

Canadian HIV/AIDS Legal Network

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Legislation contagion: building resistance

The HIV/AIDS Policy & Law Review recently carried a feature article recounting the spread of problematic new HIV laws in west and central Africa.¹ It outlined less-than-model approaches in the AWARE-HIV/AIDS “model” law and described how its provisions had been replicated in many national HIV laws. At the time of writing that article, eight national HIV laws had been passed in the region.² Since that date, the rush to legislate HIV in west and central Africa in ways that do not accord with human rights law or policy has continued unabated.

Legislation by intuition

At the time of writing this article, 14 countries in west and central Africa have passed HIV laws.³ All have done so since 2005. If anything, this momentum to legislate HIV in west and central Africa appears to be increasing, rather than slowing. Currently, there are HIV bills under consideration in (at least) four additional countries in that region. In addition, there are HIV bills in development in a number of jurisdictions in southern and eastern Africa.⁴

As was the case with the earlier laws, the more recent laws emulate the AWARE-HIV/AIDS “model” law to varying degrees.⁵

As with the earlier laws, there are some positive aspects to the recent laws. For example, they often

cont'd on page 5

Special Section: AIDS 2008

This issue of the *Review* includes a special section containing the most relevant presentations on legal, ethical, and human rights issues from the XVII International AIDS Conference, held in Mexico City, Mexico in August 2008.

See page 51.

Número en Tres Idiomas

Este número ha sido publicado en tres idiomas — inglés, francés y español. Esta es la primera vez que una edición de la *Revista* se publica en español. Esto es en reconocimiento al hecho que este número contiene una sesión especial sobre la Conferencia Internacional en México (ver siguiente punto). La versión en español está ubicada en el medio del ejemplar, y los bordes de sus páginas tienen un sombreado gris.



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

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Comments?

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

CONTENTS

FEATURE

- Legislation contagion: building resistance 1

CANADIAN DEVELOPMENTS

- Results of the first North American prescription heroin study are promising 11
New excessive demand policy for immigration applicants 13
British Columbia adopts *E-Health Act* 14
(Most) political parties respond to questionnaire on AIDS issues during federal election 16
Immigration and Refugee Protection Act amended 17
In brief 18
 Federal Government announces new strategy to eliminate illegal drugs in federal prisons
 Manitoba passes forced testing legislation
 Alberta to make personal medical information available on-line

INTERNATIONAL DEVELOPMENTS

- Mexico: General Recommendations issued against mandatory HIV testing and discharge from armed forces 19
Cambodia: human trafficking legislation threatens HIV response 21
U.S.: Interim step towards elimination of HIV travel ban 22
Global: Review of injecting drug use and HIV prevalence among users 24
In brief 25
 Uganda: Civil society expresses concern about HIV bill
 China: Hu Jia wins human rights prize
 WHO commission reports on social determinant's of health

HIV/AIDS IN THE COURTS — CANADA

- Vancouver's supervised injection facility granted constitutional exemption from federal drug law 28
HIV-positive man from DRC deemed a "person in need of protection" 30
Federal Court sets aside decision denying Mexican couple's claim of persecution 31
Court dismisses HIV-positive man's application for review of decision not to defer removal from Canada 32
Criminal law and cases of HIV transmission or exposure 33
In brief 39
 Court dismisses Ottawa's application to uphold federal medical marijuana restrictions

cont'd

HIV/AIDS IN THE COURTS — INTERNATIONAL

Supreme Court of India approves government commitments on health care for people living with HIV	40
European Court rejects Ugandan woman's claim to stay in the U.K.	41
South African court bans promotion of vitamin treatments as cures for AIDS	43
South African Court: Military cannot exclude HIV-positive people	44
Criminal law and cases of HIV transmission or exposure	45
In brief	47
HIV-positive Kenyan awarded compensation after being fired	
Kyrgyzstan: Nine health care workers guilty of negligence causing HIV transmission among children	
China: Judicial interpretation imposes stricter responsibility for contaminated blood sales	
Brazilian Appeals Court rules that criminal prosecution for drug possession is unconstitutional	
Egypt: Sentences upheld for men convicted of "debauchery"	

AIDS 2008: LAW, ETHICS AND HUMAN RIGHTS

Human rights and HIV/AIDS: where are we? and what next?	52
Human rights remain marginalized	53
Rights and policy front and centre at the conference	54
Lessons from Africa: combating the twin epidemics of domestic violence and HIV/AIDS	57
Sexual assault, domestic violence and HIV: promoting women's rights through legislation	63
HIV is a virus, not a crime	64
Pretrial detention: scale and relevance to HIV/AIDS	68
Central & Eastern Europe and Central Asia: Police raids and violence put sex workers at risk of HIV	71
Violence against sex workers by police and military in Democratic Republic of Congo	73
People with disabilities and the AIDS pandemic: making the link	75
Coerced and forced sterilization of HIV-positive women in Namibia	77
Using strategic litigation to strengthen rights in southern Africa	78
Civil society strategy for the compulsory licensing of lopinavir/ritonavir: the Brazilian case	80
Abuses of women's rights in sexual and reproductive health-care settings	82
Drawing conceptual linkages: property rights and HIV	84
Measuring for change: a new research initiative by and for people living with HIV	86
Continued challenge posed by HIV-related restrictions on entry, stay and residence	88
Putting the right back into sexual and reproductive rights	89
Yogyakarta Principles: Applying existing human rights norms to sexual orientation and gender identity	92
Rejecting the evidence: Russia's drug dependence treatment system	93
U.N. guidance note on HIV and sex work "reworked" by activists	95
Recognize sex work as legitimate work	97

Legislation contagion: building resistance

cont'd from page 1

provide for HIV information and education campaigns in a variety of sectors of society. In addition, they frequently guarantee the confidentiality of HIV test results.

Some laws guarantee the involvement of persons living with HIV (PLHIV) in the provision of certain services, such as outreach. Perhaps of most value, the region's HIV laws all offer progressive language to prohibit discrimination against PLHIV (although gaps in the drafting would leave a number of obvious forms of discrimination without legal redress.)

However, as will be seen, many of these national HIV laws appear to have been developed hastily, with little or no attention given to the procedural steps that encourage responsive and rational laws.

In many cases, one is left with the impression that the national HIV law is a reflection of legislator's desire to be seen to do something, rather than a reflection of what is required, what is effective and what is just. These laws often reflect approaches to HIV issues that are based on intuitive beliefs about their effectiveness, for which there is seldom any evidence.

Few policy makers appear to have enquired whether legislation as such, as opposed to other forms of government action, is required. Little or no consideration has been given to the wrongs these laws might do if administered by a less than ideal legal system. Without exception, the national laws have been adopted without reference to the well-established framework of international law and policy guidance that has been developed on

the issue of how best to respond to the HIV epidemic in law.⁶

The HIV laws in west and central Africa contain a number of poorly-considered legislative provisions. Some such provisions are relatively harmless. Others, however, risk undermining "the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups" that, according to the UN General Assembly, should characterize legislation, regulation and other measures to address the HIV epidemic in law.⁷

The HIV laws in west and central Africa contain a number of poorly-considered legislative provisions.

Instances of poorly-considered provisions are scattered throughout the recent HIV laws of the region. For example:

- The laws are marked by an insistence on use of the criminal law. The creation of criminal offences is the primary means to address cases of "intentional" HIV transmission and/or exposure (as discussed below.) But the criminal law is also used to address other

HIV issues, ranging from the administration of contaminated blood by health care professionals (including when administered through "negligence, carelessness, clumsiness or failure to follow regulations") to the "abandonment" of PLHIV.⁸ Acts of discrimination and even stigmatization are also criminal offences.⁹

- The laws contain little or no provisions addressing HIV among those who are particularly vulnerable to HIV infection. The laws rarely refer to prevention, treatment, care or support services among women, and never among men who have sex with men. In stark comparison to these omissions, a number of national laws make it illegal for sailors to embark on boats without a document from the port authority stating that they have received training on HIV.¹⁰
- Some of the provisions have been drafted with little consideration as to whether legislation as such is the appropriate place to reflect the policy in question. For example, an early version of the HIV Bill in Mozambique would have created a legislative obligation on all PLHIV to undertake "regular physical activity" and to "permanently raise the awareness of other people ... about their obligations in all matters regarding the illness."¹¹

Disclosure obligations and the "duty to warn"

In many cases, the recent HIV laws establish overly-broad disclo-

sure requirements for PLHIV on their spouses or sexual partners. Frequently, the laws give health care practitioners a “duty to warn” spouses or sexual partners with little or no direction as to how to exercise this power.

For example, the law of Cape Verde requires disclosure to a spouse or sexual partner as soon as possible and within six weeks of diagnosis and gives health care professionals a broad power to disclose that person’s HIV status.¹² The law of the Democratic Republic of the Congo simply states that the PLHIV must “immediately inform” their spouse and sexual partners.

The law of Burkina Faso establishes that the PLHIV must inform his or her spouse or sexual partner of his or her HIV status “without delay” and where the PLHIV does not voluntarily inform their spouse or sexual partner, healthcare professionals “must ensure that disclosure takes place” [*doivent veiller à ce que l’annonce se fasse*].¹³

The *International Guidelines on HIV/AIDS and Human Rights* recommend that a health care professional may, where he or she considers that counselling has failed to achieve the appropriate behavioural changes by the PLHIV, and a real risk of HIV transmission to the partner(s) exist, disclose to the partners. Importantly, the International Guidelines recommend disclosure with certain safeguards, such as giving the PLHIV reasonable advance notice and concealing the identity of the PLHIV (if practicable).¹⁴

Compulsory HIV testing

Frequently, the recent HIV laws provide a number of exceptions to the principle that HIV testing should be

voluntary. The language of these provisions is often drawn from the AWARE-HIV/AIDS “model” law’s own enumeration of situations where HIV testing is compulsory.¹⁵ Recent HIV laws frequently provide for compulsory testing on charges of rape and “HIV infection” (or attempted infection) or “to resolve a marital dispute.”¹⁶

Again, these laws ignore the detailed guidance available to legislators. The UNAIDS/World Health Organization policy statement on HIV testing clearly states:

The conditions of the ‘3 Cs’, advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be:

- Confidential;
- Be accompanied by counselling;
- Only be conducted with informed consent, meaning that it is both informed and voluntary.¹⁷

Criminalization of HIV transmission or exposure

All the recent HIV laws in west and central Africa create offences of HIV transmission or exposure.¹⁸ While the wording of these offences varies between countries, the provisions are characterized by startling imprecision in their formulation.

Frequently, the HIV laws in the region establish an offence of “wilful transmission.”¹⁹ However, when “wilful transmission” is defined, it is defined in ways that do not require deliberate intention, i.e., the desire to transmit the virus to another person. Rather, “wilful transmission” is defined as transmission of HIV “through any means by a person

with full knowledge of his/her HIV/AIDS status to another person.”²⁰

In other words, these laws deem a desire to infect another person (the mental element of the crime) on the part of the PLHIV from two elements that are not actually determinative of a deliberate intention: (a) that the PLHIV knew his or her status; and (b) that transmission occurred.

With regard to the HIV law of Burkina Faso, the version of the Bill that was circulated immediately prior to adoption had no fewer than four distinct articles criminalizing “voluntary transmission.”²¹ These provisions overlap in some of the conduct they criminalize, although each contain differences in terminology and differences in the conduct they would criminalize, resulting in a law that is profoundly confusing.²²

What is to be done?

Amend existing laws

Although the challenges may be greater in situations where laws have been recently adopted, there always exists the possibility of amendments. For people and organizations working on issues related to HIV and human rights, this will require a long and taxing effort to roll-back some of these laws. As a matter of urgency, some of the more egregious provisions of certain national laws must be amended. Such work is difficult, but by no means impossible.²³

While most countries have provisions in their HIV laws that should be removed or changed, certain countries with profoundly problematic provisions in their HIV laws appear open to the possibility of amendment. The examples of Sierra Leone

and Guinea are discussed below. Interestingly, at a UNAIDS-convened meeting in Dakar, Senegal in April 2008, both countries were among those that stated their openness to amending and improving their HIV laws.²⁴

Sierra Leone's HIV law is an obvious one to focus on. The wording of the offence of "HIV transmission" explicitly criminalizes mother-to-child transmission (MTCT). According to one provision, a PLHIV who is aware of his or her infection must "take all reasonable measures and precautions to prevent the transmission of HIV to others and in the case of a pregnant woman, the foetus."

To roll-back some of these laws will require a long and taxing effort.

According to another provision, a PLHIV who is aware of his or her infection must not knowingly or recklessly place another person ("and in the case of a pregnant woman, the foetus") at risk of becoming infected with HIV, unless that person knew of the fact and voluntarily accepted the risk of being infected.²⁵

First, this provision would violate the right to medical treatment with voluntary informed consent. In addition to being a human right, informed consent to undergoing antiretroviral therapy to reduce MTCT is important

because the treatment may affect the health of the pregnant woman.²⁶

Second, the Sierra Leonean law does not specify what "all reasonable measures and precautions" would include. Indeed, it is not at all clear that such "measures and precautions" are sufficiently articulated and understood by health care professionals and pregnant women in a way that makes it appropriate to apply criminal sanctions for a departure from those "measures and precautions." To cite just one example, would HIV transmission that occurred during breastfeeding attract criminal liability?²⁷

Third, fear that giving birth in a health care facility could expose women to criminal liability risks driving women away from health care facilities and, particularly, maternity care. Fourth, it is highly doubtful that criminal punishment of a mother could be in the best interests of her newly-born child.

It is worth noting that, while the criminalization of MTCT is explicit in the case of Sierra Leone, the criminal law offences of "intentional" HIV transmission or exposure in a considerable number of HIV laws in the region could have exactly the same effect.²⁸

Another country whose HIV law obviously needs amendment is Guinea. For example, the Guinean law specifically forbids providing HIV/AIDS education to children under 13 years old. There is no rational justification for restricting children's access to health education in this way. Rather, comprehensive education programs that provide complete, factual, and unbiased information about HIV prevention (including information about the correct and consistent use of condoms) are

crucial in for adolescents and young adults.

Rather than establish legislative barriers to scientifically-accurate and age-specific education and information in educational settings, the law should establish a positive obligation on the relevant ministries to provide access to health education.

The Guinean law also mandates HIV testing before marriage.²⁹ There is little evidence that mandatory pre-marital HIV testing has any effect on reducing rates of HIV. The supposed effectiveness of mandatory HIV testing before marriage rests on a number of false assumptions.

First, the approach assumes that HIV testing is accurate, when reports of false positives and false negatives indicate otherwise.

Second, a negative test does not preclude the possibility of infection. Testing may occur during window periods when HIV antibodies cannot be detected, and a partner may become infected *after* the HIV test takes place, and indeed after the marriage takes place. Pre-marital testing may thus create a false sense of security that married people do not need to be concerned about HIV infection.

Third, the policy assumes that the individuals getting married have not already exposed their partners to the virus.

Improving Bills before they come laws

Experience has shown that policy makers and civil society can work together to develop HIV laws in Africa that are qualitative improvements on these recent laws.³⁰ To assist in this process in west and central Africa, UNAIDS recently released a document containing alternative language to some of the problematic

articles in the AWARE-HIV/AIDS “model” law. The document recognized that the AWARE-HIV/AIDS “model” law is

a positive step towards the realization of commitments made in the *Declaration of Commitment* and the *Political Declaration* and captures many elements of law that should form support for national responses to HIV. However, there are some provisions in the N’Djamena [AWARE-HIV/AIDS “model”] law which could benefit from reconsideration and revision so as to best meet two critical concerns in the response to the HIV epidemic: that of protecting public health and that of protecting human rights.³¹

Policy makers and civil society can work together to qualitatively improve HIV laws in Africa.

UNAIDS proposed alternative language on criminalization of HIV transmission or exposure that is designed to address a context in which legislators are firmly convinced that it is necessary to include an offence criminalizing HIV transmission or exposure, but where there may be opportunities to mitigate the negative effects of such provisions. The proposal would clearly remove criminal liability from those acts

and scenarios where the injustice of criminal sanctions would be most manifest. It reads:

No person shall be criminally responsible under this Act or any other applicable law where the transmission of HIV, or exposure to the risk of HIV infection, arises out of or relates to:

- i. an act that poses no significant risk of HIV infection;
- ii. a person living with HIV who was unaware of his or her HIV infection at the time of the alleged offence;
- iii. a person living with HIV who lacked understanding of how HIV is transmitted at the time of the alleged offence;
- iv. a person living with HIV who practiced safer sex, including using a condom;
- v. a person living with HIV who disclosed his or her HIV-positive status to the sexual partner or other person before any act posing a significant risk of transmission;
- vi. a situation in which the sexual partner or other person was in some other way aware of the person’s HIV-positive status;
- vii. a person living with HIV who did not disclose his or her HIV status because of a well-founded fear of serious harm by the other person; or
- viii. the possibility of transmission of HIV from a woman to her child before or during the birth of the child, or through breastfeeding of an infant or child.³²

As noted above, there are a number of African jurisdictions with draft bills under consideration at the moment. These represent opportunities for sensible and sensitive law

reform. Again, such a task is difficult but not impossible. For example, the Liberian HIV Bill that passed the lower house of that country’s parliament in September 2008, and which is currently being debated in the upper house, is a marked improvement on any other law in the region.³³

Conclusion

HIV legislation is inherently sensitive and the problems found in national HIV laws are, all too often, predictable. In order to avoid the types of problems that recur in west and central Africa’s HIV laws, it’s crucial to adopt a more sensitive and thoughtful approach to HIV legislation.

Without doubt, certain legislatures must be encouraged to revisit particularly egregious provisions in their national laws. Further, as the momentum towards adopting HIV legislation shows no signs of slowing, both policy-makers and civil society organizations must cast a more critical eye over their HIV bills.

People and organizations working in countries that are currently developing HIV legislation must actively engage in the drafting process by informing themselves of the content of the bills and proposing amendments.

National legislative responses to HIV in west and central Africa — and elsewhere — would be improved if people involved in making HIV laws answered some preliminary questions, including:

- What are the current gaps in the national response to the epidemic that must be filled?
- Is law reform required to fill the gaps, or is it some other form of action (e.g., a regulation, a policy, or a budget) that is missing?

- Is an “omnibus” HIV law necessary, or is amendment of existing laws (e.g., public health law, employment law, anti-discrimination laws) appropriate?
- What are the existing recommendations regarding law reform from organizations such as UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR)?
- What evidence exists that similar approaches to HIV issues from other countries have worked?
- Are there any potential unintended negative consequences from law reform? How can these be avoided?
- Once law reform has taken place, what additional steps (e.g., regulations, trainings, support for legal representation) will be needed for the law reform to make a meaningful difference in the lives of those it purports to benefit?

A failure to ask these sorts of questions will mean more poorly-considered and hastily-adopted national laws which, in their worst provisions, breach states’ human rights commitments towards people living with and vulnerable to HIV infection. Asking such questions may help ensure that HIV laws are effective, responsive and just.

— Richard Pearshouse

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¹ R. Pearshouse, “Legislation contagion: the spread of problematic new HIV laws in Western Africa”, *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 1–11.

² At that stage, Benin, Burundi, Guinea, Guinea-Bissau, Mali, Niger, Togo and Sierra Leone and Burundi had passed national HIV laws. The article referred to in the previous endnote discussed the laws in all of these countries except Burundi.

³ Since the first article covering these developments (see the first endnote above), Cape Verde, Chad, Mauritania, Equatorial Guinea, Burkina Faso and the Democratic Republic of the Congo have passed HIV laws.

⁴ At the time of writing, Senegal, Cote d’Ivoire, Liberia and Gambia are all at various stages of developing HIV laws. Outside west and central Africa, Mozambique, Uganda and Malawi are also at various stages of the legislative process. These lists are non-exhaustive.

⁵ For example, Cape Verde and Mauritania follow the “model” law closely.

⁶ See, for example, UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf; UNAIDS, Inter-Parliamentary Union and United Nations Development Programme, *Taking Action against HIV — Handbook for Parliamentarians*, 2008, at http://data.unaids.org/pub/Manual/2007/20071128_ipu_handbook_en.pdf.

⁷ United Nations General Assembly, *Political Declaration on HIV/AIDS*, Res/60/262, 2 June 2006.

⁸ For example, Mauritania’s law “On the prevention, care and control of HIV/AIDS,” No. 2007.042, (2007), art. 23, 25 and 26. In criminalizing “negligence, carelessness, clumsiness or failure to follow regulations” of health care professionals, the Mauritanian law follows the AWARE-HIV/AIDS “model” law closely.

⁹ For example, Mauritania’s law establishes a criminal offence of discrimination (with a minimum period in prison of one month): see art. 22. With respect to the criminalization of stigmatization, the HIV law of the Democratic Republic of the Congo establishes that “all behaviour tending to deliberately discredit, scorn or render ridicule towards a person living with HIV and AIDS [sic], his or her sexual partners, children or parent, on the basis of his or her HIV serostatus, real or presumed” is liable for a criminal offence carrying a minimum sentence of a month in prison. Such behaviour is undoubtedly objectionable, but inappropriate for a criminal offence. Instead, HIV laws might (appropriately) criminalize vilification (sometimes called “incitement to hatred”).

¹⁰ See, for example, Mauritania’s law “On the prevention, care and control of HIV/AIDS,” No. 2007.042, (2007), art. 6. In this, the Mauritanian law follows the AWARE-HIV/AIDS “model” law closely.

¹¹ Mozambique’s “Bill on Defending Human Rights and the Fight against the Stigmatisation and Discrimination of People living with HIV and AIDS” (2008), art. 7. The Bill is currently under revision and it is not clear what will happen to this provision.

¹² Art. 22. In this, as in its other text, the law of Cape Verde follows the AWARE-HIV/AIDS “model” law closely.

¹³ Art. 7 and 8.

¹⁴ See International Guidelines, guideline 3(g).

¹⁵ Article 18 of the AWARE-HIV/AIDS “model” law provides for compulsory HIV testing “when a person is

indicted for HIV infection or attempts to infect another person with HIV”; when a person is indicted for rape; “when determining HIV status is necessary to solve a matrimonial conflict”; in the case of organ, cell or blood donations; or “when a pregnant woman undergoes a medical checkup.” For an unknown reason, the provision establishing compulsory testing of pregnant women in pre-natal care appears in the English version of the model law, but not the French version.

¹⁶ See, for example, Cape Verde’s law No. 19/VII/2007, art. 15; Mauritania’s law “On the prevention, care and control of HIV/AIDS,” No. 2007.042, (2007), art. 15; Burkina Faso’s HIV law, art. 19(2).

¹⁷ UNAIDS/WHO, *Policy Statement on HIV Testing*, 2004, p. 2.

¹⁸ It is worth noting that the current version of the HIV Bill in Côte d’Ivoire does not contain an offence of HIV transmission or exposure.

¹⁹ See, for example, the Democratic Republic of the Congo’s HIV law (2008), art. 43.

²⁰ See, for example, Mauritania’s law “On the prevention, care and control of HIV/AIDS,” No. 2007.042, (2007), art. 1. In this, the Mauritanian law follows the AWARE-HIV/AIDS “model” law closely.

²¹ It appears that the law was adopted without changes from the form of the Bill described here.

²² Art. 20 establishes that “Every person who is aware they are infected with HIV and who deliberately has unprotected sex with a partner who is not informed of their HIV status, including if that person is HIV positive, is guilty of a crime of voluntary transmission and punished according to the Penal Code”; art. 22 establishes “Whoever, voluntarily, by whatever means, transmits substances infected with HIV, is guilty of voluntary transmission of HIV”; art. 26 establishes “Anyone who is aware of their HIV infection and who does not take necessary and sufficient precautions for the protection of his or her partners, incurs penal sanctions.” The article then establishes the sanctions as a fine of 100,000 to 1,000,000 CFA francs (about \$290 to \$2,900), if no transmission occurs, or attempted homicide if transmission occurs; art. 27 then repeats the wording of art. 22 in the first paragraph. The second paragraph addresses accomplices to the offence in the first paragraph, while the third paragraph states that those responsible for an act of voluntary transmission or accomplices to the same are to be punished in conformity with the Penal Code.

²³ For example, at time of writing, revisions to improve the national HIV law of Togo are being considered.

²⁴ See UNAIDS et al., *Capacity Building Workshop on Human Rights and Gender in HIV Legal Frameworks — Final Report*, 2008. Copy on file with the author.

²⁵ See “The Prevention and Control of HIV and AIDS Act (2007)” [Sierra Leone], art. 21(a) and (b).

²⁶ See Centre for Reproductive Rights, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, Briefing Paper, 2005, at www.reproductiverights.org/pdf/pub_bp_HIV.pdf.

²⁷ According to some studies, breastfeeding may be responsible for one-third to one-half of HIV infections in infants and young children in Africa (K.M. De Cock et al., “Prevention of mother-to-child HIV transmission in resource-poor countries — translating research into policy and practice,” *JAMA* 283 (2000): 1175–1182.) At

the same time, according to current UN recommendations, infants should be exclusively breastfed for the first six months of life to achieve optimal growth and health (WHO, *New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations*, 2001).

²⁸ “Wilful transmission” is defined in art. I of the AWARE-HIV/AIDS “model” law as transmission of HIV “through any means by a person with full knowledge of his/her HIV/AIDS status to another person.” Taking into account the definition of “HIV transmission” also in art. I, the phrase “through any means” could extend

to a mother who transmits HIV to a child, including *in utero* or during labour and delivery. Countries that have replicated this approach in their national laws thus risk criminalizing MTCT.

²⁹ “Law on prevention, care and control of HIV/AIDS” (No. 2005-25) [Guinea], art. 2 and 28.

³⁰ For example, criminal law sanctions in the HIV Bill of Mauritius were removed from the eventual law. See Mauritius “HIV and AIDS Act” (2006) and International Planned Parenthood Federation, Global Network of People Living with HIV, and International Community of Women Living with HIV/AIDS, *Verdict on a Virus: Public*

Health, Human Rights and Criminal Law, 2008, p. 36.

