Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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Introduction

1. The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education and community mobilization. Established in 1992, it is Canada's leading organization working on the legal and human rights issues raised by HIV/AIDS, and is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

2. This submission describes five key national human rights priorities and provides recommendations for the Canadian Government to better respect, protect and fulfill human rights within Canada and, consistent with its obligation of international assistance and cooperation, beyond its borders. We focus in particular on various aspects of the obligation to realize progressively the right to the highest attainable standard of health under the International Covenant on Economic, Social and Cultural Rights (Article 12), which Canada has ratified. These priorities are: 1) the right to health and HIV/AIDS funding; 2) Canada's commitment to increase access to medicines in developing countries; 3) the right to health of people who use drugs; 4) the right to health of prisoners; and 5) the right to health of sex workers.

The right to health and HIV/AIDS funding

3. In May 2004, the Canadian Government announced that annual federal funding for its domestic HIV/AIDS strategy would be doubled over a five-year period, to reach a level supported by all federal political parties following Parliamentary hearings in 2003. (1) However, in 2007, the Canadian Government cut funding for existing and planned programs and services by almost 15 percent, with further cuts in 2008. This is happening against a backdrop of an estimated 58,000 Canadians living with HIV, representing a 16 percent increase from 2002, and a reported 2,300 to 4,500 people newly infected with HIV in 2005 (the last year for which such national estimates are currently available). (2) The funding cuts come at the expense of existing commitments to HIV-prevention programs and support services, even as the HIV epidemic continues to spread and affect a growing and increasingly diverse cross-section of Canadians.

4. In such a context, cutting HIV/AIDS funding is "a deliberately retrogressive measure", which the Committee on Economic, Social and Cultural Rights has noted is "not permissible" in relation to the right to health (3, 4). The Canadian HIV/AIDS Legal Network submits that the Canadian Government has failed to justify this retrogressive measure "by reference to the totality of the rights provided for in the Covenant and in the

context of the full use of the maximum available resources" (4). As such, the Canadian Government has violated the right to the highest attainable standard of health and should fully reinstate federal HIV/AIDS funding.

Canada's commitment to increase global access to medicines

5. Canada's Access to Medicines Regime (CAMR) was created by legislation passed in Canada's Parliament in May 2004. It is intended to allow compulsory licensing of patented medicines, so that generic drug companies in Canada can legally produce and export lower-cost versions of patented, brand-name medicines to developing countries. The Government claimed at the time that CAMR would "go a long way toward improving global health" (5). However, the actual effect of the law has been lacklustre. In 2008, Canada's largest generic manufacturer successfully bid on a contract to supply the Government of Rwanda with a tablet that contains a new fixed-dose combination of three existing anti-retroviral drugs used in AIDS treatment. While this development is welcome, the Canadian HIV/AIDS Legal Network is deeply concerned that it took four years for the agreement to be reached under the terms of this law, while signs indicate that, absent reform, future use of CAMR is doubtful, meaning the promised contribution to improving access to medicines in developing countries will be but illusory.

6. CAMR does not work as intended because it is unnecessarily complex and cumbersome, requiring separate negotiations with patent-holders for a separate licence for each purchasing country and each order of medicines. Further, a generic manufacturer can only apply for a compulsory licence authorizing exports after tentatively lining up a contract with a purchasing country. Apotex has indicated it is unlikely to try again, while developing countries have repeatedly pointed out ways in which Canada's law does not accommodate the practical realities of drug procurement (6). Canada's Access to Medicines Regime could be easily fixed. A process that enables a single, and more flexible, legal authorization for generic manufacturers to produce a production, in advance of determining specific anticipated quantities with potential purchasers, is preferable, so they can bid on supply contracts with many potential purchasers without being hamstrung. In order to meet its stated intention of assisting developing nations with access to affordable lifesaving medicines, Canada needs to simplify its Access to Medicines Regime to allow developing countries quicker access to treatment for HIV/AIDS and other health needs (6). Failure to take such action, in line with Canada's legislatively-stated commitment to improving access to medicines, is to disregard its obligation of international assistance and cooperation in realizing the right to health under the International Covenant on Economic, Social and Cultural Rights (Article 2).

