretary for health for the Pan African Congress, made a public statement criticizing the Minister of Health for refusing to provide AZT to pregnant HIV-positive women.

Dr Gazidis was subsequently interviewed by a newspaper, which quoted

him as saying that he was “gathering support to seek manslaughter charges against the Minister of Health for her refusal to make it policy to give the protective AZT drug to pregnant HIV positive women.” In December 1999, a disciplinary enquiry was instituted against Dr Gazidis, following which he was found guilty of misconduct and given a written warning and fined.

Dr Gazidis applied to have the decision of the disciplinary enquiry overturned, arguing that it amounted to an undue infringement of his right to expression. The judge of the High Court found that the “limitation to the applicant’s right to expression [was] reasonable and justifiable when all relevant factors are taken into account, particularly the gravity of the comments made by the applicant.”

In the court’s view, Gazidis had failed to set out convincingly why the limitation was not reasonable or why the provision that sets out the offence of misconduct should be struck down. The AIDS Law Project in South Africa was granted leave to appeal the High Court’s decision and will appear before a full bench of the High Court.

– Arryn Ketter

### South African activists awarded court costs

In December 2004 the Treatment Action Campaign (TAC) was awarded the costs of its legal action to gain

access to the Ministry of Health’s documents on an AIDS treatment plan.<sup>8</sup>

The basic rule in legal proceedings is that costs should be awarded to the successful party in litigation. Even though TAC withdrew its original application for access, the judge found that the Minister of Health and her department had acted in breach of legal obligations and inconsistently with the Constitution in their failure to respond to a request for production of documents.

As a result, the High Court ordered the Ministry of Health to pay TAC the costs the group unnecessarily incurred. TAC is a non-governmental organization whose principle objective is to campaign for access to treatment for all people with HIV.

– Arryn Ketter

<sup>1</sup> *R (on the application of DB) v Immigration Appeal Tribunal*, [2005] All ER (D) 125 (EWHC).

<sup>2</sup> HIV-positive man loses appeal to reduce jail term. *New Strait Times*, 29 July 2004.

<sup>3</sup> Man sent to jail for lying about HIV. *New Zealand Herald*, 17 December 2004.

<sup>4</sup> Bar Roma’s £40,000 bill for sacking the manager; HIV worry proves recipe for unfair dismissal. *The Herald* (Glasgow), 30 October 2004.

<sup>5</sup> For a report of the original High Court decision, see B Mysko, India: Challenge to constitutionality of criminal law banning homosexual acts dismissed. *Canadian HIV/AIDS Policy and Law Review* 2004; 9(3) 54-55.

<sup>6</sup> *Ibid.*

<sup>7</sup> *Costa Gazidis v Minister of Public Services and Administration*. Case No. 25519/01, High Court of South Africa, Transvaal Provincial Division.

<sup>8</sup> *Treatment Action Campaign v Minister of Health*. Case No. 15991/04, High Court of South Africa, Transvaal Provincial Division.