³¹ UNAIDS, *UNAIDS Recommendations for Alternative Language to Some Problematic Articles in the N'Djamena Legislation on HIV (2004)*, 2008, p. 1, at http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf. The author was involved in the development of this document.

³² UNAIDS, *UNAIDS recommendation*, p. 17.

³³ See J. Fahngon, “New AIDS law calls for confidentiality,” *The News*, 4 September 2008, online at <http://allafrica.com/stories/printable/200809040848.html>.

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. Readers are invited to bring stories to the attention of Alison Symington, editor of this section, at asymington@aidslaw.ca.

Results of the first North American prescription heroin study are promising

In October 2008, the North American Opiate Medication Initiative (NAOMI) research team released the primary outcomes of a randomized controlled trial aimed at testing whether the provision of pharmaceutical-grade heroin under medical supervision benefits people suffering from chronic opiate addictions who have not benefitted from other treatments. The treatment phase was completed in June 2008. Retention and response rates were high, suggesting that heroin-assisted therapy is a safe and highly effective treatment for people with chronic heroin addiction.¹

NAOMI is a Canadian Institutes for Health Research-funded study with two study sites: Montreal and Vancouver. Enrolment began in 2005. A total of 251 clients met the study's eligibility criteria and provided informed consent to participate

in the study, including 59 people in Montreal and 192 in Vancouver.²

The target population was long-term, chronic opioid injectors with severe health and social problems and several previous addiction treatment attempts. Strict eligibility criteria

were applied at recruitment, including that all participants had to be 25 years of age or older, have had five years or more of opioid use, have had regular opioid injection use in the past month and in at least eight of the past 12 months, and had not been enrolled in

any other opioid substitution program within the prior six months.

Exclusion criteria included pregnancy, being on parole or likely to have an extended period of incarceration during the study period (e.g., scheduled trial for an indictable offense), and suffering from certain conditions including chronic respiratory disease, bipolar mood disorder, schizophrenia and major depression.³

The following are some of the characteristics of the resulting study group:

- mean age was 39.7 years;
- 38.6 percent of participants were female;
- 23.9 percent defined themselves as Aboriginal;
- 72.9 percent stated that they lived in an unstable housing situation;
- 70.9 percent had been regularly unemployed in the previous three years, with public assistance and illegal activity cited as the most common sources of income; and
- 62.9 percent were positive for hepatitis C and 9.6 percent were HIV positive.⁴

Study participants were randomly assigned into three groups. Participants in the investigative arm received either injectable diacetylmorphine (DAM, which is heroin) (45 percent of participants) or injectable hydromorphone (HMO, a medically available potent opioid) (10 percent of participants).

This was done on a double-blind basis, meaning that neither the participants nor the clinic nurses, doctors and researchers knew which of the two drugs any individual was receiving.⁵

The control arm of the study (45 percent of participants) received optimized methadone maintenance

therapy (MMT). Because MMT is given orally, it was impossible to double-blind the MMT comparison.⁶

Participants in the investigative arm of the study received the treatment for a maximum of 15 months. They attended the NAOMI clinic up to three times per day where they were given a sterile, pre-filled syringe of DAM or HMO.

After 12 months, these participants entered a transition or weaning off period and were supported into the appropriate treatment of their choice (e.g., methadone maintenance, abstinence, or other available programs).⁷ Members of the methadone group attended the clinic once a day for an oral dose of methadone.⁸

The primary outcomes of the study consider two variables: treatment *retention* (i.e., compliance with study medication or, in a detoxification program, a drug-free program or abstinence) and treatment *response* (i.e., decline in illicit drug use and criminal justice involvement).⁹

The retention and response rates were high in both the DAM and MMT groups, but significantly higher in the DAM group. In terms of retention, 87.8 percent of the DAM group and 54.1 percent of the MMT group were retained in the program at 12 months.¹⁰ The treatment response rates were 67.0 percent and 47.7 percent in the DAM and MMT groups, respectively.¹¹

In the DAM group, 63.5 percent achieved both primary outcomes, while only 35.1 percent of the MMT group did the same.¹² In addition, there were marked improvements in both physical and psychological health scores in both groups, particularly during the early phase of the treatment.¹³

The primary outcomes were similar between those receiving heroin

(DAM) and those receiving HMO. In addition, most participants did not seem to be able to distinguish between the two drugs.¹⁴

Further research is needed to establish that HMO is in fact as effective as heroin-assisted therapy. If this is proved, HMO could provide a legal, less politically contentious alternative to prescription heroin for treatment of chronic opioid addictions.¹⁵

Approximately 60 000 to 90 000 people in Canada are addicted to illicit opiates such as heroin.¹⁶ MMT is the current standard of care, and is effective in many cases. This study suggests that prescription heroin or HMO may be an effective alternative for those suffering from chronic opiate addiction for whom other treatments, including MMT, have proven ineffective. Further data analysis and follow-up with participants will continue into 2009.

— Alison Symington

¹ The NAOMI Study Team, *Reaching the Hardest To Reach — Treating the Hardest To Treat: Summary of the Primary Outcomes of the North American Opiate Medication Initiative (NAOMI)*, 17 October 2008, at www.naomistudy.ca/pdfs/NAOMI.Summary.pdf.

² *Ibid.*, p. 7.

³ *Ibid.*, pp. 5–6.

⁴ *Ibid.*, pp. 7–8.

⁵ *Ibid.*, p. 3.

⁶ *Ibid.*, p. 3.

⁷ North American Opiate Medication Initiative (NAOMI), *Status Report*, October 2008, p. 2.; North American Opiate Medication Initiative (NAOMI), *Questions and Answers*, April 2006, p. 5. Available via www.naomistudy.ca.

⁸ NAOMI Questions and Answers, p. 5.

⁹ The NAOMI Study Team, p. 4.

¹⁰ *Ibid.*, p. 10.

¹¹ *Ibid.*

¹² *Ibid.*, p. 11.

¹³ *Ibid.*, p. 15.

¹⁴ *Ibid.*, p. 12.

¹⁵ *Ibid.*, p. 18.

¹⁶ NAOMI Status Report, p. 3.

New excessive demand policy for immigration applicants

Under a new policy adopted in September 2008, Citizenship and Immigration (CIC) officers must now consider all evidence presented by an immigration applicant before making a decision of inadmissibility due to excessive demand on social services. Evidence regarding both ability and intent to mitigate the cost of social services in Canada must be considered, if presented.¹

In the 2005 decisions of *Hilewitz v. Canada* and *de Jong v. Canada*,² the Supreme Court of Canada held that the personal circumstances of two immigration applicants who had applied under the “investor” and “self-employed” classes set out in the *Immigration Act* were relevant factors in an assessment of their anticipated impact on social services.

In the Court’s view, consideration of an applicant’s ability and intention to pay for social services is necessary to determine realistically what “demands” will be made. The threshold as to whether an individual’s medical condition might reasonably be expected to result in excessive demand is reasonable probability.

The Federal Court of Appeal subsequently held in *Canada v. Colaco* that such individualized assessments also applied to skilled worker applicants.³

Accordingly, the CIC issued an Operational Bulletin which states that *Hilewitz* and *De Jong* apply to all categories of immigrants. The bulletin says that immigration applicants should “provide the officer with information of sufficient quality and detail to permit an assessment of the probable need for social services.”⁴ The bulletin also says that immigration applicants “may provide evidence of ability and intent to reduce the cost impact on Canadian social

services, and this would have to be considered in making a decision.”⁵

Commentary

Individualized assessments of immigration applicants presumably allow prospective immigrants greater opportunities to prove they do not pose an “excessive demand” on social services, but the implications of CIC’s new policy for prospective immigrants who are HIV-positive are not clear.

Historically, HIV-positive immigration applicants have been denied entry into Canada on the basis they may access government-subsidized health care for their HIV treatment once they are in Canada. Since CIC’s new policy refers only to individualized assessments of probable need for social services, *and not health services*, HIV-positive immigration applicants do not have the same opportunity to prove they could offset the cost of any anticipated demand on health care services.

In *Hilewitz*, the Supreme Court observed that social services are regulated by provincial statutes, and that the relevant legislation in Ontario, where both plaintiffs had expressed their intention to live, manifestly contemplated the possibility of financial contributions from families able to make them.

The Court said that even if the plaintiffs’ stated intentions to privately fund their anticipated use of social services did not materialize, the financial resources of both families were such that they likely would be required to contribute a substantial portion, if not the entirety, of the costs associated with certain social services provided by the province.

Similarly, health services in Canada are regulated by provinces, and entitlement to government-subsidized prescription drug coverage may be based on income, age and disability, among other factors, depending on the province of residence.⁶

In Ontario, for example, subsidized drug coverage is only provided to people 65 years of age and older, people on social assistance, people residing in homes for special care and long-term care homes, people receiving professional home care services, and individuals with high prescription drug costs in relation to their net household incomes.⁷

Since prescription drugs will constitute the bulk of health care costs for many HIV-positive immigration applicants, they ought to be able to argue that the cost of HIV medication will be individually borne, and therefore does not pose an “excessive demand” on health services, an argument that should have more leverage

in provinces where prescription drug coverage is less likely to be subsidized by the province.

However, this argument may not carry much weight, since the new CIC policy does not apply to health services.

– Sandra Ka Hon Chu

Sandra Ka Hon Chu (schu@aidslaw.ca) is a senior policy analyst with the Canadian HIV/AIDS Legal Network.

¹ CIC, "Assessing Excessive Demand on Social Services," Operational Bulletin 063, 24 September 2008.

² *Hilewitz v. Canada (Minister of Citizenship and Immigration); De Jong v. Canada (Minister of Citizenship and Immigration)*, [2005] 2 S.C.R. 706 (Supreme Court of Canada).

³ *Canada (Citizenship and Immigration) v. Colaco*, 2007 FCA 282 (Federal Court of Appeal) (CanLII).

⁴ CIC.

⁵ *Ibid.*

⁶ Canadian AIDS Treatment Information Exchange, *Access to HIV Drugs: Federal, Provincial and Territorial Drug Access Programs*, undated, at www.catie.ca/eng/Publications/drugaccess/drugaccessIndex.shtml.

⁷ Ontario Ministry of Health and Long-Term Care, *Ontario Drug Benefits: Questions and Answers*, 23 June 2008, at www.health.gov.on.ca/english/public/program/drugs/drugsfaq_dt.html.

British Columbia adopts *E-Health Act*

On 29 May, 2008, Bill 24 passed into law in British Columbia. The *E-Health (Personal Health Information Access and Protection of Privacy) Act* puts in place a framework for the establishment of government databases of personal health information.

The *E-Health Act* enables the Ministry of Health to implement a system of electronic health records that will be accessible by authorized persons throughout the province.

The Act allows the collection, use and distribution of personal health information through health information banks for a range of purposes — including to provide health services to an individual, to prevent or manage chronic conditions, to facilitate health insurance or health service billing, to assess and address public health needs, to engage in health service planning, and to conduct research.¹

The Act requires the minister to allow individuals whose personal health information is contained in the health information bank to make "disclosure directives."² By writing a disclosure directive, a person can limit

the use or disclosure of their personal health information, in effect masking some of the information so that it is not available to users of the system.

The minister can limit the making of disclosure directives to one or more types of personal health information, one or more purposes, and one or more persons or classes of persons.³

The Act requires the minister to appoint a data stewardship committee, to be composed of not more than 12 persons — including one person from within the ministry; one representative of regional health boards or the Provincial Health Services Authority; one person nominated by each of the council of the College of Physicians and Surgeons of British Columbia, the council of the College of Pharmacists of British Columbia

and the board of the College of Registered Nurses of B.C.; a health researcher; and three representatives of the general public.⁴

The data stewardship committee can make recommendations to the minister that disclosure directives should not apply to a specific health information bank.⁵ The data stewardship committee will also be tasked with reviewing requests for information for planning and research purposes.⁶

Under the Act, the data stewardship committee may approve requests for personal health information to be used for health research only if: the research cannot reasonably be accomplished unless personal health information is disclosed; the information is not used for the purpose of contacting a person to participate in

research, unless the privacy commissioner approves it; the information disclosure is not harmful to the individuals concerned and the benefits to be derived are clearly in the public interest; and the data stewardship committee has imposed conditions relating to security, confidentiality, removing of individual identifiers and subsequent use or disclosure of the information.⁷

The Act also sets out that a person may access his or her own personal health information and disclosure directives that are contained in a health information bank, as well as information regarding who has collected, used or disclosed that person's health information.⁸ Finally, the Act contains provisions for information-sharing agreements, a provider registry and whistleblower protection, offences and regulations.⁹

Commentary

While the government's stated intention with the e-Health project is to provide better health care to citizens of British Columbia, critics charge that the *E-Health Act* does not adequately address privacy and confidentiality concerns.

The B.C. Persons with AIDS Society, the B.C. Freedom of Information and Privacy Association, the B.C. Civil Liberties Association and the B.C. Coalition of People with Disabilities were involved in the consultation process leading up to the adoption of the Act. They pushed for the right of patients to control their own personal health information to be enshrined in the Act, with only strict limited exceptions for emergencies and audits.¹⁰

Critics also noted that the disclosure of personal health information permitted under the Act includes a

wide range of purposes for which it is not necessary. For example, the Act allows officials to collect and use personal health information for purposes of health services planning, maintenance and improvement, but aggregate information would be sufficient for these purposes.¹¹

Similarly, the act permits the disclosure of personal health information to researchers without the patient giving informed consent.¹² It also permits the disclosure of personal health information to many government employees and even outside Canada without the express consent of the patient.¹³

Given the sensitivity of the information at issue — including medical records, prescriptions, test results, etc. — safeguards to protect privacy are particularly important. As explained by Ross Harvey, of the B.C. Persons with AIDS Society:

For HIV-positive people trying to keep their serostatus confidential in their home communities, the problems with this system are obvious. The potential for unauthorized people to find out about their serostatus is enormous — especially in smaller centres where there may be only one pharmacy, for example. This can lead to cruel and destructive discrimination if their HIV-positive status becomes public knowledge.¹⁴

The e-Health initiative will be implemented incrementally, with different databases and privacy protections being brought on-line in stages. This has raised further concerns amongst advocates that an individual's personal health information may be accessible before the systems are in place for that individual to place disclosure directives on his or her medical records.

In addition, the e-Health system may ultimately be integrated into a larger "integrated case management system" that allows information sharing between different government departments, such as Children and Family Development, and Employment and Income Assistance.¹⁵

It is expected to take several years for BC's e-Health system to be fully developed and implemented. Alberta already has a similar system in place, and several other provinces are working towards electronic health information-sharing systems.

— Alison Symington

¹ *E-Health (Personal Health Informational Access and Protection of Privacy) Act*, 29 May 2008, ss. 4 and 5.

² *Ibid.*, s. 8(1).

³ *Ibid.*, s. 8(2).

⁴ *Ibid.*, s. 12 (1) and (2).

⁵ *Ibid.*, s. 8(3).

⁶ *Ibid.*, s. 14.

⁷ *Ibid.*, s. 15.

⁸ *Ibid.*, s. 17(1).

⁹ *Ibid.*, ss. 19–26.

¹⁰ British Columbia Persons with AIDS Society, "Government wants carte blanche over your personal health information: privacy advocates take aim at BC Government's e-Health legislation," news release, Vancouver, 23 April 2008.

¹¹ *E-Health Act*, s. 4(g); *Briefing Note: eHealth, Bill 24 and Individual Consent*, 20 May 2008, presented to the Hon. George Abbott, Minister of Health, by Representatives of the B.C. Civil Liberties Association, the B.C. Coalition of People with Disabilities, the B.C. Freedom of Information and Privacy Association and the B.C. Persons with AIDS Society, pp. 5–6 [on file with author].

¹² *E-Health Act*, s. 15; *Briefing Note*, p. 7.

¹³ *Briefing Note*, pp. 6–10.

¹⁴ R. Harvey, "Big brother is coming" *living +*, July-August 2008, p. 8.

¹⁵ *Ibid.*, p. 9.

(Most) political parties respond to questionnaire on AIDS issues during federal election

During the recent federal election campaign, the Canadian HIV/AIDS Legal Network and the Interagency Coalition on AIDS and Development sent out a questionnaire to the leaders of the five main federal political parties asking about their parties' positions on several key issues related to HIV/AIDS.¹ The Liberals, New Democratic Party (NDP), Bloc Québécois and Green party responded. The Conservative Party did not.²

(On October 14, Canadians went to the polls in a federal election. The Conservative party won 143 ridings [up from 127 in the 2006 election] and the Liberal party was elected in 76 ridings [down 19 seats]. Bloc Québécois candidates were elected in 50 ridings, the NDP in 37, and two independents held on to their seats.)³

The questionnaire contained seven questions addressing Canada's Access to Medicines Regime; harm reduction services; prison needle exchange programs; funding for research on new HIV prevention technologies; strengthening health systems in developing countries; contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria; and funding for the Federal Initiative to Address HIV/AIDS in Canada.

With respect to streamlining Canada's Access to Medicines Regime, the Liberal party indicated that it would favour improving the Regime in order to improve accessibility for those in need of life-saving medicines. The NDP indicated that it would move to make whatever adjustments are necessary to overcome the obstacles that have arisen.

The Bloc Québécois stated that it would carefully monitor the results

and in due course ask a parliamentary committee to look at problems with the current mechanisms. The Green Party indicated that it would support Canada's Access to Medicines Regime, balancing Canada's trade and intellectual property obligations with the urgency of the humanitarian objective.⁴

On the issue of supporting harm reduction services as a component of an overall federal strategy on drugs, the Bloc acknowledged the positive aspects of harm reduction services and indicated that provinces have the authority and competence to open supervised injection facilities as medical services. The Liberal Party indicated that it would like to see continued support for the supervised injection facility in Vancouver and its success replicated across the country.

The NDP stated that it has consistently supported harm reduction strategies — including supervised injection facilities — as a pillar of its approach to health problems arising from drug use. The Green Party also indicated its support for supervised injection facilities and needle exchange programs.⁵

Finally, when asked whether the party would implement needle

exchange programs in Canadian prisons, the Bloc Québécois, Liberal Party and NDP all expressed their support. The Green Party stated that it does not currently have a policy on this issue, but was eager to develop partnerships towards improving the health of prisoners and the public at large.⁶

– Alison Symington

¹ Letter dated 15 September 2008, available via www.aidslaw.ca/election2008.

² The responses are available via www.aidslaw.ca/election2008.

³ "Harper 'very pleased' with stronger minority," *CBC News*, 15 October 2008.

⁴ The responses.

⁵ *Ibid.*

⁶ *Ibid.*

Immigration and Refugee Protection Act amended

With the passage of Bill C-50 (*Budget Implementation Act, 2008*) in June 2008, proposed changes to the *Immigration and Refugee Protection Act (IRPA)* contained in Part 6 of Bill C-50, were adopted.

As reported in Vol. 13(1) of the *Review*, the amendments give the Minister of Citizenship and Immigration increased discretion with respect to various aspects of the immigration and refugee application process.¹ Notably, humanitarian and compassionate applications no longer have to be examined if the applicant is outside Canada, and the ministry will now have the power to decide the order in which applications will be processed.

Critics charge that the changes give too much arbitrary power to the Minister to decide what kinds of immigrants will be allowed to enter Canada, and that there will be a lack of checks and balances in the decision-making process.²

Moreover, immigration applicants lose their legal right to receive a visa even if they meet the requirements of the law, and the processing of family reunification applications will be deprioritized in favour of skilled workers' applications.³

Finally, according to the critics, IRPA amendments should not be included in a budget bill, but rather dealt with through separate legislation and debated on their own merits.⁴

In July and August 2008, then Minister of Citizenship and Immigration Diane Finley consulted with stakeholders on the implementation of the recently adopted amendments in a round of invitation-only meetings.

An online questionnaire and the possibility of sending comments by email were available to stakeholders not invited to participate in the consultation meetings. The consultations focused on aligning the immigration system with labour market needs and did not address the full range of issues associated with the IRPA amendments.⁵

Commentary

The ultimate impact of these amendments on persons living with or affected by HIV will depend on the ministerial instructions that are ultimately adopted, and future revisions of those instructions.

As long as the priority remains on satisfying labour market needs through immigration, as opposed to fully considering immigrants' rights, needs and contributions to Canadian society, there is reason to be concerned that the amendments will

increase the obstacles already facing people living with or affected by HIV who seek to enter Canada.

– Alison Symington

¹ A. Symington, "Changes to the *Immigration and Refugee Protection Act* proposed in 2008 Budget," *HIV/AIDS Policy and Law Review*, Vol. 13(1) (2008): 32–33.

² Ontario Council of Agencies Serving Immigrants (OCASI), "OCASI deputation on changes to the IRAP under Bill C-50," online at <http://ocasi.org/index.php?qid=967>.

³ *Ibid.*

⁴ *Ibid.*; Canadian Council for Refugees, "10 reasons to be concerned about proposed amendments to Immigration and Refugee Protection Act in Bill C-50," online at www.ccrweb.ca/documents/c50tenreasons.htm.

⁵ OCASI, "OCASI comments on CIC's consultation on the new process for the selection of immigrants," online at www.ocasi.org/index.php?qid=976.

In brief

Federal Government announces new strategy to eliminate illegal drugs in federal prisons

The Honourable Stockwell Day, Minister of Public Safety, announced on 29 August 2008 that \$120 million in funding will be provided over five years to help detect and eliminate illegal drugs in federal prisons. According to Public Safety Canada, the prison anti-drug policy will:

- expand significantly the drug detector dog program at all federal prisons;
- increase security intelligence capacity in institutions and the surrounding communities;
- purchase new ION scanners, X-ray machines and other security equipment for maximum and medium-security federal prisons;
- enhance perimeter security around institutions, including technical support;
- implement a scheduled visits policy and better control drug entry points to federal prisons;
- introduce a zero tolerance drug searching policy at federal prisons; and
- protect children from being used to traffic drugs into prisons.¹

This new policy follows from a 2007 panel report on Correctional Services Canada that contained 109 recommendations on five issue areas, one of which was eliminating drugs from federal prisons.²

– Alison Symington

Manitoba passes forced testing legislation

The *Testing of Bodily Fluids and Disclosure Act* passed into law on 12 June 2008, with no amendments from the original text introduced by the Minister of Health in April 2008.

As reported in Vol. 13(1) of the *Review*, the legislation permits a person who has come into contact with a bodily fluid of another person to apply for a testing order if the contact happened as a result of being a victim of a crime, while providing emergency health services or first aid, or while performing duties as a firefighter or emergency medical responder.³

If a testing order is issued, the source person can be fined \$10,000 per day or imprisoned for a term up to six months if they do not comply with the order.⁴

– Alison Symington

Alberta to make personal medical information available on-line

Alberta will be the first province to allow patients to access their personal medical records via the internet. A web portal is being developed that will allow residents of Alberta to access their own health information, including such things as vaccination records, prescriptions, X-ray and laboratory test results, as well as educational information on various health-related topics.⁵

Initially, limited information will be available. Over time, the intention is to make a patient's complete medical record accessible via the website.⁶

The executive director of information management for Alberta Health reportedly stated that security and privacy concerns will be paramount as the new e-health service is developed.⁷ Confidentiality of personal health information and the possibility of security breaches are issues of concern with respect making medical information available electronically.

Alberta's auditor general has warned that government records in the province are not as secure as they should be. The auditor-general found numerous vulnerabilities in the government websites that were tested.⁸

Alberta already has a website hosting a province-wide electronic health record system that is accessible to health care providers.⁹ Other provinces are pursuing similar initiatives.

– Alison Symington

¹ Public Safety Canada, "Government takes action to eliminate drugs in federal prisons," news release, Agassiz, British Columbia, 29 August 2008.

² See A. Symington, "Independent review of prisons released," *HIV/AIDS Policy & Law Review* 13(1) (2008): 33.

³ A. Symington, "Manitoba legislation would authorize testing for HIV without informed consent," *HIV/AIDS Law & Policy Review* 13(1) (2008): 27–28.

⁴ *The Testing of Bodily Fluids and Disclosure Act*, S.M. 2008, c. 19, s. 20.

⁵ K. O'Neill, "Alberta first to offer medical information online," *Globe and Mail*, 17 October 2008.

⁶ *Ibid.*

⁷ *Ibid.*

⁸ Auditor General Alberta, *Report of the Auditor General of Alberta, October 2008*, pp. 57–60.

⁹ www.albertanetcare.ca/.

INTERNATIONAL DEVELOPMENTS

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

Mexico: General Recommendations issued against mandatory HIV testing and discharge from armed forces

In September and October 2008, Mexico's National Human Rights Commission (NHRC) issued three separate Recommendations addressing the practice of mandatory HIV testing and discharging HIV-positive personnel from Mexico's armed forces.

On 11 September 2008, the NHRC issued Recommendation 45 of 2008, which concerned the case of two naval personnel.¹ Following their diagnosis as being HIV positive, one was stood down from active duty and forced to retire, while the other was

considered “discharged for uselessness” (*“retiro por inutilidad”*).

The Commission found that the Navy had violated the two staff persons' right to equality and right to be free from discrimination. The Commission recommended that the

Secretary of the Navy “make amends for the material and moral damage” inflicted on the two people and that their discharge from service be annulled.

On 23 September 2008, the NHRC issued Recommendation 49 of 2008,

which concerned the case of three national defense (i.e. army) personnel.² All three had been discharged following their HIV-positive diagnosis.

The Commission found that the Secretary of National Defense had violated the three persons' right to equality and right to be free from discrimination. It recommended that the Secretary of National Defense "make amends for the actual and moral damage" inflicted on the three people and that their discharge from service be annulled.

Shortly after these two cases, on 15 October 2008, the NHRC released another Recommendation directed at the Secretary of National Defense.³ This Recommendation concerned the case of an employee of the national defense force, referred to as A1.

In August 2005, the Company to which A1 belonged was ordered to attend a military hospital and undergo HIV testing. A1 tested positive and, subsequently, the test results were made known to the Company commander without A1's authorization. Shortly afterwards, A1 was discharged.