The right to health of people who use drugs

7. The Canadian HIV/AIDS Legal Network is concerned that the right to health of people who use drugs, who are often among the most marginalised of Canadians, is routinely violated. According to the Committee on Economic, Social and Cultural Rights, one of the core obligations of the right to health is the obligation "[t]o ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups" (4).

8. The Government of Canada launched a new *National Anti-Drug Strategy* in October 2007. In contrast with previous national strategies, the new document funds law enforcement, prevention and treatment programs — three of the four so-called "pillars" common in many drug strategies — and eliminates the long-standing fourth pillar, harm reduction, which includes needle exchanges, methadone clinics and supervised injection facilities, services of particular importance in protecting the health of people who use illegal drugs. Harm reduction programs are proven to lessen the harms associated with illicit drug use, including by reducing transmission of HIV and hepatitis C (HCV); they are, therefore, essential for the protection of the right to health of people who use drugs.

9. Insite, Vancouver's supervised injection facility, has decreased the rates of syringe-sharing and deaths from overdose, reduced the risk of HIV and HCV transmission and increased the chances of directing drug users to addiction treatment services (7, 8). Research demonstrating the benefits of Insite was confirmed recently by the federal Government's own expert advisory committee (7) and several other Canadian cities have expressed interest in creating similar sites. Despite its proven effectiveness in protecting the health of people who use drugs, the Government threatened to withdraw its legal permission to operate. In May 2008, the Supreme Court of British Columbia issued a court order protecting Insite's staff and service-users from prosecution, on the basis that, absent such an exemption, the law would unjustifiably infringe users' right to security of the person by exposing them to avoidable morbidity and mortality (9). The Government has launched an appeal of this decision, and has declared a moratorium on considering new applications for exemptions to allow any other such facilities.

10. Needle and syringe programs (NSPs) are a proven, cost-effective way of reducing the transmission of blood-born viruses such as HIV and HCV among people who inject drugs, yet multiple barriers prevent access to NSPs in Canada. The distribution of clean syringes is far below what is required to stop the spread of blood-borne infections. It has been estimated that about 5% of the required number of syringes is distributed in the province of Ontario each year (10). Police crackdowns and other law enforcement operations targeting illegal drugs interfere with NSPs' work and discourage the most marginalised users from accessing NSPs. Available evidence indicates police crackdowns may lead to a significant decline in sterile syringes distributed (11). Elevated police presence has also deterred some people from using their customary source of sterile syringes and encouraged lending and borrowing of injection equipment (10 at 18). Moreover, NSPs across Canada are insufficiently funded: under the current system, provinces and territories establish or fund NSPs at their discretion, with few or no incentives from the federal Government (10).

11. The Committee on Economic, Social and Cultural Rights characterises "insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized" as a violation of the obligation to fulfil the right to health (4). The Canadian HIV/AIDS Legal Network urges the federal Government to support harm reduction by increasing funding and facilitating access to NSPs as a key part of a pragmatic, evidence-based, comprehensive approach to dealing with drugs. Provincial and territorial Governments

need to explicitly identify NSPs as necessary services in every health region, in order to fulfil requirements for the right to health of people who use drugs in Canada. Law enforcement and health policy branches of government should ensure that the enforcement of drug laws does not interfere with the delivery of, and access to, health services (10).

The right to health of prisoners

12. In Canada, estimates of HIV prevalence in prisons are at least ten times the reported prevalence in the population as a whole and estimates of hepatitis C virus (HCV) prevalence in Canadian prisons are at least 20 times the estimated HCV prevalence in the population as a whole (12). A survey by Correctional Service Canada (CSC) of the federal prison system (comprising 52 institutions), revealed that 11 percent of federal prisoners reported having injected an illegal drug since arriving at their current institution (13). The scarcity of sterile syringes and the punitive consequences of being caught using drugs in prisons leads prisoners to use non-sterile injecting equipment. An even greater percentage of prisoners (approximately 45%) have reported receiving a tattoo in prison; however, there is little in the way of access to sterile equipment (13).