The Commission found violations of the rights to equality and the right to be free from discrimination. It criticized the policy of discharging HIV-positive military personnel in the following terms:

[T]his approach contributes to the marginalization of these people and translates to a discriminatory act on the basis of health status, as well as impeding them, on the basis of the presence of the illness, from receiving the social security payments that legally enable them to receive the medical care necessary to control this same illness.⁴ [translation]

The Commission also found that the military had violated Mexican law that establishes HIV testing must only take place where there is informed consent by the person being tested and confidentiality of test results.⁵ As well as recommending that the Secretary of National Defense provide redress for the moral damage occasioned to A1, and that A1's order of discharge be annulled, the Commission recommended that the military authorities:

take the necessary measures so that the Secretary of National Defense abstain from undertaking HIV tests on its personnel without previously obtaining express, specific, unequivocal and informed free consent, and respect the confidentiality [of the results of the same]; which means that whoever agrees to undertake this analysis will do it with sufficient understanding and in a voluntary manner and be certain that the right to confidentiality regarding the [health] record will be respected. [translation]

The two Recommendations to the Secretary of National Defense were accepted.⁶ Once accepted, the institution normally has a period of a month to demonstrate to the NHRC that it has followed the Recommendation. The Recommendation to the Navy was rejected.⁷ The complainants may proceed before the courts.

All three Recommendations cited the 2007 decision by Mexico's National Supreme Court of Justice that ruled unconstitutional an article of the Social Security Law for the Armed Forces.⁸ This law was invoked in the discharges of all personnel. The law determines that military personnel who have certain diseases or accidents are to be discharged. The list of diseases includes

HIV seropositivity.⁹ All three Recommendations cite the reasoning in the Supreme Court's decision, namely:

The legislator, through [creating] the legal recourse to discharge, intends to protect the efficacy of the armed forces, as well as to protect the integrity of its personnel and third parties, which are constitutionally valid goals; however, the said regulation creates a legal distinction between personnel of the Mexican Armed Forces that violates the guarantees of equality and no discrimination on the basis of health status found in article 1 of the Political Constitutional of the United States of Mexico.

It lacks proportionality and legal reasonableness, given that 1) it is inadequate to achieve the intended outcome, because medical science (as reflected in various national and international guidelines) has demonstrated the inexactitude of assuming that those that those carrying the said virus are — *per se* — casually contagious and thus inherently unable to carry out required functions within the Army; 2) it is disproportionate, because the legislator, to achieve the stated objective, had at his or her disposition less damaging alternatives, given that military law makes possible to transfer someone to a different area, according to their physical abilities that develop during an illness ... ; 3) it lacks legal reasonableness, as there are no reasons to justify the legislator's association of the illness with a lack of ability....¹⁰ [translation]

Despite this decision by Mexico's National Supreme Court of Justice, the law continues to be applied.

— Richard Pearshouse

¹ National Human Rights Commission [Mexico], "Regarding discrimination on the basis of health status against naval personnel suffering from HIV," Recommendation 45/2008, 11 September 2008. The full text (in Spanish) of this Recommendation is available at www.cndh.org.mx/recomen/2008/045.htm.

² National Human Rights Commission [Mexico], "Regarding discrimination on the basis of health status against national defence personnel suffering from HIV," Recommendation 49/2008, 23 September 2008. The full text (in Spanish) of this Recommendation is available at www.cndh.org.mx/recomen/2008/049.html.

³ National Human Rights Commission [Mexico], "Regarding discrimination on the basis of health status," Recommendation 52/2008, 15 October 2008. The full

text (in Spanish) of this Recommendation is available at www.cndh.org.mx/recomen/2008/052.html.

⁴ National Human Rights Commission [Mexico], "Regarding discrimination on the basis of health status," Recommendation 52/2008.

⁵ Official Mexican Rule for the Prevention and Control of Human Immunodeficiency Virus Infection, NOM-010-SSA2-1993 (Norma Oficial Mexicana NOM-010-SSA2-1993 para la Prevención y Control de la Infección por Virus de la Inmunodeficiencia Humana).

⁶ "Sedena (Secretary of National Defense, acronym in Spanish) accepts NHRC recommendation on HIV case," *El Universal*, 6 November 2008. See www.eluniversal.com.mx/notas/553283.html.

⁷ "NHRC concerned by Semar (Secretary of Mexico's Marines and Navy, acronym in Spanish)'s rejection of recommendations on HIV cases," *El Universal*, 30 September 2008. See www.el-universal.com.mx/notas/vi_542875.html.

⁸ See R. Pearshouse, "Mexico: Supreme Court rules discharge of HIV-positive troops unconstitutional" *HIV/AIDS Policy & Law Review* 12(1) (2007): 47–48.

⁹ Article 226, category II, no. 45 of the Social Security Institute Law for the Armed Forces (la Ley del Instituto de Seguridad Social de las Fuerzas Armadas).

¹⁰ Cited in National Human Rights Commission [Mexico], "Regarding discrimination on the basis of health status against naval personnel suffering from HIV," Recommendation 45/2008.

Cambodia: human trafficking legislation threatens HIV response

In February 2008, Cambodia's new *Law on the Suppression of Human Trafficking and Sexual Exploitation* was promulgated and went into effect. The law criminalizes sex for money, public soliciting for prostitution and many forms of financial transactions connected to sex work.¹ The law has been criticized for conflating sex work and trafficking.²

Following the adoption of the law, police began a widespread crackdown on brothels and street-based sex workers.³ According to the Cambodian human rights organization Licadho, the crackdown against sex workers was part of a wider campaign against socially marginalized populations. Licadho found that

the government has been removing the homeless, beggars and sex workers and dumping them in two detention centers supposedly for rehabilitation and education. The reality however is that these people are being unlawfully detained and forced to live in appalling conditions where meals consist of a small plastic bag of rice, and a buck-

et in the middle of the room serves as a communal toilet.⁴

According to another observer,

a number of sex workers were arrested and brothels closed across the country. The sex workers were sent to rehabilitation centres where they were held in communal cells without bathrooms or running water. They received little food and some reported being beaten or raped. Those living with HIV were reportedly denied antiretroviral drugs (ARVs).⁵

One outcome of the crackdown among sex workers has been an increased fear that condoms may be

considered evidence of a crime, making sex workers reluctant to carry and use them. One news report quotes Srey Mao, a Phnom Penh-based sex worker, as follows:

When the police come, I run down into a hole, and sometimes I climb up a tree, not daring to bring a condom along because if the police find it, they will accuse me of prostitution and disorder.⁶

The police crackdown met significant resistance. On 16 June 2008, around two hundred Cambodian sex workers protested the police repression.⁷ According to a United Nations, donor and civil society position statement,

implementation of the law is “having serious negative public health consequences and threatens Cambodia’s remarkable success in cutting HIV prevalence from 2.0 percent in 1998 to 0.9 percent in 2007.”⁸

UNAIDS Cambodia country coordinator Tony Lisle stated that “[the human trafficking legislation] has had unintended consequence that have interrupted HIV prevention services in the sex industry.”⁹ According to Lisle, NGOs are having “significant” difficulty working on HIV prevention among sex workers because they working from the streets and bars as opposed to brothels, in order to evade police.¹⁰

In 1999, Cambodia adopted a 100 percent condom use policy that mandated the provision of condoms in all brothels. The policy has been credited as a main factor in a decline in Cambodia’s HIV prevalence rates. Between 1998 and 2003, HIV prevalence was almost halved among brothel-based sex workers, and decreased significantly among non brothel-based

sex workers.¹¹ According to Tia Phalla of Cambodia’s National AIDS Authority, “Enforcement of the anti-trafficking law harms the 100 percent condom use in brothels.”¹²

Cambodia’s human trafficking law should be considered against the backdrop of annual assessments by the U.S. Department of State of national efforts to combat human trafficking. In 2006 Cambodia was elevated from the U.S. Department of State list’s lowest designation (“Tier 3”) and remained on the higher “Tier 2 Watch” until 2008, when it was upgraded to “Tier 2.”¹³ Significant amounts of funding are reportedly at risk should the country be downgraded.¹⁴

– Richard Pearshouse

¹ U. Singh, “Case study: Cambodia’s law on suppression of human trafficking and sexual exploitation,” HealthDev.net, at <http://healthdev.net/site/post.php?s=3840>.

² C. Barton, “Brothel busts drive sex workers underground,” *Phnom Penh Post*, 15 May 2008.

³ S. Ratana, “Condoms feared criminal in sex crackdown,” *Voice of America (VOA)*, 2 September 2008. Available via www.voanews.com.

⁴ Licadho: Cambodian League for the Promotion and Defence of Human Rights, “Cambodian Government operating unlawful detention camps in Phnom Penh, locking up homeless, beggars and sex workers,” 2 July 2008, at www.licadho.org/articles/20080702/79/index.html.

⁵ U. Singh, “Effective advocacy against law on suppression of human trafficking,” HealthDev.net. Available via <http://healthdev.net/site/post.php?s=3839>.

⁶ S. Ratana.

⁷ “Cambodian sex workers gather at Buddhist temple to protest against crackdown,” *The Associated Press*, 16 June 2008.

⁸ C. Barton.

⁹ “Cambodia: Human trafficking crackdown also hits HIV prevention,” *IRIN/PlusNews*, Phnom Penh, 21 October 2008.

¹⁰ *Ibid.*

¹¹ N. Chaya, “Cambodia and HIV: Winning round two of a preventative fight,” *Research Commentary: Population Action International* 1 (7): 3. Some sex worker organizations have criticized 100 percent condom use programs, particularly where such programs are designed without meaningful involvement of sex workers and where the programs involve inspection and supervision of sex workers by police or the military. See, for example, Network of Sex work Projects, “The 100% condom use program: a sex workers’ rights perspective,” January 2003, at www.nswp.org/safety/100percent.html.

¹² “Cambodia faces new HIV threat as ‘condom campaign at risk,’” *Agence France Presse*, Phnom Penh, 10 September 2008.

¹³ Embassy of the United States, Phnom Penh, Cambodia, “Cambodia placed on Tier 2 in 2008 Trafficking in Persons report,” press release, Phnom Penh, 5 June 2008, at http://cambodia.usembassy.gov/pr_060508.html.

¹⁴ C. Barton.

U.S.: Interim step towards elimination of HIV travel ban

On September 29, 2008, the U.S. Department of Homeland Security (DHS) promulgated new regulations streamlining the travel authorization process for people living with HIV wishing to enter the United States as non-immigrants.¹

Previously, HIV-positive travelers applying for a U.S. visa had to get case-by-case authorization from

DHS, which took, on average, 18 days.² Under the new regulations, people living with HIV who meet

regulatory requirements may receive authorization from local consular officers, without needing specific

authorization from DHS, to enter the U.S. on a 30-day visa. In most cases this authorization can be given on the same day as the interview.

The new regulations are a response to a December 2006 directive by President George W. Bush instructing DHS to adopt regulations that would create a streamlined process for authorizing HIV-positive non-immigrants to enter the U.S.³

The ban on HIV-positive individuals entering the United States has been in force since 1987. In 1987, U.S. Department of Health and Human Services (HHS) first placed HIV and AIDS on its list of dangerous and contagious diseases that could be used as a basis for preventing foreign individuals from entering the U.S.⁴ The HIV travel ban was codified in the 1993 reauthorization for the National Institutes of Health.⁵

In July 2008, President George W. Bush signed the reauthorization bill for the President's Emergency Plan for AIDS Relief (PEPFAR), which removed the statutory ban on travel and immigration to the United States by HIV-positive individuals.⁶

HIV remains on the HHS list of "communicable disease[s] of public health significance," for which infected individuals may be prevented from entering the country. The President's bill did not require the HHS to strike HIV from this list.⁷ This is why a regulatory change was needed to complete the process of lifting the ban.

The new regulations still contain the old regulations' requirements that HIV-positive individuals wishing to travel to the U.S. must not exhibit symptoms of active infections associated with HIV. HIV-positive individuals must also prove that their presence in the U.S. poses a minimal

risk of transmission and minimal danger to public health; that no United States agency will incur any costs as a result of the traveler's presence in the country; and that they have sufficient appropriate medication and financial assets to cover the cost of any potential medical care they may require.

However, the new regulations add a requirement that HIV-positive individuals who enter the U.S. under the streamlined authorization process must waive their opportunity to apply for an extension of their stay, or to apply for an adjustment of status to that of permanent residency.⁸

In the preamble to the new regulations, DHS stated that the new rules are categorical, meaning that "authorization is granted ... to any alien applicant who meets the requirements and conditions" of the regulation.⁹ However, the text of the regulation itself states that authorization "may be issued" by consular officers.¹⁰ Thus, it is unclear to what extent consular officers have the discretion to deny authorization to HIV-positive applicants who meet the regulatory requirements described above.

Although the regulations provide little detail on how consular officers are to make determinations about particular individuals' financial services, access to appropriate medicines, and risk to public health, DHS indicated that it has issued specific instructions to consular officers on how to evaluate applications.

Furthermore, the regulations noted the Department of State "has extensive experience processing applications under the existing HIV authorization process," which consular officers would draw upon.¹¹

DHS received some 700 comments during the public comment

period prior to promulgation of the final regulation. Many commentators were concerned that U.S. travel restrictions discriminate against people living with HIV, especially those from developing countries who may not be able to meet the financial regulatory requirements.¹² Many comments also emphasized that the requirements focusing on risk of transmission were outdated and no longer supported by medical science.¹³

In response to these concerns, DHS noted that the new regulations were an interim measure because HHS was expected to remove HIV from its list of communicable diseases.¹⁴ However, it is worth noting that no timeline has been announced for this step.

As with the old regulations, people living with HIV are not eligible for the Visa Waiver program. The Visa Waiver program generally allows residents of 27 countries (mostly in Europe, but also Australia, Brunei, Japan New Zealand, and Singapore) to enter the U.S. for up to 90 days without a visa.¹⁵

There does not appear to be a situation where the HIV status of travelers entering the U.S. under the Visa Waiver program would become known to U.S. authorities, and hence this allows people living with HIV from certain countries to enter the US despite their positive status.¹⁶

Currently, sixty-six percent of all non-immigrant, non-resident travelers admitted to the U.S. each year are from Visa Waiver countries, where the total average HIV prevalence rate is 0.2 percent (ranging from 1.1 percent to 0.1 percent).¹⁷

The HIV prevalence rates in countries not participating in the Visa Waiver program, especially in

developing countries in Asia, South America and Africa, are much higher. Thus, the HIV travel ban primarily impacts people living with HIV from developing countries.

— Anna Dolinsky

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Nonimmigrant Aliens Infected with HIV, 73 Fed. Reg. 58,023 (Oct. 6, 2008) (to be codified at 8 C.F.R. pts. 100, 212).

² *Ibid.* at 58,024.

³ White House, *Fact Sheet: World AIDS Day 2006*, at www.whitehouse.gov/news/releases/2006/12/20061201-2.html.

⁴ See 52 Fed. Reg. 22,149, 21,532 (Jun. 8, 1987); 52 Fed. Reg. 32,529, 32,541 (Aug. 28, 1987) (replacing AIDS with HIV on the list of dangerous, contagious diseases).

⁵ See P.L. 103-43, § 2007, 107 Stat. 82 (1993).

⁶ See Tom Lantos and Henry J. Hyde *United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008*, P.L. 110-293, 122 Stat. 2918 (2008) (amending P.L. 103-43, 107 Stat. 82 (1993)).

⁷ 42 C.F.R. 34.2 (2008)

⁸ 73 Fed. Reg. at 58,030 (to be codified at 8 C.F.R. § 214.4(f)(5)).

⁹ 73 Fed. Reg. at 58,026

¹⁰ 73 Fed. Reg. 58,030 (to be codified at 8 C.F.R. § 214.4(f)(2)).

¹¹ 73 Fed. Reg. at 58,029.

¹² See 73 Fed. Reg. 58, 025. DHS invited comments from the public in its notice of proposed rulemaking. See also 72 Fed. Reg. 62,593 (Nov. 6, 2007). These comments are summarized and addressed in the final regulations. The financial solvency requirement applies generally to all non-resident, non-immigrant individuals seeking a visa to enter the United States. See 8 C.F.R. § 217.2 (2008).

¹³ See 73 Fed. Reg. 58, 025.

¹⁴ *Ibid.*

¹⁵ See U.S. Department of State, *Visa Waiver Program* at http://travel.state.gov/visa/temp/without/without_1990.html.

¹⁶ Personal communication from Congressional staff member.

¹⁷ U.S. Department of Homeland Security, *Annual Flow Report, Non-Immigrant Admissions to the United States: 2007, 2008*; Central Intelligence Agency, *The World Factbook, HIV/AIDS Adult Prevalence Rate* (last updated 23 October 2008) at www.cia.gov/library/publications/the-world-factbook/rankorder/2156rank.html.

¹ Issuance of a Visa and Authorization for Temporary Admission into the United States for Certain

Global: Review of injecting drug use and HIV prevalence among users

In September 2008, *The Lancet* published one of the few worldwide estimates of the number of people who inject illicit drugs and of the prevalence of HIV among this population.¹

The researchers, the 2007 Reference Group to the United Nations on HIV and Injecting Drug Use, systematically reviewed both peer reviewed and non-peer reviewed (so-called “grey literature”) data covering 200 nations or territories. Of these 200 jurisdictions, injecting drug use was documented in 148.

The study estimates that, in 2007, 15.9 million people injected drugs in the 148 jurisdictions where use of injecting drugs had been documented. However, the range for this estimate

was between 11.0 and 21.2 million.

Within this population, the study found that “[e]xtrapolated estimates of HIV prevalence ... are extremely tenuous, but around 3 million (range 1–7 million) injectors might be living with HIV.”² The study notes that the largest populations of injecting drug users who are living with HIV are found in eastern Europe, east and south-east Asia and Latin America.

In nine countries — Argentina, Burma, Brazil, Estonia, Indonesia, Kenya, Nepal, Thailand and Ukraine

— HIV prevalence among people who inject drugs was over 40 percent. The largest numbers of injectors were found in China, the U.S. and Russia, where mid-estimates of HIV prevalence among people who inject drugs were 12 percent, 16 percent, and 37 percent, respectively.

The study claims that injection drug use and HIV infection among people who inject drugs are both major challenges to global public health. In a commentary accompanying the study, Kamyar Arasteh

and Don Des Jarlais, of Beth Israel Medical Center's Baron Edmond de Rothschild Chemical Dependency Institute in New York, note:

The one optimistic aspect of this rather gloomy situation is that, if HIV-prevention efforts are implemented on a large scale when prevalence is low in injecting drug users, it is possible to avert HIV epidemics in users. Thus it should be an imperative for both resource-constrained countries and international donors to implement large-scale evidence-based programs for HIV-prevention whenever there is an indication of a developing injecting-drug-use problem.³

Indeed, the study itself noted the success of certain countries in implementing HIV-prevention interventions among people who inject drugs, such as needle and syringe programmes, opioid substitution treatment and treatment and care for those who are living with HIV. According to the authors,

Australia and New Zealand have maintained very low levels of HIV

infection despite a higher prevalence of injecting than in some other countries; this difference has been attributed to geographic isolation, as well as the swift introduction of needle and syringe programmes when HIV infection was first noted in the 1980s.⁴

The study also expressed concern about the potential for drug use to emerge in countries where it is not yet established. In particular, the authors note that:

Little is known about injecting drug use in sub-Saharan Africa, but a constellation of risk factors exist for the development of injecting drug use, as has occurred elsewhere, for example in central Asia. First, injecting drug use is already well-established in a number of countries (Kenya, Mauritius, Nigeria, South Africa, and Tanzania). Second, socioeconomic hardship is common, and many people are exposed to conflict situations.

Third, many countries in the region are being increasingly used for the transit of illicit drugs into Europe. Because sub-Saharan Africa is a

region within particularly high HIV-1 prevalence, with a range of social and biological risk factors having a role, the potential emergence of injecting drug use as an additional route of HIV transmission warrants serious attention.⁵ [citations omitted]

– Richard Pearshouse

¹ B. Mathers et al, "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review," *The Lancet* (online edition), 24 September 2008. One of the few earlier published studies was C. Aceijas et al, "Global overview of injecting drug use and HIV infection among injecting drug users," *AIDS* 18 (2004): 2295–2303.

² B. Mathers et al at p. 10.

³ K. Arasteh and D. Des Jarlais, "Injecting drug use, HIV, and what to do about it," *The Lancet* (online edition), 24 September 2008.

⁴ B. Mathers et al at p. 11.

⁵ *Ibid.*

In brief

Uganda: Civil society expresses concern about HIV bill

A group of HIV activists in Uganda has recently forced the reconsideration of a problematic draft HIV bill. The "HIV and AIDS Prevention and Control Bill 2008" has been widely

criticized by people living with HIV in Uganda.¹ It was felt that instead of helping Uganda fight the epidemic, the draft bill in fact risked undermining the national response to HIV.

The draft bill was not in conformity with the *International Guidelines on HIV/AIDS and Human Rights*.² The bill contained a number

of problematic provisions, including: compulsory HIV testing for pregnant women; mandatory HIV testing of "a person convicted of drug abuse or being in possession of hypodermic instrument associated with drug abuse"; mandatory HIV testing of sex workers; and broad criminalisation of HIV transmission.

The draft bill also failed to provide for any initiatives to address the HIV-related vulnerability, needs and rights of vulnerable groups, such as women and girls, prisoners and men who have sex with men.

According to Paddy Masembe, the executive director of Young People Living with HIV/AIDS, “We should avoid creating scenarios where people living with HIV/AIDS are looked at as either criminals or potential criminals.”³ A formal statement by people living with HIV and AIDS in Uganda said, “We request the donor funding the HIV bill to please identify a more useful intervention to invest in rather than reverse the good success Uganda has achieved over the years.”⁴

The civil society criticism of Uganda’s HIV bill is welcome, given the recent trend to adopt similar HIV laws in a number of other African jurisdictions.⁵

– Richard Pearshouse

China: Hu Jia wins human rights prize

In October 2008, the European parliament awarded Hu Jia the Sakharov Prize for Freedom of Thought.⁶ The prize is Europe’s most prestigious human rights award.

The press release announcing the decision described Hu Jia as

a prominent human rights activist and dissident in the People’s Republic of China. He has embraced a wide range of causes, including environmental issues, HIV/AIDS advocacy and a call for an official enquiry into the 1989 Tiananmen Square massacre. He has also acted as a coordinator of the “barefoot lawyers movement.”⁷

Hu Jia began his AIDS activism in 2000. He has worked with the Beijing-based NGO Loving Source, a grassroots organization dedicated to helping people living with HIV and AIDS orphans.⁸

Hu Jia has been the Executive Director of the Beijing Aizhixing Institute of Health Education, which advocates for the rights of those living with HIV in China. He has previously been placed under house arrest (in 2004) and was detained by Chinese authorities in 2005 and again in 2006.⁹

On 26 November 2007, Hu Jia testified via conference call to the European Parliament’s Human Rights Subcommittee on human rights issues within China. He was under house arrest at the time.

Following a series of essays and interviews in which he criticized the human rights record of the Chinese Communist Party, he was arrested on 27 December 2007 and charged with “incitement to subvert state power.” On 3 April 2008, he was sentenced to three-and-a-half years’ in jail.¹⁰

Hu Jia remains imprisoned and his wife, also a human rights advocate, remains under house arrest.

– Richard Pearshouse

WHO commission reports on social determinant’s of health

In August 2008, the World Health Organization’s Commission on the Social Determinants of Health released a comprehensive global report on the links between economic and social conditions and physical and mental health.

The report, entitled *Closing the Gap in a Generation: Health*

Equity Through Action on the Social Determinants of Health, is the culmination of three years of research and investigation by a group of well-respected policy makers, academics as well as former heads of state and ministers of health.

The report states bluntly that “social injustice is killing people on a grand scale.”¹¹ According to the report

[s]ocial justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. A girl born today can expect to live for more than 80 years if she is born in some countries — but less than 45 years if she is born in others. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.¹²

The report was praised by editorials in both *The Lancet* and the *British Medical Journal*.¹³ The latter welcomed the report’s “unprecedented broad scope,” noting that

unlike many other reports that have focused on one country or on groups of countries at similar economic levels, the commission has produced a global picture of economic and social deprivation that makes it impossible not to recognise the importance of economic redistribution, health care, and the direct material consequences of poverty and social inequality across the life course on health...¹⁴

– Richard Pearshouse

INTERNATIONAL DEVELOPMENTS

¹ A. Bugembe, "AIDS activists reject Bill," *The New Vision*, 28 October 2008.

² UNAIDS and the Office of the High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version*, at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (English).

³ Quoted in A. Bugembe.

⁴ F. Kyomukama, "Statement by People Living with HIV and AIDS in Uganda," statement presented at the Joint Aids Review Conference and Partnership Forum, 13–17 October 2008, Kampala, Uganda.

⁵ For a discussion of these HIV laws, see the feature

story in this issue of the Review; see also R. Pearshouse, "Legislation contagion: the spread of problematic new HIV laws in Western Africa," *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 1–11.

⁶ European Parliament, "Sakharov Prize 2008 awarded to Hu Jia," news release, Strasbourg, 23 October 2008. Available via www.europarl.europa.eu.

⁷ *Ibid.*

⁸ Amnesty International, "Hu Jia jailed for three and a half years," news release, 4 April 2008. Available via www.amnesty.org.

⁹ M. Magnier, "EU honors Chinese activist Hu Jia for human rights work," *Los Angeles Times*, 24 October 2008.

¹⁰ J. Yardley, "Chinese activist is jailed," *New York Times*, 4 April 2008.

¹¹ WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, August 2008, at www.who.int/social_determinants/final_report/en/index.html.

¹² *Ibid.*, p. 1.

¹³ G. Smith and N. Krieger, "Tackling health inequities," *British Medical Journal* 337 (2008): 1526; "Editorial: Addressing the inequities of health care: a new and vital mandate," *The Lancet* 372(9640) (2008): 689.

¹⁴ G. Smith and N. Krieger.

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 Sandra Ka Hon Chu, Editor of this section, at schu@aidslaw.ca. Unless otherwise indicated, the articles in this section were written by Ms Chu.

Vancouver's supervised injection facility granted constitutional exemption from federal drug law

In a landmark decision on 27 May 2008, the B.C. Supreme Court held that because Insite — North America's only supervised injection facility (SIF) — provided health care, denial of access to Insite and safe injection would threaten individuals' rights to life, liberty and security of the person.¹

In September 2003, the Vancouver Coastal Health Authority, in partnership with the PHS Community Services Society (PHS), opened Insite, North America's first SIF. Insite operated under the purview

of an exemption from prosecution for possession of a controlled substance contrary to section 4(1) of the *Controlled Drugs and Substances Act* (CDSA), based on necessity for a scientific purpose.

The exemption was originally granted by the Minister of Health in 2003 and subsequently extended to June 2008.

PHS and its co-plaintiffs, Dean Wilson, Shelly Tomic and the

Vancouver Area Network of Drug Users (VANDU), launched separate actions seeking relief that would obviate the need for a ministerial exemption. In its action, PHS claimed that Insite is a health care undertaking and, therefore, a provincial concern which the federal government was interfering with.

In the alternative, PHS argued that the application of the CDSA to Insite was unconstitutional, deprived “persons addicted to one or more controlled substances of access to health care at Insite” and, therefore, violated the rights conferred by section 7 of the *Charter of Rights and Freedoms* to life, liberty, and security of the person.

VANDU sought a number of declarations, including a declaration that the CDSA does not apply to the medical treatment of persons addicted to a controlled substance at Insite, and a declaration that the offence of possession of all addictive drugs set out in the CDSA violates section 7 of the *Charter*.

After a review of the evidence, including the findings of the Expert Advisory Committee on Supervised Injection Site Research established by the federal Minister of Health,² the B.C. Supreme Court concluded that addiction is an illness; that “the use of unsanitary equipment, techniques, and procedures for injection” permits the transmission of HIV and hepatitis C; and that “the risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals.”³

While the Court acknowledged that Insite provides health care, it also recognized that the CDSA represented the use of Parliament’s criminal law power. Where there is

an operational conflict between the province’s initiatives in health care and the criminal law which is directed in part to health, the Court held the conflict must be resolved by the application of the doctrine of federal paramountcy, and so the criminal law must prevail.

With respect to the section 7 violation, the Court held that the CDSA interferes with drug users’ access to health care services that reduce the risks of morbidity and mortality, amounting to an unjustifiable infringement of the constitutional right to life, liberty and security of the person. In particular, the court held that

Section 4(1) of the CDSA ... prevents healthier and safe injection where the risk of mortality resulting from overdose can be managed, and forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death.

Moreover, the Court said, section 4(1) of the CDSA threatened security of the person because it “denies the addict access to a health care facility where the risk of morbidity associated with infectious diseases is diminished, if not eliminated.”⁴

Significantly, while the Government of Canada argued that the threat to life resulted from an individual’s choice to inject rather than state action, the B.C. Supreme Court recognized that “the subject with which these actions are concerned has moved beyond the question of choice to consume in the first instance,” and “the result is an illness called addiction.”⁵

Instead of being rationally connected to a reasonable apprehension

of harm, the Court found that “the blanket prohibition [on possession of controlled substances] contributes to the very harm it seeks to prevent. It is inconsistent with the state’s interest in fostering individual and community health, and preventing death and disease.”⁶

As such, the B.C. Supreme Court declared the relevant provisions of the CDSA inconsistent with the *Charter* and of no force and effect, and granted Insite an ongoing, constitutional exemption to permit its continued operation without fear of criminal prosecution of its users or staff.

The federal government was granted a one-year suspension of the effect of the declaration of constitutional invalidity so it could rewrite its laws to allow for the medical use of illegal drugs if they are part of a health-care program.

In response, the Government of Canada launched an appeal of this decision. The appeal is scheduled to be heard in April 2009.⁷

¹ *PHS Community Services Society v. Attorney General of Canada*, 2008 BCSC 661.

² Expert Advisory Committee on Supervised Injection Site Research, *Vancouver’s INSITE Service and Other Supervised Injection Sites: What Has Been Learned from the Research?*, Final Report, 31 March 2008, at www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/insite/index-eng.php.

³ *PHS Community Services Society* at para. 87.

⁴ *Ibid.* at para. 144.

⁵ *Ibid.* at para. 141.

⁶ *Ibid.* at para. 152.

⁷ “Court date set for Insite; appeal for safe-injection site to be heard next April,” *The Daily Courier* (Kelowna), 15 August 2008, p. A2.

HIV-positive man from DRC deemed a “person in need of protection”

In an *in camera* hearing on 9 July 2008, the Refugee Protection Division of the Immigration and Refugee Board of Canada, accepted that the manner in which the government of the Democratic Republic of the Congo (DRC) dealt with the HIV epidemic in its country posed a “risk to life” to an HIV-positive man from that country who was applying for asylum in Canada.¹

The applicant, whose identity was concealed, alleged that in August 2006, when he was living in Kinshasa, the capital of the DRC, he was mistaken for a man who had shot and killed a soldier during a confrontation between demonstrators and the DRC army. When members of the DRC army pursued the applicant, he fled his home and hid for several months in a friend’s house to escape capture.

In December 2006, the applicant left the country and travelled to the Congo, South Africa and the United States before he entered Canada in January 2007, where he sought asylum on the basis of being a Convention refugee or a “person in need of protection” pursuant to articles 96 and 97 of the *Immigration and Refugee Protection Act* (IRPA).²

During his hearing, the applicant presented a letter from his doctor which stated that he did not believe the applicant would be able to reliably access the medications, monitoring and care he required if he were to return to the DRC, “which would mean that his health would deteriorate to the point where he would

develop life-threatening complications of AIDS and die.”³

The Board accepted that the DRC government willfully neglects people with HIV and is willfully indifferent to the spread of HIV infection. This was demonstrated by the government’s unwillingness to pay for anti-retroviral treatment despite its many resources and its significant military expenditures; by the stigmatization of people living with HIV/AIDS in health care settings; and by the government’s tolerance of widespread rape by its military and police, which has led to HIV transmission.

While article 97 of the IPRA excludes “persons in need of protection” whose risk to life or risk of cruel and unusual treatment is caused by the inability of that country to provide adequate health or medical care, the Board held that when access to treatment to save one’s life is refused to a person for reasons similar to persecution, it was appropriate to confer the protection provided under Article 97.

In light of the evidence concerning the DRC government’s actions with respect to HIV, the Board concluded that it was more probable than not

that the applicant’s life was threatened, and that if he was deported to the DRC, the authorities would not provide him with adequate treatment. Therefore, the Board held that the applicant was a “person in need of protection,” and accepted his request for asylum.

¹ Immigration and Refugee Board of Canada, Refugee Protection Division, RPD File No. TA7-00219.

² Section 96 of *Immigration and Refugee Protection Act*, 2001, c. 27 defines a “Convention refugee” as a person who has “a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion.” Section 97 defines a “person in need of protection” as “a person in Canada whose removal to their country or countries of nationality or ... their country of former habitual residence, would subject them personally (a) to a danger, believed on substantial grounds to exist, of torture within the meaning of Article 1 of the Convention Against Torture; or (b) to a risk to their life or to a risk of cruel and unusual treatment or punishment if (i) the person is unable or, because of that risk, unwilling to avail themselves of the protection of that country, (ii) the risk would be faced by the person in every part of that country and is not faced generally by other individuals in or from that country, (iii) the risk is not inherent or incidental to lawful sanctions, unless imposed in disregard of accepted international standards, and (iv) the risk is not caused by the inability of that country to provide adequate health or medical care.”

³ Immigration and Refugee Board of Canada, p.2.

Federal Court sets aside decision denying Mexican couple's claim of persecution

On 11 April 2008, the Federal Court allowed the application of Castillo Ramirez and Viccon Palacios for judicial review of a decision by the Refugee Protection Division (RPD) of the Immigration and Refugee Board, which found that the applicants were neither Convention refugees nor persons in need of protection.¹

Ramirez and Palacios, both Mexican nationals, had been in a relationship for eight years, during which both were the victims of homophobic attacks and harassment. On 5 November 2005, in Mexico, the couple was arbitrarily stopped by a group of police officers who recorded their names and vehicle information. When Ramirez and Palacios refused arrest, the police threatened them with death, but ultimately released them.

Several days later, an unidentified person shot a bullet through the windshield of the car Ramirez and Palacios were driving. The couple was not injured and decided against reporting the incident for fear that it was the police who were responsible.

In the ensuing months, both Ramirez and his mother received threatening phone calls, one of which referred to the shooting. They reported these calls to the Office of the Attorney General for the Federal District. In March 2006, Ramirez and Palacios were followed for some distance by a police car. This led them to arrange to leave Mexico for Canada three days later, claiming protection upon their arrival.

In Canada, Palacios was diagnosed with HIV, which was raised as an additional element of his claim. Palacios alleged that he would not receive adequate medical treatment in

Mexico, that he would face discrimination from health care staff and that he would not be able to find employment on account of his HIV status.

The RPD held that there was evidence of treatment possibilities for people living with HIV in Mexico, and it was not established that the Mexican government would refuse to offer Palacios adequate treatment. The RPD further noted that even if Mexico was unable to provide sufficient medical services, this was expressly excluded as a basis for a claim for protection under the *Immigration and Refugee Protection Act*.

With respect to the claim of persecution, the RPD concluded that the incident of 5 November 2005 could not be counted as persecution against which there would be no state protection, since the police refrained from arresting Ramirez and Palacios. In the RPD's view, the police showed an awareness that their actions could be sanctioned in accordance with mechanisms put in place by the state.

The RPD also concluded that there was no indication that the police were making the threatening phone calls, and added that it did not believe Ramirez and Palacios. Finally, the RPD held that the couple failed to avail themselves of every means of obtaining domestic state protection.

The Federal Court held that the RPD's findings were to be reviewable against a standard of reasonableness. With respect to the claim relating to Palacios' HIV status, the Court said that the RPD dealt only with the availability and accessibility of medical services for those living with HIV and did not address the allegation that HIV-positive patients are discriminated against by health care staff in the provision of care and services.

Although Palacios alleged that Mexican employers conduct medical testing and would dismiss or refuse to hire HIV-positive workers, the Court found that the RPD also failed to address the allegation that Palacios would face discrimination in employment; and, therefore, that the RPD failed to consider whether the cumulative effect of all of the grounds raised by Ramirez and Palacios could amount to persecution.

The Court also found the RPD's statement that it did not believe Ramirez and Palacios problematic in its ambiguity. The Court said that this affected the intelligibility of the reasons advanced by the RPD. Moreover, given Ramirez' and Palacios' multiple and essentially fruitless attempts to seek the assistance of the authorities, the Court held the RPD should have articulated why it believed the couple had not

availed themselves of every means of obtaining domestic state protection.

The Court concluded the RPD's decision could not be qualified as

reasonable, set aside the decision, and ordered that the matter be reconsidered after a new hearing by a differently constituted panel.

¹ *Ramirez v. Canada (Minister of Citizenship and Immigration)*, [2008] F.C.J. No. 1028 (QL).

Court dismisses HIV-positive man's application for review of decision not to defer removal from Canada

On 7 July 2008, Wilson Gumbura sought judicial review of a decision by an enforcement officer not to defer his removal from Canada until a decision had been made on his humanitarian and compassionate application.¹

Gumbura, a citizen of Zimbabwe, arrived in Canada in 2001, at which time he made a refugee claim. The claim was rejected by the Immigration and Refugee Board because it did not find him credible. Gumbura subsequently made a Pre-Removal Risk Assessment application, which was denied in October 2004 on the ground that Gumbura had not established that he would be at risk upon his return to Zimbabwe.

Gumbura, his wife, and one of his seven children are HIV-positive. While in Canada, Gumbura had been convicted of fraud and related charges and had been incarcerated since February 2007. During his incarceration, Gumbura's children were under the care of their mother with support from the Children's Aid Society.

Gumbura had initially submitted a humanitarian and compassionate application in 2005, which had

been returned with a request that he re-submit a separate application for himself and his wife, which he did in November 2007.

Gumbura's request for deferral of his removal from Canada until his humanitarian and compassionate application could be determined was denied by the enforcement officer. However, his removal was stayed until the application for judicial review was disposed of.

The Federal Court held that the enforcement officer's findings were reviewable on a standard of reasonableness. The officer had considered Gumbura's HIV-positive diagnosis, but the fact that better medical care was available in Canada was not a ground for deferral. The Court also held that the issue of discrimination or stigma that Gumbura may face in Zimbabwe due to his HIV status was not a ground for deferral and was outside the scope of an enforcement officer.

The Court said that because Gumbura had not resided with his wife or children since February 2007, the removal of Gumbura would not affect the fact that the children would remain in Canada under the care of their mother. While Gumbura's wife and his three oldest children were not Canadian citizens, no steps had yet been taken to remove them. In the Court's view, the officer's responsibilities did not require him to undertake a substantive review of the children's best interests.

Finally, the Court held that a late-filed humanitarian and compassionate application did not warrant a deferral even if there had been a backlog in processing the applications. Accordingly, the Federal Court dismissed Gumbura's application.

¹ *Gumbura v. Canada (Minister of Public Safety and Emergency Preparedness)*, [2008] F.C.J. No. 1059 (QL).

Criminal law and cases of HIV transmission or exposure

Developments in Johnson Aziga case

Challenge to prospective jurors

In June 2008, Johnson Aziga, who is charged with first degree murder and aggravated sexual assault for having unprotected sex with 13 women without disclosing his HIV-positive status, applied to the Ontario Superior Court of Justice for an order allowing a challenge to prospective jurors for cause on the basis of racial bias, HIV bias and media publication.¹

To determine cause, Aziga requested that four questions be posed to jurors concerning: bias related to the fact that Aziga is an HIV-positive black Canadian who was born in Uganda, while his alleged victims are white; possible bias arising from recent media coverage of HIV and criminal transmission; perceived risks of HIV transmission; and “fears, assumptions or prejudices” about HIV that would affect their judgment and their ability to assess the evidence.

The Court held that there is a “presumption of impartiality” which may be rebutted by satisfying the Court that there is a realistic potential for partiality among potential jurors. In light of precedents established in earlier cases of challenge for cause, the issue related to the racial identity of Aziga and the alleged victims was accepted by both the Crown and the Court as a question that could be put to prospective jurors.

The Court also held that the media reports arising from Aziga’s case

could prevent a juror from being indifferent and allowed a challenge for cause on the basis of pre-trial publicity.

With respect to HIV bias (i.e. perceived risks of HIV transmission or “fears, assumptions or prejudices” about HIV) that would render jurors incapable of delivering an impartial decision, the Court was not convinced that jurors would be unable to set aside their opinion when provided with evidence in the courtroom and the trial judge’s instructions.

Absent evidence, the Court held that it was “highly speculative” to suggest that the emotions surrounding HIV/AIDS would lead to prejudicial and unfair juror behaviour. The Court did not permit a challenge for cause on that basis.

In the end, then, the Court only permitted questions related to racial bias and pre-trial media publication to be put to prospective jurors in a challenge for cause.

Cruel and unusual punishment alleged

On a separate issue, in August 2008 Aziga sought to establish before the Ontario Superior Court of Justice that his conditions of detention were so excessive as to constitute “cruel and unusual treatment or punishment.”² In August 2003, Aziga had been placed in custody in a maximum security provincial remand facility to await his trial. During his admission, Aziga formally requested protective custody and expressly acknowledged that certain benefits and privileges

normally available to the general population would potentially not be available to him.

Subsequently, Aziga was placed in protective custody. After two altercations in which he intentionally bit another prisoner, he was placed in close confinement, which he alleged was a violation of his constitutional right not to be subjected to any cruel and unusual treatment or punishment. Aziga further alleged that he was stigmatized by other prisoners and staff as a result of his HIV status and the charges which he faces, and was not provided with adequate health care.

The Court held that while Aziga’s altercations were not “disproportionately excessive,” his medical isolation was a necessary precaution in order to protect others. In Justice Lofchik’s view, the altercations Aziga was involved in arose from interpersonal conflicts rather than any stigmatization resulting from his HIV status.

The Court also concluded that Aziga received reasonable and appropriate medical care and remained in reasonable health. As such, Aziga failed to establish that his detention conditions were so excessive as to constitute cruel and unusual treatment or punishment.

Civil suit

Also in August 2008, one of the complainants in Aziga’s case commenced a six million dollar civil suit against Aziga, the Hamilton police, and the Hamilton health department for failing to warn her of Aziga’s

HIV status.³ The lawsuit alleges that city police and the health department knew of Aziga's HIV status but they used her as "bait" to implicate Aziga.⁴

The woman, who contracted HIV, claimed she would not have had sex with Aziga had she known of his health condition. At the time of writing, the City of Hamilton was preparing its defence.

On 6 October 2008, Aziga pleaded not guilty to two charges of first-degree murder and 11 counts of aggravated sexual assault after he was arraigned before a panel of 250 potential jurors. His trial commenced in Hamilton on 20 October 2008, and was expected to run six to eight weeks.

Manitoba court considers condom use and HIV viral load in analysis of "significant risk"

In July 2008, the Manitoba Court of Queen's Bench convicted Clato Lual Mabior on numerous counts of aggravated sexual assault for failing to disclose his HIV status prior to engaging in sexual intercourse with six females.⁵ He was acquitted of similar charges in relation to three other females.

In reaching her decision, the judge considered whether Mabior had placed each of the females at a "significant risk" of HIV infection, taking into account both whether condoms were used and what his viral load was at the time of sexual intercourse. In October 2008, Mabior was sentenced to 14 years imprisonment.⁶

According to the Supreme Court's 1998 decision in *Cuerrier*, the key legal issue in HIV-related sexual assault cases is whether the complainant "consented" to the sexual

act.⁷ A person cannot truly consent to sex with an HIV-positive person where the HIV-positive person lied about or failed to disclose his or her HIV status and, as a result, the other person was exposed through sex to a "significant risk" of HIV infection.

The majority of the Court in *Cuerrier* raised the possibility that the careful use of a condom might decrease the risk of HIV transmission during intercourse to the point where it could no longer be considered significant – and thus the person would not have a legal duty to disclose his HIV status prior to sexual intercourse.

In this case, the judge found that Mabior did not disclose (or lied about) his HIV status to all the female complainants and that none would have consented to sexual intercourse with him had they known he was HIV-positive. She then went on to interpret and apply the "significant risk" standard in the circumstances of the case, taking the Supreme Court's *Cuerrier* decision as her starting point.

The judge considered in detail the effectiveness of condoms in preventing HIV and the relationship between a person's HIV viral load and potential for HIV transmission. The judge accepted expert medical evidence that condoms, even if properly used, were only 80 percent effective at preventing the transmission of HIV. She also accepted expert evidence that "there was a very high probability that that the accused was not infectious, i.e. could not have transmitted HIV" when his HIV viral load was undetectable.

In the judge's view, the significance of the risk of HIV transmission during sex should be established with reference to the Ontario Court of

Appeal's decision in *Thornton*.⁸ In *Thornton*, a man was criminally convicted of common nuisance because he donated blood knowing that he was HIV-positive, and knowing that he should not do so because of the risk his blood donation posed to the public blood supply.

The Court of Appeal found that the public was "endangered" even though the blood safety screening process was 99.3 percent effective at detecting HIV, and had detected HIV in this case.

Taking into account the potential effect of viral load and condom use on HIV transmission, and the *Thornton* case, the judge interpreted "significant risk" as follows:

[116] ... it is important to recall the evidence of Dr. Smith which stated that condoms are only 80% reliable and constitute an 80% reduction in HIV incidence.... Further, cases such as *Thornton* have demonstrated that a 99.3% screening safety rate was still considered to be too significant a risk in those circumstances. *I am persuaded that in those circumstances where protection was used and the accused was regarded as infectious by the medical evidence, that a significant risk of serious bodily harm existed.* [Emphasis added.]

[117] ... *I am persuaded that the combination of an undetectable viral load and the use of a condom would serve to reduce the risk below what would be considered a significant risk of serious bodily harm.* The facts and medical evidence in this case have brought me to the conclusion that consent would not, in this particular circumstance, be vitiated. [Emphasis added.]

The judge also examined what Mabior knew or ought to have known

about HIV transmission, condom use and viral load. The judge was satisfied that public health nurses counselled Mabior on numerous occasions to disclose his HIV status to prospective sexual partners and to always use “protection” when engaging in sex; and that he was never told by any medical professional that having an undetectable viral load meant that he could not infect another person and need not use condoms for sexual intercourse.

The judge proceeded to analyze each charge of aggravated sexual assault. She convicted Mabior of aggravated sexual assault against four females because he did not use a condom during sexual intercourse. He was also convicted in relation to two females where he used a condom for sexual intercourse, *but* his viral load was not undetectable.

He was acquitted of charges in relation to sexual intercourse with three females because his viral load was undetectable *and* the Crown prosecutor did not prove beyond a reasonable doubt that a condom was not used during intercourse.

In October 2008, the judge sentenced Mabior to 14 years imprisonment. The sentence reflected not only his convictions for aggravated sexual assault, but also one conviction each for invitation to sexual touching and sexual interference. At the time of the assaults, many of the females were minors, were in the care of child protection authorities, and were given drugs or alcohol by Mabior prior to sex.

Commentary

This decision is legally significant because it is the first case since *Cuerrier* to analyze in detail the meaning of the term “significant

risk.” The judge analyzed medical and scientific evidence about the effectiveness of condoms and the impact of viral load on the sexual transmission of HIV, including the recent Swiss Commission statement and selected responses (e.g., WHO/UNAIDS).⁹

The judge’s reliance on the *Thornton* decision when assessing the risk of harm in the context of sexual relations is questionable. Statistically, the likelihood of HIV transmission during protected sexual intercourse with an HIV-positive person is greater than the risk of an HIV-infected blood donation entering the blood system. However, the potential harm is of a completely different magnitude. The number of people who could be infected through HIV in the blood system far exceeds the one person at risk of becoming HIV infected if a condom failed during sexual intercourse. The judge failed to adequately account for this difference before transposing the risk of harm analysis from the blood system to sexual relations.

According to the judge, an HIV-positive person does not have a duty to disclose his HIV status prior to intercourse if he uses a condom *and* his viral load at the time of intercourse is undetectable. It is unclear for a number of reasons whether this will ultimately become the law in Canada. First, this was a decision of a Manitoba court and, as such, is not binding on courts in other provinces and territories. Second, it is a decision of a lower, trial court and does not bind other courts, even in Manitoba. Third, the decision may be appealed and a higher court may interpret the law differently.

– Glenn Betteridge

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New trial ordered in B.C. case of non-disclosure of HIV-positive status¹⁰

In December 2005, Adrien Nduwayo was convicted in the B.C. Supreme Court of five counts of aggravated sexual assault, one count of attempted aggravated sexual assault, and one count of sexual assault.

The charges of aggravated sexual assault and attempted aggravated sexual assault were based on allegations that Nduwayo had unprotected sex with six complainants without disclosing his HIV-positive status.

At trial, the only fact in issue with respect to each of the first six counts was whether Nduwayo had unprotected sex with each of the complainants, which he denied. The jury was instructed that if Nduwayo’s evidence, or any other evidence, left them with a reasonable doubt on any count, they must acquit.

Nduwayo appealed to the B.C. Court of Appeal and contended that the trial judge failed to instruct the jury to consider each count separately, and not to use the evidence of one complainant on one count to support the credibility of a complainant on any other count.

Furthermore, Nduwayo contended that the trial judge failed to instruct the jury not to treat Nduwayo’s conduct with respect to other counts or to uncharged conduct as proof that he had a propensity to commit the offences with which he was charged.

In the Court of Appeal’s view, the trial judge’s instructions as a whole did not adequately caution the

jury against the risk of improperly using evidence of a complainant on one count in their consideration of Nduwayo's guilt on any other count.

This problem was compounded by the submissions of Crown counsel encouraging the jury to look at the evidence as a whole and to assess a complainant's testimony favourably because it was consistent with other evidence in the case.

As a result, the Court of Appeal said the fairness of the trial was compromised. Nduwayo's appeal was allowed and a new trial was ordered.

Man acquitted of sexual assault for non-disclosure of HIV status before oral sex

In May 2008, the Court of Québec acquitted a man of sexual assault for not disclosing his HIV-positive status before oral sex because the Crown had not presented any proof allowing the Court to conclude that oral sex met the required risk threshold of serious bodily harm.¹¹

The complainant, whose identity is subject to a publication ban, testified that after meeting the accused in March 2002, they returned to her house where he performed oral sex on her before they had unprotected vaginal intercourse. The complainant further testified that the accused did not disclose his HIV status to her until the following morning.

According to the accused, he performed oral sex on the complainant but they did not engage in vaginal intercourse. He testified that he had not divulged his HIV status to the complainant prior to oral sex because the risk of HIV transmission was so low. The accused also testified that

he subsequently revealed his HIV status to the complainant because he wanted to explain why they did not have vaginal intercourse.

While the Court found that only oral sex had occurred, it held that the complainant would not have had oral sex with the accused had she known that he was HIV-positive. The Court also held that the accused deliberately concealed his disease from the complainant.

However, the Court did not find beyond a reasonable doubt that there was a significant risk of serious bodily harm arising from oral sex because there was a lack of proof of the risks associated with oral sex.

The Court added that the case did not constitute judicial approval of the notion that, in the absence of disclosure, oral sex does not pose a significantly high risk to warrant convicting for sexual assault. Rather, it held that oral sex without disclosure could constitute criminal behaviour, but evidence of the risks of transmission through oral sex would have had to have been presented.

Court dismisses Trevis Smith's appeal from his conviction on two charges of aggravated sexual assault

On 14 May 2008, the Saskatchewan Court of Appeal rejected Trevis Smith's argument that the Provincial Court judge presiding over his trial violated his right to remain silent and right to be presumed innocent.¹²

Smith discovered he was HIV-positive in 2003, after which he allegedly had unprotected sex with two complainants without disclosing his HIV-positive status. Neither of the

complainants tested positive for HIV. During the trial, Smith maintained that he had used protection with all his partners, including the complainants, after discovering his HIV status.