13. However, in December 2006, the Government of Canada cancelled a ground-breaking "safer tattooing" pilot project developed by CSC, despite the preliminary positive evaluation of the program. Deliberately withdrawing access to such programs, implemented to address a documented public health risk, is a "retrogressive measure" at odds with the obligation of progressive realization of the right to health of those in the state's custody and fully subject to its control (3, 4).

14. Furthermore, no Canadian jurisdiction has established a prison-based needle and syringe program (PNSP). To date, PNSPs have been introduced in over 60 prisons of varying sizes and security levels in 11 countries (14). Evaluations of PNSP programs have consistently demonstrated that PNSPs reduce the use of non-sterile injecting equipment and resulting blood-borne infections, do not lead to increased drug use or injecting, reduce drug overdoses, lead to a decrease in abscesses and other injection-related infections, facilitate referral of users to drug treatment programmes and have not resulted in needles or syringes being used as weapons against prisoners or staff (14-16).

15. Under international law, persons in detention retain the right to the highest attainable standard of health and the right to equality in the enjoyment of human rights (except insofar as necessarily limited by incarceration) (4, 17-20). Given that HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states' obligation to take effective measures to prevent HIV and HCV transmission in prisons (21). Prisoners have a right to access a standard of health care equal to that available outside of prisons (the "principle of equivalence") and this includes preventative measures comparable to the treatment and services available in the community as a whole. Although NSPs operate in communities across Canada, in some cases for more than two decades, with funding from various levels of government (primarily provincial/territorial and municipal), no such program operates in a single prison anywhere in Canada. According to the Committee on Economic, Social and Cultural Rights, "States are under the obligation to respect the right

to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees… to preventive…health services." (4)

16. Providing sterile syringes to prisoners as a means to prevent the spread of blood-borne viruses has been supported by the Canadian Medical Association (22) and the Correctional Investigator of Canada (23), as well as international organisations as a matter of sound public health policy and human rights (18, 20, 24). Yet the Canadian Government has flatly refused to implement such health services in federal prisons, and no provincial or territorial government has yet taken steps to implement such health programs either. Canada should respect prisoners' right to health and implement NSPs in prisons under its jurisdiction, as well as reinstating safer tattooing measures.

The right to health of sex workers

17. Under both Canadian and international law, Canada has an obligation to guarantee sex workers' right to health. (25) In practice, sex workers' rights — not only to health, but also to life, safe working conditions, non-discrimination and freedom of expression and association — are routinely violated (25, 26).

18. While the exchange of sex for money and other valuable consideration is legal in Canada, certain provisions of the *Criminal Code* make illegal virtually every activity related to prostitution and render sex workers vulnerable to violence and potential exposure to HIV (25). Sections 210 to 213 of the federal *Criminal Code* make it illegal for a person to keep or transport a person to a "bawdy house" (i.e. a place regularly used for prostitution), to encourage or force a person to participate in prostitution or to live on the money earned from prostitution by someone else, and to communicate in public for the purposes of prostitution. The preponderance of credible evidence demonstrates that these overly-broad, poorly-drafted provisions both directly and indirectly contribute to sex workers' risk of experiencing violence and other threats to their health and safety (25, 26). Further, these risks are borne disproportionately by street-based sex workers, many of whom are transgender or Aboriginal, and also disproportionately affects women (25). The Canadian HIV/AIDS Legal Network submits that Sections 210 to 213 of the *Criminal Code* lead to violations of sex workers' right to health because those provisions interfere with sex workers' right to control their "health and body" and do not protect them against "gender-based expressions of violence" (4). Canada's Parliament should repeal sections 210 to 213 of the *Criminal Code*.

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