One of the complainants, B.C., testified in detail about one sexual encounter with Smith in 2005 which Smith denied took place. The Provincial Court judge did not believe Smith's testimony, and accepted B.C.'s account based on the degree of detail that B.C. provided. Moreover, he drew an adverse inference from Smith's failure to cross-examine B.C. on the question of why she would have unprotected sex with someone rumored to be HIV-positive.

Smith asserted the other complainant, O.A., was out for revenge. Smith claimed he had disclosed his HIV-positive status to O.A., and pointed to the fact that O.A. intended to act as an organ donor for her father in support of his assertion that she would not engage in unprotected sex with him. In rejecting Smith's testimony, the Provincial Court judge put significant weight on the fact Smith failed to disclose to a public health nurse that he had a past sexual relationship with O.A.

The Court of Appeal dismissed Smith's appeal on the basis that the Provincial Court judge gave adequate reasons for accepting B.C.'s testimony over Smith's, and held that the judge was entitled to draw an adverse inference from Smith's failure to cross-examine B.C. on a crucial question.

Furthermore, the Court of Appeal held that the judge was entitled to consider Smith's non-disclosure of his relationship with O.A. in light of his credibility.

The Court of Appeal held that the Provincial Court judge made no error

in finding Smith lacked credibility on the totality of evidence. Smith's lawyer has said that Smith will be seeking leave to appeal the decision to the Supreme Court of Canada.¹³

HIV-positive man pleads guilty to two counts of attempted aggravated sexual assault

Patrick Green pleaded guilty in April 2008 to two counts of attempted aggravated sexual assault for not disclosing his HIV-positive status before having unprotected sex with two complainants.¹⁴

Green, a hemophiliac, contracted HIV in 1985 through a tainted blood transfusion. In December 2005, he was arrested and charged with aggravated sexual assault after police received a complaint from a woman who alleged she had unprotected sex with Green between 1998 and 2003, during which Green never told her he was HIV-positive.

One month later, a second charge of aggravated sexual assault was laid involving another complainant who had unprotected sex with Green in 2005. Neither complainant contracted the virus.¹⁵

Since his arrest, Green has been kept in segregation because of the risk he would suffer uncontrolled bleeding if injured by other prisoners. During Green's sentencing, his lawyer argued that Green's hemophilia would make it difficult for him to serve time in jail.

However, the presiding judge said there was no evidence the jail system could not care for Green's medical needs. In September 2008, Green was sentenced to 14 months in jail.¹⁶

HIV-positive woman acquitted of aggravated sexual assault

In August 2008, the Ontario Superior Court of Justice acquitted Tanya LaLonde of aggravated sexual assault after it rejected the testimony of the complainant who claimed LaLonde did not disclose her HIV-positive status to him before they had unprotected sex.¹⁷

The complainant, whose identity is protected by a court order, testified that he had unprotected sex with LaLonde on a number of occasions in 2006. After discovering she was HIV-positive, the complainant reported the case to public health authorities and provided a statement to the Hamilton police, which issued a nationwide warrant for LaLonde's arrest.

In a taped statement to the police after her arrest, LaLonde acknowledged going out with the complainant but denied ever having sex with him. She added that she was aware of the risks of unprotected sex, having contracted HIV from her late husband.¹⁸

In the Court's view, the complainant, who tested negative for HIV, exaggerated his sexual exploits and gave different versions about the number of times he had sex with LaLonde. Therefore, it concluded that the Crown had not proved its case against LaLonde beyond a reasonable doubt.

Halifax man convicted of aggravated sexual assault for failure to disclose HIV-positive status

In May 2008, the Nova Scotia Supreme Court found Blaine Holland guilty of aggravated sexual assault for having unprotected sex with his

former girlfriend without disclosing his HIV-positive status to her.¹⁹

Although Holland was diagnosed with HIV in 1995, the complainant claimed she believed he had only learned his HIV status in March 2006, after they had begun dating. As such, she chose not to report Holland to the police and continued to have a sexual relationship with him. The complainant, who did not contract HIV, ended the relationship in September 2006 after she discovered Holland had been aware of his condition for much longer.

During the trial, the complainant testified that had she known Holland was infected, she would never have entered into a sexual relationship with him. She further testified that they did not always use a condom during sex. Holland testified that he had always insisted on practicing safer sex and disclosed his HIV status to the complainant when they started dating. However, Holland could not specifically recall when he had this discussion with the complainant.

The Court did not find Holland credible on the basis that he could not recall when he disclosed his HIV-positive status to the complainant, and because the complainant tested for HIV in March 2006, one year after Holland claims he told her he was HIV-positive.

In October 2008, Holland was sentenced to 3.5 years in prison and placed on a sex offender registry.²⁰

Man sentenced to five-year prison term for failing to disclose his HIV-positive status

Edward Kelly was sentenced in September 2008 to five years impris-

onment after pleading guilty to aggravated sexual assault for not disclosing his HIV-positive status to a woman he had unprotected sex with.²¹

Kelly, who had been previously convicted in 2003 and sentenced to a three-year prison term for not disclosing his HIV-positive status to four women he had unprotected sex with, met the complainant in June 2005.

After the relationship ended in July 2005, Kelly's roommate told the complainant Kelly was HIV-positive. The complainant, who did not contract the virus, reported Kelly to the police.

Kelly, who pleaded guilty in July 2008, was also ordered to provide a DNA sample and his name will be added to the sex offender registry for life.

Winnipeg man convicted of aggravated sexual assault for failing to disclose his HIV status to former girlfriends

In July 2008, an HIV-positive Winnipeg man was convicted of two counts of aggravated sexual assault for failing to tell two former girlfriends that he was HIV-positive before having unprotected sex with them.²² In August 2008, he was sentenced to eight years in prison.²³

During his trial, the Winnipeg man, whose identity is protected by a publication ban, testified that he had told both women, neither of whom contracted HIV, about his HIV status prior to having sex with them and that the conversations took “only a matter of minutes.”²⁴ The man further testified that the topic only re-arose with one woman after she became pregnant with their child.

The presiding judge held that “[t]o have discussions of such life-threatening issues lasting only minutes is simply not believable,” and found the accused not credible.²⁵

Having already served 34 months in prison, and being credited for double that time, the man must serve an additional 28 months before his release. He also faces automatic deportation to Africa once he completes his sentence.²⁶

Man sentenced to seven years imprisonment on eight counts of aggravated sexual assault

In July 2008, Tendai Mazambani was sentenced to seven years in prison on eight counts of aggravated sexual assault for failing to tell his sexual partners that he was infected with HIV before having unprotected sex with them.²⁷ The eight complainants, none of whom were infected, had unprotected sex with Mazambani between 2003 and 2006.

Born in Zimbabwe, Mazambani immigrated to Toronto in 2001 with his wife. After they immigrated, Mazambani's wife discovered she was HIV-positive. Mazambani subsequently also tested positive.

In 2003, Mazambani began a sexual relationship with a woman in Toronto and moved to London, Ontario with her. They broke up in November 2004. Over the next two years, Mazambani had a series of overlapping relationships, in which he had unprotected, consensual sex with seven other women in London.

Mazambani was charged in October 2006 and pleaded guilty to aggravated sexual assault in July 2008. Given credit for 20 months

in custody, counted as double time, Mazambani will serve another four years in prison. He will also be required to submit his DNA for the federal sex offender registry and comply with the law's regulations upon release.

¹ *R. v. Aziga*, [2008] O.J. No. 2431 (QL).

² *R. v. Aziga*, [2008] O.J. No. 3052 (QL).

³ S. Clairmont, “One word can save a life: people knew her lover had AIDS, no one told her,” *Hamilton Spectator*, 14 August 2008, p. A5.

⁴ A. Dreschel, “Privacy versus the public's right to know,” *Hamilton Spectator*, 15 August 2008, p. A15.

⁵ *R. v. Mabior*, 2008 M.B.Q.B. 201 (Manitoba Court of Queen's Bench).

⁶ M. MacIntyre, “14 years for HIV-positive 'predator,’” *Winnipeg Free Press* (online edition), 11 October 2008.

⁷ *R. v. Cuerrier*, [1998] 3 S.C.R. 371.

⁸ *R. v. Thornton* (1991), 1 O.R. (3d) 480 (Ontario Court of Appeal).

⁹ R. Pearshouse, “Switzerland: Statement on sexual transmission of HIV by people on ART,” *HIV/AIDS Policy & Law Review* 13(1) (2008): 37–38.

¹⁰ *R. v. Nduwaya*, [2008] B.C.J. No. 1132 (B.C. Court of Appeal) (QL).

¹¹ *R. v. C.* (1 May 2008), Longueuil 765-01-010423-024 (Court of Québec, Criminal and Penal Division).

¹² *R. v. Smith*, [2008] S.J. No. 283 (Saskatchewan Court of Appeal) (QL).

¹³ D. Driver, "Football player loses sexual assault appeal," *The Lawyers Weekly*, 30 May 2008, p. 2.

¹⁴ P. Downs, "Living in terror he gave them HIV, women tell man's sentencing hearing," *Canadian Press*, 11 September 2008.

¹⁵ "Man with HIV faces second sex assault charge," *The Hamilton Spectator*, 21 December 2005, p. A5.

¹⁶ K. Walker, "HIV-positive man sentenced to 14 months in jail," *St. Catherines Standard*, 23 September 2008.

¹⁷ "Massey woman acquitted of aggravated sex assault in HIV Trial," *Sudbury Star*, 8 August 2008, p. A4.

¹⁸ P. Legall, "HIV accused denied sex claims," *Hamilton Spectator*, 7 August 2008, p. A5.

¹⁹ "N.S. man guilty of not disclosing HIV status — judge," *The Daily Gleaner (Fredericton)*, 16 May 2008, p. A6.

²⁰ "Halifax man gets prison for having sex with woman who didn't know he has HIV," *Canadian Press*, 30 October 2008.

²¹ J. Sims, "HIV-positive man given five years for latest offence; COURTS: Edward Kelly sentenced to three years in 2003," *The London Free Press*, 9 September 2008, p. A3.

²² P. Turenne, "Sleeping with the devil," *The Winnipeg Sun*, 14 August 2008, p. 16.

²³ M. McIntyre, "'Devil' with HIV gets 8 years for unprotected sex," *Winnipeg Free Press*, 23 August 2008, p. B5.

²⁴ D. Pritchard, "Judge rejects HIV small talk, convicts man of assault," *The Winnipeg Sun*, 19 July 2008, p. 3.

²⁵ *Ibid.*

²⁶ M. McIntyre, "HIV positive man to be deported," *Winnipeg Free Press*, 14 August 2008, p. B4.

²⁷ K. Seggewiss, "Man sentenced to seven years; COURT: Tendai Mazambani, 34, didn't reveal to his eight sexual partners that he was HIV positive," *The London Free Press*, 1 August 2008, p. A3.

In brief

Court dismisses Ottawa's application to uphold federal medical marijuana restrictions

On 27 October 2008, the Federal Court of Appeal dismissed the federal government's application to review a decision by the Federal Court to strike down a key restriction in Ottawa's medical marijuana program.¹

The lower court decision had granted approved medical marijuana users more freedom in picking their own grower and allowed growers to supply the drug to more than one patient, essentially providing greater choice and access for medical marijuana users.²

The government had argued that allowing one grower to supply a large number of users creates security risks. This argument was rejected

by the three-judge panel, as was the argument that the federal supply policy ensured there was an effective, legal supply being provided to users. The judges challenged the government on the lack of statistical evidence on whether government-provided marijuana met the medical needs of users.³

The government's failed application came after it won a stay of the Federal Court judgment until the outcome of its application for review. The Federal Court of Appeal rejected the government's request for a one-year delay to enforce the Court's ruling in order to give the government time to develop an alternative solution.⁴

According to Alan Young, who represented the medical marijuana users, Health Canada could now determine, on a case-by-case basis, how many patients a grower can

supply or it could establish a new limit of patients a grower can supply, either of which could send the case back to court.⁵

¹ *Sfetskopoulos v. Canada (Attorney General)*, 2008 FC 33 (CanLII).

² S. Chu, "Court strikes down restriction in Ottawa's medical marijuana program," *HIV/AIDS Policy & Law Review* 13(1) (2008): 45–46.

³ "Ottawa's grip on medical marijuana loosened," *Canadian Press*, 27 October 2008.

⁴ *Ibid.*

⁵ *Ibid.*

HIV/AIDS IN THE COURTS – INTERNATIONAL

This section presents a summary of important international cases relating to HIV/AIDS or of significance to people living with HIV/AIDS. It reports on civil and criminal cases. Coverage is selective. Only important cases or cases that set a precedent are included, insofar as they come to the attention of the Review. Coverage of U.S. cases is very selective, as reports of U.S. cases are available in *AIDS Policy & Law* and in *Lesbian/Gay Law Notes*. Readers are invited to bring cases to the attention of the editors of this section — Leah Utyasheva (lutyasheva@aidslaw.ca) and Alison Symington (asymington@aidslaw.ca). Both are senior policy analysts with the Canadian HIV/AIDS Legal Network.

Supreme Court of India approves government commitments on health care for people living with HIV

In August 2008, the Government of India issued a list of directives with respect to its national response to HIV/AIDS.¹ A panel of the Supreme Court approved the directives on 1 October 2008 and directed that all state governments comply with them. The panel's order also directed that the National AIDS Control Organisation (NACO) submit a progress report on compliance within four months.² As a result, a legally binding framework for healthcare and treatment of people living with HIV now exists for all of India.

The process leading to this ruling originated in three separate public interest petitions that were filed with the Supreme Court in 1998, 1999 and 2003, seeking direction from the Court requiring that the state ensure that no person living with HIV be denied treatment.

One petition was on behalf of Sahara House (a residential care and rehabilitation centre), another on behalf of Sankalp Rehabilitation Trust, and the third on behalf of the Voluntary Health Association of Punjab. The three petitions were ultimately joined.

The petitions asserted that the denial of treatment to a person living with HIV is unconstitutional and illegal. They sought orders for the state to formulate guidelines for treating people living with HIV and to provide free and equitable access to antiretroviral treatment (ART).³

The petitions relied on Articles 14 (equality before the law), 21 (protection of life and personal liberty), 32 (remedies for enforcement of rights), 41 (right to work, education and public assistance), 42 (conditions of work) and 47 (nutrition, standard of living and public health) of the *Constitution of India*.⁴

As a result of these petitions, the government engaged in consultations with various stakeholders on steps to be taken to increase and improve the extent and efficiency of treatment of people living with HIV in India. Consensus was reached on a number of issues.

An Office Memorandum was issued on 26 August 2008 with a list of the directives that had been agreed on and the actions taken (or required to be taken) for each directive.⁵ The government's directives on comprehensive care for all people living with HIV, as outlined in the Office Memorandum, include the following:

- making available functional ART centres throughout the country;
- procuring CD4 machines for future ART centres;

- ensuring that ART centres are hygienic and providing clean drinking water, adequate seating and clean toilet facilities;
- creating a mechanism for redressing grievances at ART centres;
- ensuring that drugs to treat opportunistic infections for all people living with HIV are made available at no charge;
- ensuring that sufficient HIV testing kits are available;
- providing safe working environments for all health care workers, including the provision of post-exposure prophylaxis and safety equipment such as gloves and masks;
- requiring that all doctors and nurses in the public and private sectors comply with the protocols and policies of NACO, and ensuring that these protocols are made part of the teaching curriculum for health care professionals; and
- proclaiming that no doctor or nurse shall refuse to treat a person living with HIV on account of his or her positive status, and that all people living with HIV shall be treated with dignity and care.⁶

Further consultations are required to address the outstanding issues, and a monitoring mechanism needs to be put into place in order to ensure compliance with the directives.⁷

– Alison Symington

For further information on this case, consult the websites of the Lawyer's Collective and the Human Rights Law Network (see urls in the endnotes below).

¹ NACO, Ministry of Health and Family Welfare of the Government of India, Office Memorandum, 26 August 2008, Doc No. T-1/020/29/1998/NACO (Admin ART). Available online via www.lawyerscollective.org/hiv-aids/current-cases/sankalp or via www.hrln.org/issue.php?id=2&pil=1&pilid=102.

² *Sahara House v. Union of India and Ors.*, Writ Petition No. 535 of 1998, 1 October 2008.

³ Lawyers Collective, Sankalp webpage, www.lawyerscollective.org/hiv-aids/current-cases/sankalp; and Human Rights Law Network, PILs & Cases webpage, www.hrln.org/issue.php?id=2&pil=1&pilid=102.

⁴ *Ibid.*

⁵ Affidavit on behalf of Respondent — Union of India, In the matter of *Sahara House vs. Union of India & Ors.* (and connected matters), 2 September 2008, available online via www.hrln.org/issue.php?id=2&pil=1&pilid=102.

⁶ NACO.

⁷ Affidavit on behalf of Respondent.

European Court rejects Ugandan woman's claim to stay in the U.K.

In May 2008, the Strasbourg Court issued its judgment in the case of an HIV-positive woman who sought to stay in the U. K., where she was receiving antiretroviral treatment. While treatment may be inaccessible in Uganda, the Court ruled that the humanitarian grounds against removal were not compelling enough to find that her removal would constitute inhuman or degrading treatment.¹

The applicant, "N.", claimed that given her serious medical condition and the lack of available antiretroviral and other necessary medical care and social support in Uganda, her removal from the U.K. to Uganda would

constitute a breach of Article 3 (prohibition of torture and inhuman or degrading treatment) of the *European Convention on Human Rights*. The European Court of Human Rights rejected her claim by 14 votes to three.

N. had entered the U.K. in 1998. She was seriously ill at the time and was admitted to hospital where she was diagnosed HIV-positive. She developed AIDS-related illnesses. After receiving treatment, her condition stabilized over time.²

Two days after her arrival in the U.K., solicitors lodged an asylum application on her behalf, at that time claiming that she had been victimized by the National Resistance Movement and would be in danger if she were returned to Uganda. A report was also prepared indicating that without continuing regular anti-retroviral treatment and monitoring to ensure that the correct combination of drugs was used, her life expectancy would be less than a year.³

The Secretary of State refused her asylum claim in 2001.⁴ She appealed the decision to the House of Lords, which unanimously dismissed her appeal in 2005.⁵

In one previous similar-fact case, *D. v. United Kingdom*, the Court had found an Article 3 violation. In that case, the applicant was in the advanced stages of AIDS. The medical facilities in his country of origin did not have the capacity to provide him with the treatment that he needed, nor did he have family to care for him there.

Given the compelling humanitarian considerations of these exceptional circumstances, the Court ruled that deporting him would be a violation.⁶ Subsequent to this judgement, the Court has never found a proposed

removal of an alien to give rise to a violation of Article 3 on grounds of the applicant's ill-health.⁷

Reviewing the case-law, the Court found that aliens who are subject to expulsion cannot, in principle, claim any entitlement to remain in order to benefit from medical, social or other services provided by the expelling state. The Court emphasized that it is only in "very exceptional cases" where the humanitarian grounds against removal are compelling.⁸

With respect to N.'s circumstances, the Court did not find that her case met the high threshold. The Court said that antiretroviral medication is available in Uganda (although at a cost which is prohibitive to many who need it); and, moreover, the fact that the U.K. has provided her with medical and social assistance during the nine years it has taken for her claims to be settled does not in itself entail a duty to continue to so provide for her.⁹

In conclusion, the Court stated:

The Court accepts that the quality of the applicant's life, and her life expectancy, would be affected if she were returned to Uganda. The applicant is not, however, at the present time, critically ill. The rapidity of the deterioration which she would suffer and the extent to which she would be able to obtain access to medical treatment, support and care, including help from relatives, must involve a certain degree of speculation, particularly in view of the constantly evolving situation as regards the treatment of HIV and AIDS worldwide.¹⁰

In addition, N. had argued under Article 8 of the Convention that the circumstances facing her on return to Uganda would engage her right to respect for her private life. The

Court held that it was not necessary to examine the complaint under Article 8 because no separate issues arise.¹¹

Three judges issued a joint dissenting opinion, emphasizing that Convention guarantees must be understood in the context of "prevailing practical realities."¹² They found that N.'s case should not be distinguished from *D. v. the United Kingdom*. They asserted that the Court should have found in this case a potential violation of Article 3.¹³ Moreover, they asserted that the Court should also have considered her case under Article 8 of the Convention.¹⁴

– Alison Symington

¹ *Case of N. v. United Kingdom* (27 May 2008), Application No. 26565/05.

² *Ibid.*, paras. 9, 11.

³ *Ibid.*, paras. 10, 12.

⁴ *Ibid.*, para. 13.

⁵ *Ibid.*, para. 17.

⁶ *Ibid.*, para. 33.

⁷ *Ibid.*, para. 34.

⁸ *Ibid.*, paras. 42–43.

⁹ *Ibid.*, para. 49.

¹⁰ *Ibid.*, para. 50.

¹¹ *Ibid.*, para. 53.

¹² *Case of N. v. United Kingdom* (27 May 2008), Application No. 26565/05, Joint dissenting opinion of judges Tulkens, Bonello and Spielmann, para. 10.

¹³ *Ibid.*, paras. 21–25.

¹⁴ *Ibid.*, para. 26.

South African court bans promotion of vitamin treatments as cures for AIDS

On 13 June 2008, the High Court of South Africa (Cape of Good Hope Provincial Division) ruled against a producer of alternative remedies and the Government of South Africa in a case regarding vitamin supplements being marketed as treatments for HIV/AIDS.¹ The court found that the vitamin supplements were “medicines” and hence subject to regulation under the *Medicines and Related Substances Act 101 of 1965*.

The court action was filed by the Treatment Action Campaign (TAC) and the South African Medical Association. At issue in the case was the legal status of certain vitamin and micronutrient supplements that are marketed to people living with HIV, including a product called “VitaCell,” marketed by the Matthias Rath and the Rath Foundation. The treatments have not been registered with, or approved by, South Africa’s Medicines Control Council (MCC).

VitaCell and other products have been advertised in South African newspapers and through pamphlets and posters as capable of reversing the course of AIDS. In April 2005, an advertisement ran which mentioned a “clinical pilot study” conducted with patients with advanced AIDS.

The Rath Foundation provides the supplements and operates facilities in the Western Cape, including one in Khayelitsha where they evaluate the effects of the supplements on people with AIDS.²

The twelve respondents included Matthias Rath, the Dr Rath Health Foundation Africa, David Rasnick, and South African government health authorities. The applicants sought orders declaring that the distribution or sale of the products in South Africa, and the clinical trials, are unlawful. They also sought to pre-

vent the respondents from placing false or misleading advertisements concerning the products.

In addition, they sought orders declaring that the Minister of Health and Director General of the Department of Health must investigate the allegations and take reasonable measures to prevent the unlawful acts from continuing.³

Preliminary questions in the case revolved around the applicable law. The Court first considered the meaning of the word “medicine,” as defined in section 1 of the *Medicines Act*, to determine whether the supplements were subject to the Act. The Court found that it is the use of a particular substance that is the determining factor in deciding whether or not it is a medicine.⁴

Considering that the respondents made claims in various media that the substances at issue cure or reverse the course of AIDS, the Court found that they are medicines, distributed for medicinal purposes.⁵ As a result, the Court said, the substances are controlled and regulated under the *Medicines Act*.

A “call up notice” had been issued in 2002 requiring that complementary medicines, including nutritional substances that purport to have therapeutic or medicinal effects, be brought to the attention of the MCC for it

to determine the correctness of the claims and whether the claims constitute a public health hazard.⁶

The Rath respondents had not brought their products to the attention of the MCC for evaluation. As a result, the Court ordered that they stop making claims about the efficacy of VitaCell on AIDS patients until it has been submitted to the MCC.⁷

With respect to the “clinical pilot study” conducted by the Rath respondents, the Court held that it was a “clinical trial” aimed at discovering or verifying the effects of the micronutrients on people with AIDS. The Court said, however, that Rath had not applied for authority to conduct a clinical trial as required under the regulations promulgated under the *Medicines Act*, and that their conduct was therefore unlawful.⁸ The Court ordered an interdict against the clinical trial.⁹

With respect to the conduct of the government, the Court found that the Minister of Health, together with the Director General of the Department of Health, have a duty to take reasonable measures to ensure that the provisions of the *Medicines Act* “are enforced in order to protect, promote, improve and maintain the health of the population of the country.”¹⁰

The Court said that these parties are therefore required to take reasonable measures to prevent the Rath

respondents from conducting unauthorized clinical trials, and to stop them from publishing advertisements concerning the effects of VitaCell on people with AIDS, pending the submission of VitaCell to the MCC to review the medicinal claims.¹¹

While the government respondents claimed to have properly investigated the complaints received by them from the applicants and others, the Court rejected this submission. The Court declared that they remain under a duty to investigate the complaints against the Rath respondents and in light of the facts revealed by the investigation, to take further reasonable action in accordance with their duty.¹²

In response to the judgement, TAC issued a statement declaring the decision a “victory for the rule of law and the scientific governance of medicines.”¹³ TAC called for the Minister of Health to be relieved of her duties for failing to enforce the *Medicines Act* and hampering the rollout of anti-retroviral treatment which, TAC said, resulted in many deaths.

In a related development, in October 2008, the Advertising Standards Authority of South Africa (ASASA) upheld a complaint made by TAC against Gogo’s Traditional Medicines for an advertisement which appeared in the *Sowetan* newspaper in June 2008.

The advertisement claimed that the product could reduce viral load and increase CD4 count in less than 30 days.¹⁴ ASASA ruled that the advertisement was in violation of Appendix F of ASASA’s *Code of Advertising Practice*, which requires that any advice or recommendation within an advertisement should accord with a full product registration by MCC.¹⁵ It therefore ordered that the advertisement be withdrawn immediately and not used again in its current format until the product is registered.¹⁶

– Alison Symington

The full-text of the decisions and the pleadings from the Rath case are available on

the website of TAC via www.tac.org.za/community/.

¹ *Treatment Action Campaign and South African Medical Association v. Matthias Rath et al.*, (June 13, 2008), Case No. 12156/05.

² *Ibid.*, paras. 18–22.

³ *Ibid.*, paras. 4–5.

⁴ *Ibid.*, para. 42.

⁵ *Ibid.*, para. 45.

⁶ *Ibid.*, para. 64.

⁷ *Ibid.*, para. 65.

⁸ *Ibid.*, para. 75.

⁹ *Ibid.*, para. 105.

¹⁰ *Ibid.*, para. 88.

¹¹ *Ibid.*

¹² *Ibid.*, para. 105.

¹³ “Cape High Court interdicts Matthias Rath and orders government to investigate and stop breaches of the Medicines Act: victory for the rule of law and the scientific governance of medicines,” 13 June 2008. Available via <http://tac.org.za/community/node/2348>.

¹⁴ A. Warlick, “TAC consumer complaint against advertisement for quack treatment for HIV/AIDS upheld by Advertising Standards Authority,” 10 October 2008. Available via <http://tac.org.za/community/node/2418>.

¹⁵ *Treatment Act Campaign v. Philani Gumede t/a Gogo’s Traditional Medicine*, Ruling of the ASA Directorate, 29 September 2008, p. 2.

¹⁶ *Ibid.*, p. 3.

South African Court: Military cannot exclude HIV-positive people

On May 16th 2008, the High Court of South Africa ruled that the South African National Defence Force (SANDF) HIV testing policy is unconstitutional because it excludes people living with HIV from recruitment, promotion or foreign deployment.¹

The HIV testing policy was developed by the Surgeon General during the period of 1988–2003, and imple-

mented by SANDF. According to the HIV testing policy, everyone who tests positive — regardless of their

health or qualifications — is automatically excluded from being employed, deployed or promoted within SANDF.²

The policy has been repeatedly questioned and challenged since 1994, when on numerous occasions human rights advocates tried to engage with SANDF on the fairness and legality of the policy.³

The response of SANDF had been that all members of the military — regardless of specialisation — are only deployable if they are combat ready. It considered all people who are HIV-positive to be unfit for employment, deployment or promotion because they are purportedly unable to cope with the stress, harsh conditions and armed conflict that military service implies.⁴

On 14 May 2007, the policy was formally challenged in a lawsuit launched by the AIDS Law Project (ALP), acting on behalf of the South African Security Forces Union (SASFU) and three people living with HIV who were denied recruitment, deployment or promotion in SANDF — a combat readiness trainer with particular experience in shooting; a trumpeter; and a personnel clerk who performed purely administrative functions.⁵

ALP argued that the policies were stereotypical and unfairly discriminated against people with HIV. It claimed that if any of the applicants were to be deployed or promoted, they could continue to function in the same job category for which they were employed.

Additionally, ALP said that there was no medical evidence to justify a blanket ban on all people with HIV; that the existing policy contributed to stigmatization of people living with HIV; and that it undermined HIV prevention, treatment, care and support within SANDF.

ALP also argued that the policy was contrary to the HIV and AIDS and STIs Strategic Plan for South Africa (2007-2011) and to international standards.⁶

The court held that the testing policy is

unconstitutional in that it unreasonably and unjustifiably infringes the rights of aspirant and current HIV positive SANDF members to:

a) not to be unfairly discriminated against;

- b) to privacy;
- c) to dignity; and
- d) to fair labour practices; and to administrative justice.

All of these rights are guaranteed by the *Constitution of South Africa*.

The court ordered that the HIV testing policy be reviewed and set aside, and gave the respondents six months to formulate a new health policy. The court also directed the respondents to immediately employ the third applicant, and to immediately reconsider the second applicant for external deployment and promotion.

— Leah Utyasheva

¹ ALP, "Victory against SANDF," news release, 16 May 2008, available via www.alp.org.za.

² Ibid.

³ ALP, "South African Security Forces Union and Others v Surgeon General and Others," online at www.alp.org.za/index.php?option=com_content&task=view&id=43&Itemid=8.

⁴ Ibid.

⁵ *South African Security Forces Union and Others v Surgeon General and Others*, High Court of South Africa (Transvaal Provincial Division), Case No. 18683/07, 16 May 2008.

⁶ Ibid.

Criminal law and cases of HIV transmission or exposure

Australia: Man found not guilty of deliberate HIV transmission

In July 2008, a jury found Michael Neal not guilty on two counts of

deliberately infecting a person with HIV. He was found guilty of 15 further counts, including nine counts of attempting to infect a person with HIV, two counts of rape, three counts of reckless conduct endangering a

person and one count of procuring sex by fraud.

He pled guilty to 12 additional counts, including producing child pornography, possessing child pornography, engaging in indecent acts

with a child under 16, trafficking in a drug of dependence and possessing a drug of dependence.¹

Evidence was presented at trial that Neal wanted to infect other men and did not disclose his HIV-positive to partners with whom he engaged in unprotected sex.²

Between November 2001 and April 2006, the Department of Health served Neal with three letters and four orders issued under section 121 of the Health Act requiring, amongst other things, that he seek counselling, refrain from unprotected sex, stay away from sex-on-premises venues, and maintain regular contact with DHS officials.³

Allegedly, Neal continued to have unprotected sex.

Neal's defense counsel maintained throughout the trial that Neal did not genuinely believe that he could infect others because he had an undetectable viral load.⁴ He was remanded in custody and a pre-sentencing hearing was scheduled for 29 October 2008.⁵

– Alison Symington

Finland: Ten-year sentence for HIV transmission and exposure

In August 2008, a Finnish court handed down a sentence of 10 years imprisonment in the case of Aki Matti Hakkarainen, an HIV-positive man who was found guilty of 14 counts of attempted aggravated assault, five counts of aggravated assault and one count of rape.

The unprotected sexual encounters took place between 1999 and 2004. Hakkarainen was also ordered to pay compensation to his victims totalling

approximately EUR 330,000 (about CAN\$508,000).⁶

Earlier in the proceedings, a psychiatric evaluation of the accused was ordered. Based on that evaluation, the District Court deemed him fit to be sentenced for the offences.⁷ In 2007, police had published the accused's photograph in order to identify other sexual partners who might have been exposed to HIV.⁸

– Alison Symington

Singapore: Man convicted for performing oral sex

In the first HIV exposure case to be brought in Singapore, an HIV-positive man was convicted for performing oral sex on a teenage boy in a public toilet without first informing him of the risks. The teenager had reportedly refused the man's request for anal sex.⁹ Chan Mun Chiong pled guilty and was sentenced to one year in jail.

Under Singapore's law, he could have been fined up to SGD\$10,000 (about CAN\$8,150) and/or had a jail term imposed of up to two years. He was charged before amendments came into effect that increased the possible penalties to 10 years in jail and up to a SGD\$50,000 (about CAN\$39,500) fine.

The amendments also make it a crime for a person who does not know his or her HIV status but has "reason to believe" he or she may have the virus to have sex without prior disclosure or without taking "reasonable precautions" to protect sexual partners.¹⁰

– Alison Symington

Switzerland: Man unaware that he was living with HIV held criminally liable for transmission

In June 2008, Switzerland's highest court, the Federal Court in Lausanne, ruled that a man who was unaware of his infection when he had unprotected sex that resulted in HIV transmission was still criminally liable for the resulting HIV infection.

The complainant was a woman who had unprotected sex with the defendant. Reportedly, the man had not been diagnosed as HIV-positive prior to their sexual encounters, but his sexual history did include unprotected sex.¹¹ Notably, in 2000, he had been informed by a former sexual partner that she had been diagnosed HIV-positive.

The man testified that he had not taken an HIV antibody test because he did not believe himself to have been infected during unprotected sex with this woman, based on a lack of seroconversion symptoms at the time.¹²

In Switzerland, liability for HIV exposure is based on two distinct sets of laws: public health law which aims to protect the general public, and criminal law which aims to protect individuals. The accused in this case was found to be liable under both.

The accused had appealed his original conviction under those laws to the Zurich Cantonal Court in 2007. The Cantonal Court upheld the appeal, holding that he was not liable and the scientific evidence did not prove conclusively that he had infected the complainant.¹³

The Federal Court reversed that decision in June 2008. The Federal Court said that the defendant could

not ignore the fact that his own past behaviour was risky, particularly since one of his previous partners had told him she was HIV-positive after they had unprotected sex.

The Federal Court also ruled that the woman did not have joint responsibility for her HIV infection because she did not give informed consent to the risk of unprotected sex. If she had known the man's sexual history, it was unlikely she would have had consented to unprotected sex.¹⁴

– Alison Symington

U.S.: Prison sentences for spitting

In May 2008, an HIV-positive man who spat at a police officer during his arrest for public intoxication was sentenced to 35 years in prison in Dallas, Texas.

According to media accounts, Willie Campbell had a history of spitting at police officers and biting other inmates. The jury in the case ruled that Campbell's saliva was "a deadly

weapon" because of his HIV-positive status.

The jury's finding means that he has to serve at least half of his prison term before he can be eligible for parole.¹⁵ Because Campbell had served prison time twice before, under Dallas law he is labelled a "habitual offender." As a result, the minimum sentence he can receive is 25 years.¹⁶

The U.S. Centers for Disease Control and Prevention reports that no one has ever contracted HIV through spit. The Dallas County prosecutor who handled the case reportedly stated that even if minuscule, any risk level is sufficient for the deadly weapon finding.¹⁷

In an unrelated case, an HIV-positive woman in Georgia was sentenced to three years in prison for spitting in another woman's face. She plead guilty to aggravated assault. She will have to serve her full sentence because she has three prior felony convictions.¹⁸

– Alison Symington

¹ S. Collins, "HIV-positive man guilty of attempting to infect partners," *The Age*, 1 August 2008.

² M. Iaria, "Man boasted of spreading HIV," *The Australian*, 2 July 2008; "Court told man bragged about infecting people with HIV," *ABC News*, 19 June 2008.

³ S. Collins, "HIV-positive man..."; S. Collins, "HIV man 'ignored warnings,'" *The Age*, 24 June 2008.

⁴ S. Collins, "HIV-positive man..."

⁵ *Ibid.*

⁶ "Rovaniemi HIV case brings 10-year custodial sentence and over EUR 300,000 in damages," *Helsingin Sanomat*, 25 August 2008.

⁷ "Court action against HIV man continues in Rovaniemi," *Helsingin Sanomat*, 13 August 2008.

⁸ "Publishing photograph of HIV man leads to discovery of yet another HIV-positive victim from years ago," *Helsingin Sanomat*, 10 October 2007.

⁹ E. Chong, "Man jailed for not telling boy of risk in first HIV case," *Straits Times*, 14 July 2008; S. Bennett, "Singapore jails man with HIV for performing oral sex on youth," *Bloomberg.com*, 15 July 2008.

¹⁰ S. Bennett.

¹¹ E. Bernard, "Swiss court rules all people with HIV can be criminally liable for transmission, even if untested," *Aidsmap.com*, 18 July 2008.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ T. Ellis, "HIV-positive man gets 35 years for spitting on Dallas police officer," *The Dallas Morning News*, 14 May 2008.

¹⁶ T. Ellis, "35-year sentence for HIV-positive spitter worries some," *The Dallas Morning News*, 17 May 2008.

¹⁷ T. Ellis, "35-year sentence..."

¹⁸ "Woman with HIV gets 3 years for spitting in face," *The Associated Press*, 23 July 2008.

In brief

HIV-positive Kenyan awarded compensation after being fired

In July 2008, a High Court in Nairobi ruled that it is unlawful to dismiss someone from employment on the

grounds of his or her HIV status. Furthermore, the Court declared that testing employees or prospective employees for HIV without consent constituted an invasion of privacy and was unlawful. Disclosing an employee's HIV status to his or her

employer without consent is also unlawful.¹

The decision came as a result of a law suit launched five years ago by an HIV-positive woman. She allegedly went to the hospital complaining of chest pains and rashes, where

she was tested for HIV without her consent. She further alleged that the doctor and hospital disclosed the test result to her employer without her consent, in breach of doctor-patient confidentiality.

According to media reports, her employer then fired her, stating in her letter of termination that she was being dismissed on medical grounds.²

Although neither the employer, the hospital nor the doctor admitted liability, the Court awarded the plaintiff the equivalent of CAN\$35,000 in damages.³ This is said to be the first such ruling in Kenya.

– Alison Symington

Kyrgyzstan: Nine health care workers guilty of negligence causing HIV transmission among children

In August 2008, Osh City Court of Kyrgyzstan sentenced nine doctors and nurses for negligence that resulted in HIV transmission to children in the Osh region of Kyrgyzstan through tainted blood transfusions and used needles.⁴

Charges had been filed against 14 health care workers, based on the Kyrgyz Criminal Code provisions for “negligence” (Article 316) and HIV transmission (Article 117).⁵ The court found nine workers guilty of negligence and sentenced them to prison terms of three to five years.

The nine workers will also pay damages, including compensation for medicines, moral damages, and funeral expenses for those who died.⁶ All convicted health care workers are from the same hospital in south of Kyrgyzstan.⁷

Since 2007, 72 children between the age of 12 and 18 months were

found to be HIV-positive; four of them have died. Four mothers, one doctor and one nurse were also found to be HIV-positive. The investigation of the Kyrgyz Ministry of Health determined that repeated use of disposable syringes and equipment caused the transmissions.⁸

In recent years, there have been several widely publicised cases of negligent HIV transmission in hospitals of the Central Asian countries. In 2007, in the Shymkent region of Kazakhstan, 17 health care workers were convicted of criminal negligence that resulted in HIV transmission to children who received blood transfusions. Poor hygiene, low salaries of health care staff and corruption were blamed for those outbreaks.⁹

– Leah Utyasheva

China: Judicial interpretation imposes stricter responsibility for contaminated blood sales

In September, China’s Supreme People’s Court and the Supreme People’s Procuratorate issued a new interpretation of the Chinese Criminal Law, clarifying that people found guilty of collecting or supplying blood, which is later found to have caused death or serious illness, will face 10 years to life in prison.¹⁰ (Previously, the penalties were more lenient.)

The new punishment will apply to those found guilty of collecting or supplying blood that causes at least five recipients to contract HIV, hepatitis B or C, or syphilis; or that causes them to suffer severe anemia, blood building obstructions or organ malfunction.¹¹ Other blood suppli-

ers who fail to comply with national standards will face prison sentences of less than 10 years.

A 1998 law forbids donors from giving blood more than every six months. In 2006, the Chinese Ministry of Health adopted regulations on laboratory testing, storage and transportation of blood plasma and reporting adverse reactions.¹² The new interpretation of the Criminal Code imposes stricter sanctions, clarifies the range of punishable actions and adds the names of diseases.

China is known for underground blood collection and supply which, in the mid-1990s and early 2000s, were blamed for the spread of HIV among people in rural areas of central China. Many of the 40 000 HIV-positive people in China’s Henan province were infected through unsanitary blood collection.¹³ In May 2007, six people were sentenced to prison for between six and 18 months for operating an illegal blood donation ring, which encouraged impoverished people to sell blood up to 10 times a month under false names.¹⁴

– Leah Utyasheva

Brazilian Appeals Court rules that criminal prosecution for drug possession is unconstitutional

In March 2008, the Sao Paulo Justice Court’s 6th Criminal Chamber declared that drug possession for personal use is not a criminal offense. The case involved charges against Ronaldo Lopez for possession and trafficking with respect to 7.7 grams of cocaine, for which the accused had been sentenced to two-and-a-half years in prison.¹⁵

The Appeals Court dismissed the trafficking charge as unfounded, and then dismissed the possession charge as unconstitutional. The judge indicated that the law criminalizing drug possession for personal use violated constitutional principles with respect to harm, privacy and equality.¹⁶

Reportedly, several lower courts have previously ruled in a similar way, but this is the first such ruling from an appeals court. Nearly two years prior, Brazil had changed its drug laws to remove jail sentences for — not but decriminalize — drug possession for personal use. As a result, drug possession remained a criminal offense, but penalties were limited to fines, fees, education and community service.¹⁷

– Alison Symington

Egypt: Sentences upheld for men convicted of “debauchery”

In May 2008, a Cairo appeals court upheld the three-year prison sentenc-

es imposed on five men convicted of “the habitual practice of debauchery,” an offence under Egyptian law that includes consensual sexual acts between men.

As reported in Vol. 13(1) of the *Review*, human rights groups report that these charges are part of a police campaign targeting men believed to be HIV-positive.¹⁸ Nine men have been sentenced to prison on these charges so far in 2008.

All of the men charged have allegedly been forced to undergo HIV tests without their consent. They have also allegedly been victims of abusive anal examinations and beatings by police and guards. Those who tested HIV-positive were allegedly chained to their hospital beds.¹⁹

– Alison Symington

¹ Xan Rice, “Kenya: HIV-positive waitress awarded £17,000 compensation after dismissal,” *The Guardian*, online, 10 July 2008; “Kenyan wins landmark HIV ruling,” *BBC News*, 10 July 2008.

² Ibid.

³ Ibid.

⁴ “Court finds Kyrgyz physicians guilty of HIV transmission,” *Kaiser Daily HIV/AIDS Report*, 7 August 2008.

⁵ S. Gafarova, “Kyrgyzstan: Medics that infected children with HIV are sentenced”, Information Agency Fergana.ru, 7 August 2008, at www.fergana.ru.

⁶ “Court finds...”

⁷ S. Gafarova, “Kyrgyzstan: Nine medics found guilty of infecting children with HIV,” Information Agency Fergana.ru, 7 August 2008, at www.fergana.ru.

⁸ Ibid.

⁹ L. Utyasheva, “Central Asia: Several HIV outbreaks linked to transfusions of tainted blood and poor sanitary conditions in hospitals,” *HIV/AIDS Policy and Law Review* 12(2/3) (2007): 57.

¹⁰ Xie Chuanjiao, “Illegal blood suppliers face longer jail terms,” *China Daily*, 23 September 2008.

¹¹ Ibid.

¹² Ibid.

¹³ “Chinese officials announce stricter punishment for contaminated blood sales,” *Kaiser Daily HIV/AIDS Report*, 24 September 2008.

¹⁴ Xie Chuanjiao.

¹⁵ “Brazil Appeals Court rules drug possession not a crime,” *Drug War Chronicle*, Issue 538, 30 May 2008.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ A. Symington, “Egypt: Court convicts men for ‘debauchery,’” *HIV/AIDS Policy & Law Review* 13(1) (2008): 63.

¹⁹ Human Rights Watch, “Egypt: Court upholds HIV sentences, reinforces intolerance,” news release, Cairo, 29 May 2008.



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AIDS 2008:

LAW, ETHICS, AND HUMAN RIGHTS

In this special section of the *HIV/AIDS Policy & Law Review* — made possible by funding received from the Joint United Nations Programme on HIV/AIDS (UNAIDS); the Open Society Institute Public Health Program and the Law and Health Initiative, the International Harm Reduction Development Program, and Public Health Watch; and the Levi Strauss Foundation — we reproduce some of the most relevant presentations on legal, ethical and human rights issues related to HIV/AIDS given at the XVII International AIDS Conference in Mexico City, Mexico, in August 2008. We did the same for the conferences held in Geneva in 1998, in Durban in 2000, in Barcelona in 2002, in Bangkok in 2004 and in Toronto in 2006.¹ This issue will be mailed to over 500 people and organizations with an interest in HIV/AIDS and human rights, particularly in developing countries, in addition to the Review's regular distribution list. This issue will also be distributed via the UNAIDS Information Centre to thousands of additional recipients. The goal is to increase access to materials on human rights, legal and ethical issues related to HIV/AIDS for individuals and organizations worldwide; to facilitate networking among individuals and groups active in the area; and to promote policy and legal responses to HIV/AIDS that respect human rights.

For the first time, this special section is being produced in Spanish (in addition to English and French, the regular languages of the Review).

There were more presentations on human rights at this conference than at any previous International AIDS Conference. A significant number of presentations focussed on issues of violence and abuse against women, including sex workers; this section contains a number of articles on this topic. The section starts with two overview articles: one by Ralf Jürgens and Jonathan Cohen describing the state of human rights in the HIV/AIDS epidemic and discussing what has to happen next; and one by Mandeep Dhaliwal, the rapporteur for Track E (Policy and Political Sciences), providing an overview of the presentations that were relevant to human rights.

¹ "Geneva98: Law, Ethics, and Human Rights," *Canadian HIV/AIDS Policy & Law Newsletter* 4(2/3) (1999): 78–117; "Durban 2000: Law, Ethics and Human Rights," *Canadian HIV/AIDS Policy & Law Review* 5(4) (2000): 54–117; "Barcelona 2002: Law, Ethics, and Human Rights," *Canadian HIV/AIDS Policy & Law Review* 7(2/3) (2002): 77–122; "Bangkok 2004: Law, Ethics and Human Rights," *HIV/AIDS Policy & Law Review* 9(3) (2004): 67–113; "Toronto 2006: Law, Ethics and Human Rights," *HIV/AIDS Policy & Law Review* 11(2/3) (2006): 61–93. All five supplements are available via www.aidslaw.ca/review.

Human rights and HIV/AIDS: where are we? and what next?

Issues related to HIV/AIDS and human rights received more attention at AIDS 2008 than ever before at an International AIDS Conference. Nevertheless, in this presentation at one of two sessions devoted to HIV and human rights, Ralf Jürgens warned that despite much rhetoric, real action on HIV/AIDS and human rights remains lacking. He suggested that much needed to change before human rights will be where they need to be — at the centre of the global AIDS struggle. And he proposed a number of concrete activities to get there.

Many of us are just coming from the first-ever International Rally for Human Rights at an International AIDS Conference. For the first time, there has been a Human Rights Networking Zone in the Conference's Global Village, packed with sessions on issues related to HIV and human rights.

This session, entitled "Advancing Human Rights in the AIDS Response," promises to be very rich and interesting, focusing on issues ranging from the history of the declaration, *Human Rights and HIV/AIDS: Now More Than Ever*,¹ to efforts to promote women's rights through legislation. This conference has focused on stigma and discrimination and broader human rights issues to a greater extent than other International AIDS Conferences.

But the news is not all good.

Human rights issues are not getting the attention they deserve. Without greater attention to human rights, we have no chance of ever reaching the goal of universal access to HIV prevention, treatment, care and support.

Worse, some in the public health community continue attacking human rights for which we advocate, claiming that they create barriers to getting millions of people tested for HIV.

They want to "normalize" and medicalize the response to HIV. I

would like to ask them: How do you normalize HIV when, over 25 years since HIV first appeared, there is still not one member of a national parliament worldwide who has disclosed his or her HIV status?

When a large number of countries continue to refuse to introduce HIV prevention programs for marginalized communities whose human right to health and whose dignity is not recognized?

When many countries have laws that continue to prohibit one of the most effective HIV prevention measures for people who use opioids, namely substitution therapy with methadone or buprenorphine?

When many countries in Africa quickly pass ineffective HIV laws that, among other things, establish barriers to HIV education for minors, or criminalize HIV-positive mothers for creating a risk of HIV transmission to their newborns — but at the same time fail to pass legislation securing women's rights to property, inheritance and protection from violence, including marital rape, and thus fail to reduce women's vulnerability to HIV?

When in many countries people dying of AIDS do not even have access to adequate pain medication?

How do we normalize HIV and the response to it when even in my

own country, Canada, 12 years after antiretroviral therapy has become widely available, stigma and discrimination against people living with HIV remain endemic?

Only two months ago, the departure of an airplane from an airport in a city in Atlantic Canada was delayed for many hours because one of the members of the ground crew recognized one of the passengers, an HIV-positive person who was engaged in community outreach work, and thought it was necessary to provide all airport workers with protective equipment and to disinfect all surfaces the HIV-positive person could have touched?

I could provide many more examples, from all corners of the world, of how HIV continues to receive exceptionally bad and inadequate responses. The human rights advocates who are being attacked by some members of the public health community are the same people who have fought hard for HIV treatment as a human right in resource-poor countries, and are fighting hard for universal access.

We are fighting for access to evidence-based prevention measures that governments continue to deny people. And we are also fighting for vastly increased access to HIV testing and counselling — but not for testing

for the sake of testing, but for testing and counselling as an entry point to treatment and prevention, and with adequate protection against stigma, discrimination and violence for those testing positive.

Next steps

So where do we need to go from here? At this conference, the Human Rights Networking Zone was inaccessible to a majority of conference participants, as were most other activities in the conference's Global Village, located far away from the conference centre in a tent on the field outside the centre.

Let us not tolerate this type of separation of science and community at this conference, ever again! The two human rights sessions within the main conference program both take place on the last full day of the conference, while these issues should

have received attention throughout the conference.

Edwin Cameron will give the only plenary presentation addressing human rights issues (published elsewhere in this section) at the very end, on Friday morning, when many delegates will have left the conference. In Vienna, at AIDS 2010, human rights must be a central theme of the conference, with a human rights plenary presentation early on in the conference, and an update on human rights responses to HIV (or the lack thereof) provided as part of the series of presentations on the state of the epidemic that are traditionally given on the first day of the conference.

Rather than discouraging dialogue and separating science from human rights, we need to encourage more dialogue at this conference and elsewhere between the public health community and human rights activ-

ists, recognizing that the protection of human rights is the way to protect the public's health.

But we, as human rights activists, also have a lot more work to do.

We will continue to disseminate the declaration, *Human Rights and HIV/AIDS: Now More Than Ever*, which has been endorsed by over 600 organization in over 100 countries. We will translate it into additional languages,² continue the endorsement campaign with a goal of having at least 1000 organizational endorsements by December 2009, and will undertake activities with the organizations that have endorsed the declaration, at country and regional level, to promote a rights-based approach to HIV.

As we do this, we will have to be clear that human rights are not an abstract concept or a barrier to public health approaches; but rather

Human rights remain marginalized

Those of us who advocate for greater attention to human rights in the HIV response can offer many reasons why, twenty-five plus years into the AIDS epidemic, human rights still remains a marginal element of global HIV efforts.

Human rights raises issues that are taboo and controversial and that politicians would just as soon not touch — issues such as sex between men, sex work and injection drug use. Human rights require people to give up power — whether it is the power of a police officer over a sex worker, the power of an African man over his wife, the power of a prison guard over a drug user, and so on.

Human rights are perceived by many in the public health community as conflicting with public health, whether it's the debate over HIV testing and counselling, criminalization of HIV transmission, or restrictions on travel for HIV positive people.

Human rights are under assault by dictators and tyrants from Africa to Asia to other parts of the world.

In this context, it is not easy to advance the importance of human rights in the global AIDS response. Part of the responsibility for this must lie on human rights activists ourselves, because we have largely failed to explain in clear, simple, declaratory language — and not just in English, but in many languages — why human rights must occupy the centre of the global AIDS response. And that is the genesis of the *Human Rights and HIV/AIDS: Now More Than Ever* declaration.

— Jonathan Cohen

Jonathan Cohen (jcohen@sorosny.org) is project director of the Law and Health Initiative at the Open Society Institute. This text is based on remarks made by Jonathan Cohen at the "Advancing Human Rights in the AIDS Response" session at the conference.

that concrete, practical, evaluated and cost-effective human rights programs are needed as part of national strategic HIV plans. Key components we need to advocate for include:

- education on rights for key professionals, including health care workers, police, prosecutors and the judiciary;
- “know your rights” campaigns for persons living with HIV and members of marginalized communities who are most at risk of HIV;
- legal audits and law reform, if necessary, to ensure that, instead of the ineffective, superfluous HIV/AIDS laws being adopted in an increasing number of coun-

tries, all legislative barriers to evidence-based HIV prevention and HIV treatment, care and support are eliminated;³

- vastly scaled-up, multi-year stigma reduction and anti-discrimination campaigns; and
- legal or paralegal services for persons living with HIV and members of most-at-risk communities, integrated into existing health services or at least linked to them.

Let us speak loudly and clearly about the need to ensure that human rights are where they need to be, together with efforts to strengthen health systems and other fundamental compo-

nents of the response to HIV – at the centre of the global AIDS struggle.

– Ralf Jürgens

Ralf Jürgens (rjurgens@sympatico.ca) is a former executive director of the Canadian HIV/AIDS Legal Network. He now works as a consultant on HIV and human rights, including in Eastern Europe, Central Asia, the Caucasus and Africa.

¹ Open Society Institute, *Human Rights and HIV/AIDS: Now More Than Ever*, Second edition, 2007. Available via www.soros.org/endorsehumanrights.

² As of November 2008, the declaration was available in English, French, Spanish, Portuguese, Russian, Chinese, Arabic, Romanian, Bulgarian and German.

³ See, also, International Parliamentary Union, UNAIDS, United Nations Development Programme, *Taking Action Against HIV and AIDS: Handbook for Parliamentarians*, 2007. Available via www.ipu.org/english/handbks.htm in English, French and Spanish (with additional languages to follow).

Rights and policy front and centre at the conference

There were more sessions than ever on human rights and policy at this conference — 86 abstracts, 46 poster discussions, 702 posters, and numerous crosscutting, bridging and satellite sessions. In this article, based on her summary of Track E (Policy and Politics) at the rapporteur session on the final day of the conference, Mandeep Dhaliwal presents a summary of key themes and messages that emerged from Track E.

The article is organized in three interconnected areas: human rights and law; international responses and funding; and policy analysis, implementation and evaluation.

Human rights and the law

This was a conference of many firsts:

- There was a significant focus on women’s rights, and the sexual

and reproductive health (SRH) rights of people living with HIV (PLHIV).

- It was okay to talk about the rights of “bad” women and there was a plenary address on sex work given by a sex worker.
- There was a Human Rights Networking Zone, where people gathered to share experiences and work on human rights.

- There was one of the first global assessments of the systematic failure to respond to epidemics among men who have sex with men (MSM).

This conference dispelled the myth that issues concerning MSM, sex work and drug use are not relevant to Africa. These populations exist everywhere, regardless of culture,

religion, history or political context; they are at risk and are underserved by HIV, health and social services.

Many examples were presented about communities mobilizing to respond to human rights abuses where governments have failed to act — including MSM in Africa, drug users in Thailand and sex workers in Cambodia.

An analysis of UNGASS reports revealed that 63 percent of countries report laws, regulations and policies that impede access to effective HIV prevention, treatment, care and support for key populations; and that 78 percent of countries have no performance indicators for human rights compliance.

Presentations based on the findings of the Commission on AIDS in Asia revealed that if countries hope to reverse the tide of AIDS, they must, as a matter of priority, decriminalize sex work and homosexuality; and remove, alter or relax enforcement of legal barriers which impede harm reduction.

Numerous presentations on criminalization highlighted the proliferation of “highly useless laws” that have no proven public health benefit. Several speakers noted the misguided model law from Chad, which is resulting in a proliferation of laws and policies in the region which criminalize behaviours and transmission — and which has the effect of driving people underground, well out of the reach of essential prevention, treatment, care and support services.

Presenters highlighted that criminalization is often posited as a means of protecting women. However, it can make women more vulnerable by exposing them to harassment and deterring them from accessing HIV services. Instead of implementing policies and laws that criminalize, we

should be addressing the reasons that drive the demand for criminalization.

Several speakers highlighted the state-sponsored violence experienced by sex workers in Cambodia. Even good laws and policies will not work if they are not enforced or if the enforcers are the perpetrators of the violence.

Presenters highlighted that while the cost of first line ARVs has decreased, second line ARVs, salvage therapy, and medicines for hepatitis C are still prohibitively expensive in many countries. The patent regime remains a major barrier to achieving universal access. Participants talked about the need to stop accepting the dogma of pharmaceutical companies and the governments that profit from them. There is an urgent need for advocacy for an architecture that will make medicines accessible to rich, poor and marginalized communities.

Several speakers noted that focusing on human rights is an important way of addressing the underlying causes that shape inequalities and social injustice.

International responses and funding

Speakers highlighted that while there is more money for AIDS now, resources are still dramatically insufficient to achieve universal access and the Millennium Development Goals associated with health. Decisions around funding are political, and what prevents many countries from increasing AIDS expenditure is stigma and discrimination. An analysis of UNGASS reports from 38 countries revealed that only four percent of HIV prevention expenditures went to programs directed at MSM, sex workers and injection drug users.

The debates among some donors concerning whether more funds should be invested in health systems, as opposed to being used for disease-specific interventions, such as AIDS, is unhelpful and sterile. Advocates at this conference called for more resources for both AIDS and health systems strengthening.

Funding in conflict and post-conflict political crisis situations is being invested in services to build democracies and accountable governments, but not in services for survivors of sexual violence. How accountable can governments truly be if they cannot promote and protect the rights of their own populations, especially those most vulnerable?

There were several presentations that identified stigma, discrimination and violence as the key barriers to effective prevention, treatment and care. Examples of good practice were shared, including the stigma index, evidence-based stigma reduction programming, and building political leadership. Unfortunately, there was no data presented on what level of resources are being spent on interventions to address stigma and discrimination, and violence.

Several presenters spoke about the need for multiple funding mechanisms in order to make the money work better. The Collaborative Fund, for example, has shown that community-driven models can get resources to the hard-to-reach. However, community-driven models often require technical support (TS), yet there was little discussion at this conference about the need to resource TS and to build TS capacity in the South.

Speakers discussed efforts to implement the Paris Declaration on Aid Effectiveness, especially initiatives to improve donor coordination

at country level. Presenters focused primarily on alignment and harmonization, which is but one pillar of the Paris Declaration. But, with the exception of the Global Fund, donors said little about managing for results and untying aid — both important parts of the Paris Declaration.

Speakers noted that mechanisms to hold governments to account are generally weak. And while civil society is better represented than ever in the global architecture, it has to do more to ensure that it is accountable to its constituencies.

Several speakers commented on the lack of accountability of the International Monetary Fund (IMF). IMF policies are restricting countries' fiscal space, which contributes to weakening health systems. Speakers shared experiences from Kenya and Uganda, where IMF policies lead to these countries exporting health workers even though they have their own severe health care worker shortages.

Policy analysis, implementation and evaluation

Many examples were shared on how evidence has been deliberately and systematically ignored, and ill-informed policies implemented — resulting in human rights violations, and precious resources wasted. Two particularly egregious examples were presented:

- In spite of irrefutable evidence about the effectiveness of harm reduction programs, such programs are still not being implemented for many people who use drugs.
- In spite of evidence based recommendations from the Institute of Medicine's mid-term evaluation

of the (U.S.) President's Emergency Plan for AIDS Relief (PEPFAR), the recently re-authorized PEPFAR (PEPFAR II) has retained regressive measures, such as the "abstinence and be faithful" earmark, the anti-prostitution loyalty oath, and the ban on federal funding for needle and syringe programs — all of which impede the scale up of effective HIV prevention services. Furthermore, PEPFAR II has expanded the "conscious clause" to include care as an activity that organizations may refuse to provide on moral and religious grounds; and it continues to neglect the need to provide any additional resources for SRH.

Participants discussed the destructive impact of policy incoherence and the lack of policy leadership. A prime example of this was the development of sex work guidance by the U.N. In 2007, UNAIDS developed a guidance note on sex work that can be interpreted as promoting an authoritarian approach to sex work. The guidance note misguidedly aims to reduce sex work as opposed to focusing on reducing sex workers' vulnerability to HIV. And it fails to promote the rights of sex workers, despite the fact that sex workers are one of the most marginalized and vulnerable groups, and the U.N. is required under its Charter to uphold the rights of marginalized and poor communities.

Presentations on violence against sex workers in the Democratic Republic of Congo, and on inheritance law in Zimbabwe, pointed out that human rights abuses against women are taking place despite the existence of supportive policies.

Many examples highlighted the importance of meaningful involvement of affected communities in policy development processes, but there was comparatively less discussion about where and how this is happening.

Speakers from Zimbabwe noted that women are raped as punishment for having the wrong political affiliation. In a situation where such practices prevail with impunity, women cannot effectively participate in policy development processes.

Several examples of good practice and advocacy for policy change were shared. For example:

- In the Ukraine, people who use drugs were supported, both financially and technically, to advocate for access to oral substitution therapy.
- Networks of HIV-positive women from India, Mexico and the U.K. are providing legal support alongside capacity building for advocacy and policy engagement.
- In countries such as Jamaica, civil society is organizing to document human rights abuses.

One speaker highlighted the use of diverse, inclusive trans-national networks as being the key to the success of the Treatment Action Campaign in South Africa. The use of information technology in communication (ITC) was critical to this success. ITC also helped to bring the world's attention to human rights violations of sex workers in Cambodia. In future, we can expect that ITC will feature critically in terms of advocacy and activism.

There was a prevailing sense at the conference that advocacy and activism will be needed to ensure political leadership and respect for human rights; and that advocacy and activ-

ism will have to be confrontational and constructive, and be based on optimism and an ambition for social justice for all.

Conclusion

In 2005, world leaders committed to delivering universal access by the end of 2010. But according to some U.N. reports “universal access” has now come to mean “partial access.”

In 2010, the AIDS community

must hold itself and its leaders accountable for achieving the universal access targets. At the next International AIDS Conference in Vienna in 2010, many countries will have to account for why they failed to deliver universal access for their citizens.

Finally, in order to achieve universal access, human rights for all must be at the heart of the AIDS response. Otherwise the AIDS response will

have lost its heart and its hope and we will fail to deliver universal access.

– Mandeep Dhaliwal

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Lessons from Africa: combating the twin epidemics of domestic violence and HIV/AIDS

Domestic violence and HIV/AIDS have proven a lethal combination, exacting a heavy toll on women’s lives, particularly in Africa. In this article, partially based on a presentation made at the human rights networking zone at the conference, Tamar Ezer examines the interrelation between domestic violence and HIV/AIDS, provides an analysis of obligations under human rights law, and describes innovative programs that attempt to address the intersection of these twin epidemics. The author argues for holistic approaches that address the social, economic and legal dimensions of the problem.

Introduction

Both domestic violence and HIV/AIDS exist on a vast scale: 10–50 percent of women worldwide are assaulted by their male partner¹ and, as of 2007, 32.2 million people were living with HIV.² HIV infection is growing faster among women in most regions of the world,³ and domestic violence is a key factor in the epidemic’s increasing feminization.⁴

Violence against women and HIV/AIDS are so closely intertwined that they are often referred to as the “twin epidemics.” Violence is both a cause of HIV vulnerability and a consequence of infection, because women subject to domestic violence have little control over their sexual lives, and women disclosing their HIV status to partners are at greater risk of violence. Domestic violence thus contributes to women’s infection

and impedes testing, treatment and services.

No place has suffered greater devastation from the twin epidemics than sub-Saharan Africa. It is home to 68 percent of the world population living with HIV.⁵ Women are predominantly infected, with the hardest hit being between the ages of 15 and 24.⁶

In this age group in sub-Saharan Africa, women comprise 75 percent

of the population living with HIV and, in some places, are up to six times more likely to be living with HIV than men.⁷ However, Africa has also seen the emergence of innovative programs to combat the deadly linkage between HIV/AIDS and domestic violence, offering important lessons worldwide.

There is documented evidence of the success of social and economic programs empowering women. Logically, the next phase should be the integration of legal services into health and economic empowerment programs. Legal tools play an important role in improving health outcomes by confronting underlying human rights abuses. Using the law, women can access economic resources and leave abusive situations.

The incorporation of legal services thus has the powerful potential to address drivers of the epidemic and improve access to treatment and care. By protecting women's basic rights and providing them with options, legal services can both reduce risk of infection and strengthen women's ability to take advantage of HIV care.

The intersection of domestic violence and HIV/AIDS

Violence as a cause of HIV vulnerability

Women abused by their partners are less able to protect themselves from HIV infection. They have difficulty insisting on condom use, refusing sexual advances and controlling their sexual relationships. Research from Rwanda, South Africa and Tanzania indicates that women who experience domestic violence face up to three times the risk of HIV infection of other women.⁸

Negotiating condom use is especially challenging for women in stable partnerships in sub-Saharan Africa. Women in long-term relationships often have the least control over their sexual autonomy and the greatest economic dependence.⁹ Moreover, requesting condom use implies a lack of trust, sexual desire and sexual experience, contradicting traditional gender norms for women.¹⁰

The situation is especially problematic in marriage, where the culture is for men not to be faithful while husbands want children.¹¹ Thus, contrary to expectation, marriage does not serve to protect women, but rather places them at the greatest risk.

Marriage does not serve to protect women, but rather places them at the greatest risk.

Studies in Africa find that married women have a higher rate of infection than sexually active unmarried women,¹² and conclude that “[t]he long-revered institution of marriage is unfortunately the most likely source of HIV infection for women.”¹³ According to the United Nations Population Fund, 60 to 80 percent of HIV-positive women in sub-Saharan Africa have been infected by their husbands, their sole partner.¹⁴

Not only are women who experience violence more vulnerable to HIV, but men who engage in violence

are likewise more susceptible to infection. Violent behavior comes with a whole cluster of risk factors. Abusive men tend to have more sexual partners and engage in more risk-taking, and they are thus more likely to be HIV-positive.¹⁵ The domestic violence epidemic, therefore, has important implications for the HIV status of both genders.

Violence as a consequence of infection

HIV-positive status is often a trigger for violence. In studies in sub-Saharan Africa and Southeast Asia, between 3.5 to 14.6 percent of women reported a violent reaction from their partner following disclosure.¹⁶ Disempowered socially and economically, women are easy scapegoats for the disease and often blamed for bringing it into the relationship.¹⁷

In focus group discussions in Uganda, “there was a general consensus that men would universally condemn wives for bringing the disease into the home even where the woman was faithful and the husband had extra-marital sexual contact.”¹⁸ Men may refuse to take responsibility for the infection as a matter of pride and to maintain their identity as the head of the household.

There is a close connection between physical and economic abuse. Studies show that women with greater autonomy and control over resources are better protected from violence.¹⁹ In many contexts in sub-Saharan Africa, women can only access property through the men in their lives.²⁰ As the Centre on Housing Rights and Evictions reports, “[T]he majority of women in sub-Saharan Africa — regardless of their marital status — cannot own or inherit land, housing and other prop-

erty in their own right. . . . [W]omen are made entirely dependent on their relationship to a male."²¹

Economically dependent on partners, women are especially vulnerable to abuse. Moreover, women fear abandonment and loss of economic support just as much as physical violence if they reveal their HIV status.²²

As a result, a significant number of women living with HIV/AIDS do not disclose their status to their partners. About 71 percent of women in the developed world and only 52 percent of women in the developing world share their HIV status with their partners.²³

Rates of non-disclosure are especially high among women seeking antenatal care, a time of particular vulnerability and economic dependence.²⁴ In one study in sub-Saharan Africa, 77.8 percent of HIV-positive pregnant women failed to share their status with their partners even after 18 months of follow up.²⁵

Women identified fear of accusations of infidelity, violence, abandonment, loss of economic support, and discrimination as barriers to disclosure.²⁶ These fears are justifiable: 3.5 to 14.6 percent of women in sub-Saharan Africa — generally those in the most secure relationships — report negative outcomes upon HIV status disclosure.²⁷

Domestic violence impedes women from accessing HIV testing and treatment. This is especially worrying because 90 percent of people with HIV do not know their status, and 72 percent of those who need treatment do not have access to it.²⁸

Women fear violence from their partners if they visit voluntary counseling and testing (VCT) centres and health facilities.²⁹ Furthermore, they may be unable to take or adhere to

treatment. A clinic in Zambia, which provides free antiretrovirals (ARVs) for women who test HIV-positive, reported that over 60 percent of eligible women refuse treatment because they fear violence and abandonment if their partners find out their status.³⁰

The tragedy is that all of this is preventable.

Three-quarters of the HIV-positive women participants in the clinic were unable to adhere to ARV regimens because they were trying to hide pills or were forced to share medication with an untested spouse.³¹ (Fearing stigma, men may prefer to be “tested by proxy,” sending their partner out to be tested in their place.³²) This has severe consequences for both partners as failure to take ARVs regularly increases the risk of viral resistance to cheaper and affordable medicines.

Women are further unable to benefit from strategies to prevent mother-to-child transmission of HIV (PMTCT), which has a devastating effect on the health of women and children. Even those women who are tested may not even return to get their results.³³ Currently, globally, 89 percent of pregnant HIV-positive women are not receiving PMTCT, and 530 000 children are infected with HIV.³⁴ In South Africa, AIDS is a leading killer of women in pregnancy,³⁵ and HIV has increased the childhood mortality rate in Africa by 100 percent.³⁶

The tragedy is that all of this is preventable.

Obligation for action under human rights law

The interrelation of domestic violence and HIV/AIDS is a violation of human rights. According to the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, “Every woman shall be entitled to respect for her life and the integrity and security of her person.”³⁷ Women’s right to physical integrity is further protected in international law under the rights to life,³⁸ health,³⁹ equality⁴⁰ and freedom from cruel, inhuman and degrading treatment.⁴¹

The (U.N.) Committee on Economic, Social and Cultural Rights remarked that a “major goal” under the right to health should be “protecting women from domestic violence,”⁴² and the (U.N.) Committee on the Elimination of Discrimination against Women indicated that the “definition of discrimination includes gender-based violence.”⁴³ Women’s greater susceptibility to HIV/AIDS as a result of widespread domestic violence is thus a violation of their fundamental rights. Amongst other interventions, legal services for women are a critically needed remedy.

The recent U.N. Secretary-General’s study on violence against women lays out the benefits of looking at this phenomenon through a human rights lens, especially in the context of HIV/AIDS. First, human rights provides “a unifying set of norms” to monitor government and ensure accountability.⁴⁴ Second, this framework empowers women, “positioning them not as passive recipients of discretionary benefits but as active rights-holders.”⁴⁵

Finally, it promotes “an understanding of the interrelationships between women’s human rights and how denial of these rights creates conditions for violence against them.”⁴⁶ This points to the importance of a multi-sectoral response to the intersection of HIV/AIDS and violence.

Holistic approaches to address domestic violence and HIV/AIDS

The above analysis highlights the need for holistic approaches that address the social, economic, and legal dimensions of the AIDS epidemic. As researchers increasingly recognize, medical interventions focused on individual patients are insufficient. Rather, there is a critical need for “AIDS prevention strategies based in the concept of empowerment that help women to gain control over their economic, social, and sexual lives.”⁴⁷

There are pioneering programs in Africa implementing these strategies. The two described below incorporate social and economic development strategies whose impact on HIV risk has been documented and established.

Social empowerment to reduce abuse and infection

Tackling the root causes of domestic violence is critical for HIV prevention. Domestic violence touches on core identities and definitions of masculinity and femininity.

The Stepping Stones program for HIV prevention aims to improve sexual health through better communication between partners and promotion of more equitable relationships.⁴⁸ To achieve these objectives, the program relies on participatory learning and

self-reflection.⁴⁹ The Gender and Health Research Unit of Pretoria’s Medical Research Council evaluated a South African adaptation of this program in rural Eastern Cape,⁵⁰ focusing on its ability to impact new HIV infections, sexual behaviour and male violence.⁵¹

Domestic violence touches on core identities and definitions of masculinity and femininity.

This was a cluster randomized trial among women and men aged 15 to 26 from 70 villages.⁵² Villages, containing about 20 female and 20 male subjects, were allocated to either the Stepping Stones program or a three-hour session on safer sex and HIV.⁵³ All subjects were interviewed and given an HIV test at recruitment, with follow-up interviewing and re-testing at one and two years.⁵⁴ The quantitative outcomes were supplemented by in-depth interviews with 21 participants — 11 men and 10 women.⁵⁵

The program had an impact on both individuals and the community. At two years, women in the intervention group had 15 percent fewer new HIV infections than those in the control group.⁵⁶ Men in the intervention group reported fewer partners, consistent condom use, and much lower involvement in intimate partner violence.⁵⁷

Participants in the intervention group further reported advising others

on HIV and avoiding violence and persuading partners and family members to be tested.⁵⁸ Men recounted stopping fights between friends, improved relations with parents and elders, and an end to involvement in delinquency acts such as stealing pigs or robbing street vendors.⁵⁹

Social and economic empowerment to reduce abuse and infection

Intervention with Microfinance for AIDS and Gender Equity (IMAGE) addresses the link between violence and social and economic disempowerment. South African researchers started this project, in collaboration with the microfinance organization, Small Enterprise Foundation (SEF), in 2001 in Limpopo, one of South Africa’s poorest provinces.⁶⁰

Groups of about 40 SEF participants were already meeting every two weeks to repay loans and discuss business plans, and IMAGE expanded these meetings to include sessions on gender and HIV.⁶¹ In order to receive further loans, women had to attend these workshops.⁶² Each workshop was run by a woman from the local community, trained to lead role plays and discussions about relationships, sexuality, gender roles and the effects of local culture on the treatment of women.⁶³

The IMAGE program led to a significant drop in domestic violence. After two years of participation, women were half as likely to experience domestic violence in the previous year when compared with a similar group of women who had not participated in the program.⁶⁴ IMAGE participants additionally collaborated with male community leaders, including village chiefs, police, and school principals, to raise aware-

ness around domestic violence and HIV/AIDS.⁶⁵

The program empowered women by addressing the link to economic independence. It also created a “collective social energy,” allowing women to work together on common problems they could not solve on their own.⁶⁶

Addressing legal dimensions

To build on the success of programs such as these, the next phase should be the integration of legal services into health and economic empowerment programs. Legal action is a key vehicle through which to confront the social determinants of health⁶⁷ and provide women with meaningful choices, including mechanisms for protection and redress.

As the U.N. Secretary-General’s study on violence against women recognized, survivors of violence “often need legal services” for a variety of issues they face, “such as divorce, child custody, child support and maintenance, property settlements, housing, employment and civil suits.”⁶⁸

The Open Society Institute’s Law and Health Initiative (LAHI), in collaboration with the Open Society Initiative for East Africa, is supporting pilot legal integration programs that seek to address human rights abuses that underlie vulnerability to infection and impede treatment. The hope is that providing coordinated, more complete services would improve their effectiveness and increase individuals’ access to justice.

In Kenya, one project integrates human rights training and legal services in 30 HIV facilities of the Christian Health Association of Kenya, and another integrates paralegal services into savings and loans programs run by CARE, training both

a paralegal network and leaders in the community on laws and issues affecting women.

One-stop shop for the consequences of infection

Similarly, a holistic approach is necessary to address the domestic violence consequences of HIV infection. VCT centres have an important role to play in identifying and supporting victims of violence.⁶⁹ It is thus crucial to integrate domestic violence screening, counseling and management strategies into testing centres,⁷⁰ and women should be provided with legal services to empower them to leave abusive relationships.⁷¹

LAHI is helping to support several such projects. In Kenya, the Coalition on Violence Against Women has partnered with Liverpool VCT Care and Treatment to provide women in post-rape centres with comprehensive services. A lawyer is placed in the hospital where these post-rape centres are located, enabling a “one-stop shop” health clinic with testing, counseling and legal services.

In South Africa, the University of KwaZulu Natal is integrating legal education and services into health centres offering pregnant women HIV tests as part of antenatal care.

In Swaziland, the Swaziland Action Group Against Abuse has partnered with HIV testing centres, operated by Family Life Association of Swaziland and the AIDS Information and Support Centre, to strengthen their capacity to respond to violence. Project activities include training staff from the three organizations on the intersection of HIV/AIDS and gender-based violence, assisting women to safely disclose their HIV status, screening rape survivors for HIV

infection, providing legal support, and developing a referral map for comprehensive services.

Conclusion

The twin epidemics of domestic violence and HIV/AIDS are indeed incredibly challenging issues. Domestic violence both increases women’s vulnerability to infection and constitutes a major barrier to testing, disclosure and treatment. However, programs like the ones described above, are encouraging and show that interventions can work in unraveling this lethal intersection. We need to think creatively and adopt holistic approaches that address social, economic and legal dimensions. Integrating legal services into economic empowerment and health programs can play a powerful role in confronting the underlying human rights violations fueling the twin epidemics.

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Sexual assault, domestic violence and HIV: promoting women's rights through legislation

General HIV laws seldom, if ever, address the human rights abuses that most affect women, particularly rape, sexual assault and domestic violence. In this article, which is based on his presentation at a concurrent session at the conference, Richard Pearshouse describes a Canadian HIV/AIDS Legal Network project to develop draft legislation covering certain areas of women's rights. The draft legislation is intended to be used as a practical resource for bringing about concrete law reform. This presentation won for Richard the International AIDS Society's Young Investigator Award for the conference's Track E (Policy and Political Sciences).

Legislation can be instrumental in impeding or promoting initiatives to address the HIV pandemic. A considerable number of countries have passed general HIV laws, while various areas of non-AIDS specific legislation (such as criminal law, family law and property law) also have tangible impacts on those affected by the virus as well as on efforts to end the epidemic. However, almost without exception, general HIV laws are deathly quiet on crucial issues — and human rights abuses — that perpetuate the pandemic.

Nowhere are these observations truer than with respect to issues relating to women's human rights. Rape and other forms of sexual violence in which bodily fluids are exchanged contribute to a heightened vulnerability to HIV infection.¹

Sexual violence can increase the risk of HIV infection both directly, through forced sex, and indirectly, by constraining the ability of a victim to negotiate the circumstances in which sex takes place and the use of condoms.² Additionally, several reports document a correlation between sexual violence and high-risk behaviours

in later stages of life that may also increase the risk of HIV.³

Domestic violence has also been shown to undermine HIV/AIDS prevention efforts. Abused women may be wary of accessing prevention information and materials for fear of raising suspicions about their own fidelity and health status. Because of the stigma attached to HIV infection and the abuse inflicted on so many women when their male partners or in-laws find out that they are HIV-positive, many women conceal their status or avoid getting tested.⁴

To help address this gap, the Canadian HIV/AIDS Legal Network is developing draft legislation in certain areas of women's rights, including sexual assault and domestic violence.⁵ This project draws together international human rights law and illustrative examples of national legislation as the basis for developing a draft legal framework to respect, protect and fulfil women's rights in the context of HIV.

The draft legislation references international law and progressive national laws, including several from sub-Saharan Africa. The package of

draft legislative provisions and supporting research is intended as an advocacy resource for developing countries and countries in transition. The project's current focus is on women's rights in sub-Saharan Africa, although the resource will be designed without targeting any one particular jurisdiction.

Examples of progressive, rights-protecting legal frameworks are rare. However, this project develops detailed legislative provisions to act as the basis of law reform around rape, sexual assault and domestic violence in the context of HIV. For example, the draft legislative provisions:

- standardize the definition of these crimes with international human rights law;
- provide legal definitions to criminalize marital rape;
- provide guidelines with respect to the treatment and protection of victims of sexual violence as they interact with police, prosecutors and the trial process (including access to post-exposure prophylaxis); and

- exclude evidentiary rules on rape and sexual assault that negatively impact on the willingness of victims to report crimes of sexual violence.

The draft legislation is scheduled to be completed by the end of 2008.

Using the resource for concrete law reform activities is a vital component of this project. To that end, the Legal Network will work closely with BONELA (The Botswana Network on Ethics, Law and HIV/AIDS) and other advocates in Botswana on a series of activities connected with that country's new domestic violence law.

These will include activities such as training on the new law for government functionaries, the develop-

ment of implementing regulations or guidelines, and advocacy around the issue of marital rape (which, regrettably, was not covered in the new domestic violence law).

– Richard Pearshouse

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HIV is a virus, not a crime

Criminalization of HIV transmission is an ineffective tool for combating AIDS and a costly distraction from programmes that we know work — programmes such as effective prevention, protection against discrimination, reducing stigma, empowering women and providing access to testing and treatment. In this article, which is based on a plenary presentation by Edwin Cameron, the authors advance ten reasons why criminalization is poor public health policy.

Introduction

In Texas, in 2008, a homeless man was sent to jail. He was convicted of committing a serious offence while being arrested for drunk and disorderly conduct — namely, harassing a public servant with a deadly weapon. Because of his past encounters with the law, the system ratcheted up the gravity of what he did, and he ended

up being sentenced to 35 years in jail — of which he must serve at least half before he can apply for parole.¹

The man had HIV. The “deadly weapon” he used was his saliva. He was jailed because he spat at the officers who were arresting him.

According to the most assured scientific knowledge we have, after nearly three decades studying the virus, saliva has never been shown

to result in transmission of HIV.² So the “deadly weapon” the man was accused of wielding was no more than a toy pistol — and it wasn't even loaded. Ratcheting up the criminal law because the man had HIV was thus inappropriate, unscientific and plain wrong.

Also, note the length of the sentence. Whatever his past conduct, it stuns the mind that someone who

has not actually harmed anyone or damaged any property (or otherwise spoiled the world) could be locked away for 35 years. The inference that his HIV status played a significant, probably pivotal, part in sending him away for so long is unavoidable. In short: the man was punished not for what he did, but for the virus he carried.

In Zimbabwe, in 2007, a 26-year-old HIV-positive woman from a township near Bulawayo was arrested for having unprotected sex with her lover. The crime of which she was convicted was “deliberately infecting another person.”

The strange thing is, her lover tested HIV-negative. The woman was receiving ARV therapy, so that is not surprising.³ Before sentencing her, the court tried to get a further HIV test from the lover — even though it was reported that he didn’t want to proceed with the charges.⁴ She was eventually sentenced to a suspended term of five years’ imprisonment.⁵ The threat of imprisonment, and the shame and ordeal of her conviction, will continue to hang over her.

The statute under which she was convicted, Section 79 of the Zimbabwe *Criminal Law (Codification and Reform) Act 23* of 2004, is an extraordinary piece of legislation. It doesn’t make it a crime merely for a person who knows that she has HIV to infect another. It makes it a crime for anyone who realizes “that there is a real risk or possibility” that she might have HIV, to do “anything” that she “realises involves a real risk or possibility of infecting another person with HIV.”

Although the crime is called “deliberate transmission of HIV,” you can commit this crime even if you do not transmit HIV. In fact, you can

commit the crime even if you do not have HIV.

What is more, the wording of Zimbabwe law stretches wide enough to cover a pregnant woman who knows she has, or fears she may have, HIV. For if she does “anything” that involves a possibility of infecting another person — like, giving birth, or breast-feeding her newborn baby — the law could make her guilty of deliberate transmission — even if her baby is not infected.

In all cases, the law prescribes punishment of up to twenty years in prison.

These laws are stunningly wide in their application, and fearsome in their effects.

In Sierra Leone, lawmakers have gone even further. Their law requires a person with HIV who is aware of the fact to “take all reasonable measures and precautions to prevent the transmission of HIV to others” — and it expressly covers a pregnant woman.⁶ It requires her to take reasonable measures to prevent transmitting HIV to her fetus.

Other examples:

- In Egypt, Human Rights Watch reports that men are being arrested merely for having HIV under Article 9(c) of Law 10/1961, which criminalizes the “habitual practice of debauchery [fujur]”

— a term used to penalize consensual homosexual conduct.⁷

- In Singapore,⁸ a man with HIV has been sentenced to a year in prison for exposing a sexual partner to the virus — even though the risk to the partner (whom he fellated) was minimal, if not non-existent.
- In Bermuda, a man with HIV who had unprotected sex with his girlfriend has been sentenced to ten years’ imprisonment, even though he did not infect her.⁹
- In June 2008, the highest court in Switzerland held a man liable for negligently transmitting HIV to a sexual partner when he knew that a past partner had HIV, even though he believed, because he experienced no seroconversion symptoms, that he himself did not have HIV.¹⁰

These laws are stunningly wide in their application, and fearsome in their effects. They attack with a sledgehammer rational efforts to lessen the impact and spread of the epidemic. They represent a rash phenomenon that is taking place world-wide:

- Law-makers are putting on the statute books laws that create special crimes of HIV transmission or exposure. In Africa, more than a dozen countries¹¹ have already adopted laws similar to the one in Sierra Leone.
- Courts and prosecutors are targeting men and women with HIV for special prosecution.

These laws and prosecutions are creating a crisis in HIV management and prevention efforts — and they constitute one of the biggest issues in the epidemic right now.

Rationale for criminalization

Why the push for criminalization? The rationale is that HIV is a fearsome virus, and its effects are potentially deadly; and that public officials should be able to invoke any available and effective means to counter its spread. This includes criminal statutes and criminal prosecutions. Moreover, in the abstract and from a distance from social reality, there seems a certain justice that criminal penalties should be applied against those who negligently, recklessly or deliberately pass on the virus — even against those whose actions create only the risk of doing so.

African lawmakers and policymakers, in particular, have reason to look for strong remedies. Many African countries face a massive epidemic with agonizing social and economic costs.

In addition, many lawmakers are spurred especially by the plight of woman. Many (including very young women) are infected by unwary or unscrupulous men — they need special protection, so the argument goes, and a criminal statute may give best voice to their entitlement to protection.

Why criminalization is bad public health policy

But these are bad arguments, and they need to be countered: rationally, powerfully and systematically. Here are ten reasons why criminal laws and criminal prosecutions make bad policy in the AIDS epidemic.

FIRST: Criminalization is ineffective. These laws and prosecutions don't prevent the spread of HIV.

In the majority of cases, the virus spreads when two people have consensual sex, neither of them knowing that one has HIV. That will continue to happen, no matter what criminal laws are enacted, and what criminal remedies are enforced.

SECOND: Criminal laws and criminal prosecutions are a shoddy and misguided substitute for measures that really protect those at risk of contracting HIV — i.e., effective prevention, protection against discrimination, reduced stigma, strong leadership and role models, greater access to testing and, most importantly, treatment for those who are unnecessarily dying of AIDS. AIDS is now a medically manageable condition. It is a virus, not a crime, and we must reject interventions that suggest otherwise.

Prosecutions and laws single out already vulnerable groups.

For the uninfected, we need greater protection for women, and more secure social and economic status, enhancing their capacity to negotiate safer sex and to protect themselves from predatory sexual partners. Criminal laws and prosecutions will not do that. What they do, instead, is to distract us from reaching that goal.

THIRD: Far from protecting women, criminalization victimizes, oppresses and endangers them. In Africa, most people who know their HIV status

are female because most testing occurs at ante-natal healthcare sites. The result, inevitably, is that most of those who will be prosecuted because they know — or ought to know — their HIV status will be women.

Many women cannot disclose their status to their partners because they fear violent assault or exclusion from the home. If a woman in this position continues a sexual relationship (whether consensually or not), she risks prosecution under African laws for exposing her partner to HIV.

FOURTH: Criminalization is often unfairly and selectively enforced. Prosecutions and laws single out already vulnerable groups — like sex workers, men who have sex with men and, in European countries, black males.

FIFTH: Criminalization places blame on one person instead of placing responsibility on two. This is a hard but important thing to say. HIV has been around for nearly three decades, during which the universal public information message has been that no one is exempt from it. So the risk of getting HIV must now be seen as an inescapable facet of having sex. We cannot pretend that the risk is introduced into an otherwise safe encounter by the person who knows or should know he has HIV. The risk is part of the environment, and practical responsibility for safer sex practices rests on everyone who is able to exercise autonomy in deciding to have sex with another.

The person who passes on the virus may be “more guilty” than the person who acquires it, but criminalization unfairly and inappropriately places all the blame on the person with HIV. It is true (as we have

pointed out) that the subordinate position of many women makes it impossible for them to negotiate safer sex. When a woman has no choice about sex, and gets infected, her partner unquestionably deserves blame. But the fact is that criminalization does not help women in this position. It simply places them at greater risk of victimization. Criminalization singles one sexual partner out. All too often, despite her greater vulnerability, it will be the woman. Criminalization compounds the evil, rather than combating it.

SIXTH: These laws are difficult and degrading to apply. This is because they intrude on the intimacy and privacy of consensual sex. (We are not talking about non-consensual sex; that is rape, and rape should always be prosecuted.) But where sex is between two consenting adult partners, the apparatus of proof and the necessary methodology of prosecution degrade the parties and debase the law. The Zimbabwean woman again springs to mind: Her lover wanted the prosecution withdrawn, but the law vetoed his wishes. It also countermanded her interests. The result is a tragedy for all, and a blight on HIV prevention and treatment efforts.

SEVENTH: Many of these laws are extremely poorly drafted. For instance, under the “model law” that many countries in east and west Africa have adopted, a person who is aware of being infected with HIV must inform ‘any sexual contact in advance’ of this fact. But the law does not say what “any sexual contact” is. Is it holding hands? Kissing? Or only more intimate forms of exploratory contact? Or does it apply only to penetrative

intercourse? Nor does it say what “in advance” means. The “model” law would not pass muster in any constitutional state where the rule of law applies. The rule of law requires clarity in advance on the meaning of criminal provisions and the boundaries of criminal liability.

EIGHTH: Criminalization increases stigma. From the first diagnosis of AIDS 27 years ago, HIV has carried a mountainous burden of stigma. This has been for one over-riding reason: the fact that it is sexually transmitted. No other infectious disease is viewed with as much fear and repugnance as HIV is.

It is stigma that makes those at risk of HIV reluctant to be tested; it is stigma that makes it difficult — and often impossible — for them to speak about their infection; and it is stigma that continues to hinder access to the life-saving ARV therapies that are now increasingly available across Africa. Tragically, it is stigma that lies primarily behind the drive to criminalization. It is stigma, rooted in the moralism that arises from the sexual transmission of HIV, that too often provides the main impulse behind the enactment of these laws.

NINTH: Criminalization is a blatant dis-inducement to testing. It is radically incompatible with a public health strategy that seeks to encourage people to come forward to find out their HIV status. AIDS is now a medically manageable disease. But why should any woman want to find out her HIV status, when her knowledge can only expose her to risk of prosecution? By reinforcing stigma, by using the weapons of fear and blame and recrimination, criminalization makes it more difficult for those

with or at risk of HIV to access testing, to talk about diagnosis with HIV, and to receive treatment and support.

We therefore have a dire but unavoidable calculus: Criminalization is costing lives. The International Community of Women Living with HIV/AIDS (ICW) has rightly described laws like this as part of a “war on women.”¹² They are not just a war on women. They are a war on all people with HIV.

Criminalization assumes the worst about people with HIV and punishes vulnerability.

TENTH: Criminalization assumes the worst about people with HIV and, in doing so, it punishes vulnerability. The human rights approach assumes the best about people with HIV and supports empowerment.

As Justice Michael Kirby has argued, countries with human rights laws that encourage the undiagnosed to test for HIV do much better at containing the epidemic than those that have “adopted punitive, moralistic, denialist strategies, including those relying on the criminal law as a sanction.”¹³

When condoms are available, when women have the power to use them, when those with HIV or at risk of it can get testing and treatment, when they are not afraid of stigma, ostracism and discrimination, they are far more likely to be able to act consistently for their own safety and that of others.

Conclusion

Let us send out a firm and clear message:

- Criminalization is a poor tool for regulating HIV infection and transmission.
- There is no public health rationale for invoking criminal law sanctions against those who unintentionally transmit HIV or expose others to it.
- The sole rationale for criminalization is the criminal law goal of retribution and punishment — but that is a poor and distorted aim for public health law.
- Criminalization is in general warranted only in cases where someone sets out, well knowing he has HIV, to infect another person, and achieves this aim.

Let us undertake a major international push-back against misguided

criminal laws and prosecutions. Let us return from this conference to our countries, determined to persuade law-makers and prosecuting authorities of the folly and distraction of criminalization. Let us return strengthened in our resolve to fight AGAINST stigma, against discrimination and against criminalization — and to fight FOR justice, good sense, effective prevention measures and for access to treatment.

— *Edwin Cameron, Scott Burris and Michaela Clayton*

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¹ G. C. Kovach, "Prison for man with H.I.V. who spit on a police officer," *New York Times*, 16 May 2008.

² Centers for Disease Control, "Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV," online at www.cdc.gov/hiv/resources/qa/qa37.htm.

³ Swiss HIV clinical specialists recently released a consensus statement "that individuals with HIV on effective antiretroviral therapy and without sexually transmitted infections (STIs) are sexually non-infectious." See P. Vernazza et al., "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle," *Bulletin des médecins suisses* 89(5) (2008).

⁴ Reported in the (Zimbabwe) *Herald*, 2 April 2008.

⁵ *Herald*, 8 April 2008.

⁶ Sierra Leone's *Prevention and Control of HIV and AIDS Act of 2007*, s. 21, at www.sierra-leone.org/Laws/2007-8p.pdf.

⁷ For details of these allegations, see the letter of protest at www.hrw.org/english/docs/2008/04/07/egypt18439_txt.htm.

⁸ See materials posted by E.J. Bernard at <http://criminalhivtransmission.blogspot.com/>.

⁹ UNFPA, *The Criminalization of HIV*, fact sheet, June 2008.

¹⁰ E.J. Bernard.

¹¹ Benin, Burundi, Burkina Faso, Cape Verde, Central African Republic, Chad, the Democratic Republic of Congo, Equatorial Guinea, Guinea, Guinea Bissau, Kenya, Mali, Mauritania, Niger, Sierra Leone, Tanzania and Togo.

¹² Email communication from Beri Hull of ICW.

¹³ "Australian judge slams HIV criminalization," *Poz*, 18 July 2008.

Pretrial detention: scale and relevance to HIV/AIDS

The overuse of pretrial detention worldwide has created conditions in detention facilities that expose large numbers of people to health risks, including the risk of contracting HIV. In this article, based on her presentation at a concurrent session at the conference, Denise Tomasini-Joshi describes the problems, and puts forward suggestions for how they can be addressed.

The indiscriminate use of pretrial detention (PTD) — the incarceration of accused persons before they have been determined guilty of the

crime charged — is a violation of international legal standards. These unequivocally establish that all persons are presumed innocent and that

liberty while under trial should be the rule rather than the exception.¹

In spite of these clear standards, the practice of detaining people with-

out a conviction has become more prevalent than freedom while under trial. Because PTD is so prevalent, and carries a number of undesirable social and health consequences, it has become important to address the problem from various perspectives, including those of health and HIV/AIDS.

In 2006, an average of 33.1 percent of all prisoners globally were pretrial detainees. This number, however, is both an average and a snapshot of a single day of detention. As such, it can't provide a true picture of the problem because: (a) it dilutes the numbers for the worst offending countries; (b) it fails to demonstrate how long people spend detained, but not convicted; and (c) it doesn't show how many people spend at least some amount of time in PTD.

To illustrate the point about dilution, the following is a list of the countries with the worst ratios of pretrial detainees as a percentage of all prisoners:²

Country	Percentage
Liberia	97.3
Mali	88.7
Haiti	84.2
Niger	76.0
Bolivia	75.0
India	69.7
Paraguay	68.2
Peru	67.8
Bangladesh	67.7
Philippines	67.3

Health consequences of excessive pretrial detention

PTD poses particular health risks for a number of reasons. First, prison-

ers in PTD are often subjected to extreme and erratic overcrowding.³ Some of this overcrowding takes place in police cells designed for short-term stays and not equipped to handle great numbers of permanent detainees. Since structures for long-term care are not in place, pretrial detainees often don't have access to health care, exercise, work, or education programs; and are subjected to little oversight and control.

While many people in PTD are held for extended periods of time, the population in these cells is still transient. People are sentenced, charges are dropped, and some manage to obtain provisional release. Further, pretrial detainees generally have more contact with lawyers, and family members than sentenced prisoners.

This flow guarantees that detainees are constantly exposed to communicable diseases. Since virtually all detainees are eventually released into the community, the adverse health risks of PTD are not assumed by detainees only; rather they become a public health issue. The risk of spreading any contracted illnesses is heightened upon release because former detainees may not even know that they have been infected.⁴

A further contributor to adverse health effects is poor prison conditions. Many prisons, particularly in the developing world, do not provide detainees with basic nutrition, clothing or beds. Many of the buildings where detainees are housed lack basic sanitation infrastructure, and protection from the elements or from vermin.

It is not surprising, then, that between the overcrowding and the transient population, UNAIDS now refers to prisons as "incubators" of HIV infection and other diseases,

such as hepatitis C and tuberculosis.⁵ While these conditions can be difficult for anyone, and manage to make many sick, for people already suffering from chronic illness they can become a death sentence.

PTD also poses particular risks for people whose health is compromised because there is a higher probability of torture, abuse and assault at the pretrial stage. In countries with limited police resources, cases are "solved" through confessions. Police know that they have a certain period of time to obtain these confessions before the person appears in court, and so torture is often used to obtain them.

Furthermore, because there isn't always a separation between accused persons and convicted criminals, or between youth and adults; and because there are rarely any protective measures for vulnerable detainees, many people end up assaulted and abused in PTD. The problem is particularly salient for transgendered individuals who are often mis-categorized and placed in cells that do not correspond to their gender identity.

For people already suffering from certain illnesses, particularly those with immune-compromised systems due to HIV/AIDS, the result of these frequent occurrences in PTD can be fatal. To make matters worse, much of the assault in PTD can be of a sexual nature, which increases the spread of sexually transmitted and blood-borne diseases.⁶ Since people in prisons and jails have a much higher rate of HIV/AIDS than the general population, the risk of spreading this disease is particularly high.⁷

Breaks in treatment are yet another consequence of detention. For people who are under medical treatment upon arrest, PTD often represents

an unnecessary and risky interruption of this care. Prisoners may wait months to be able to resume taking their medications. In many instances, they are unable to obtain the previously prescribed medications inside the prison.

Finally, for a great number of inmates, medications within the prison are simply not available, making release (be it provisional, through a dismissal of the charges, or through a conviction) the only option for renewing or beginning their treatment.

Solutions to the problem

Solutions to the overuse of PTD must be multifaceted and must include reforms on the ground. At the policy level, and with respect specifically to health, however, it is important to work on the following tasks:

- Develop a network of PTD experts that includes health professionals.
- Increase global awareness, expertise and resources for PTD reform.
- Codify and implement programs and interventions, including medical waiver programs, that provide safe and effective alternatives to PTD.

For health practitioners and people suffering from chronic illnesses,

changes in both legislation, and in the number and type of alternative supervision mechanisms, will be crucial. A well-designed pretrial services program that enables pretrial release could greatly reduce the collateral health consequences of PTD.

While alternatives to PTD, such as pretrial services, exist in many countries — often on paper, sometimes in practice — alternatives that target the needs of people with chronic illnesses such as HIV/AIDS are practically non-existent. A health-focused program that allows a public health exception to detention, and provisional release for treatment continuation, should be developed.

Release and detention decisions must begin to take into account health issues, in order to protect the health of inmates, criminal justice employees and the community at large.

There are many groups working on prison issues or on health issues, but these groups have tended to think of PTD as tangential to their core issues. But PTD is a problem that deeply affects the core constituencies of both groups and a joint campaign is needed to provide possible solutions.

— Denise Tomasini-Joshi

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¹ The American Convention on Human Rights, for example, provides that “every person accused of a criminal offense has the right to be presumed innocent so long as his guilt has not been proven according to law” [Article 8(2)]. The following additional provisions guide the treatment of a person in pretrial detention: “Any person detained shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to be released without prejudice to the continuation of the proceedings. His release may be subject to guarantees to assure his appearance for trial” [Article 7(5)]; “Anyone who is deprived of his liberty shall be entitled to recourse to a competent court, in order that the court may decide without delay on the lawfulness of his arrest or detention and order his release if the arrest of detention is unlawful” [Article 7(6)]; and “Every person has the right to a hearing, with due guarantees and within a reasonable time, by a competent, independent, and impartial tribunal” [Article 8(1)]. At www.oas.org/juridico/english/treaties/b-32.html.

² Statistics from the International Centre for Prison Studies' (ICPS) World Prison Brief at www.kcl.ac.uk/depsta/law/research/icps/worldbrief/.

³ In Russia for example, overcrowding in PTD centres was so dire that inmates had to take turns sleeping. Speech by Yuri Kalinin, former deputy minister of justice, at www.hawaii.edu/hivandaids/The_Russian_Penal_System__Past_Present_and_Future.pdf.

⁴ “Prison’s deadliest inmate, hepatitis C, escaping,” Associated Press, 14 March 2007, at www.msnbc.msn.com/id/17615346/.

⁵ UNAIDS, *From Crisis Management to Strategic Response: 2006 Report on the Global AIDS Epidemic*, at http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH12_en.pdf.

⁶ While prisoner rape is grossly under-reported, a U.S. Federal Bureau of Prisons study reported that 9–20 percent of federal inmates, were victims of rape. P. Nacci and T. Kane, *Sex and Sexual Aggression in Federal Prisons*, 1982.

⁷ For example, in the U.S. the prevalence of HIV/AIDS in prison is three times higher than in the general population. L. Maruschak, *HIV in Prisons, 2003*, U.S. Department of Justice, Bureau of Justice Statistics, 2005.

Central & Eastern Europe and Central Asia: Police raids and violence put sex workers at risk of HIV

In most of the countries of Central & Eastern Europe and Central Asia, sex workers report very high levels of abuse from police, particularly in the context of police raids. In this article, based on an oral presentation at the conference, the Sex Workers' Rights Advocacy Network (SWAN) report on the results of a study conducted among sex workers in several countries in the region. The authors make the link between police violence and general violence, and between violence against sex workers and vulnerability to HIV infection. The authors advance a number of recommendations, including that sex work be decriminalized.

In almost all of the countries of Central & Eastern Europe and Central Asia, sex workers report alarmingly high levels of physical or sexual violence from police officers. On average, the percentages and numbers of sex workers who reported having experienced physical sexual violence from police in the year prior to the study interviews was 41.7 percent (86/206), and 36.5 percent (77/211) respectively.

Many of the incidents described by sex workers constitute torture and are in contravention of U.N. Conventions.

These are the findings of a study conducted by SWAN in 2007 in 13 jurisdictions in 12 countries, including Bulgaria, Czech Republic, Kyrgyzstan, Latvia, Lithuania, Macedonia, Poland, Russia (Northwestern District), Russia (Siberia), Serbia, Slovakia and Ukraine. (Please see the note at the end of the article about the number of countries.) The study was created, administered and interpreted by sex workers and their allies.

Only in two countries, Czech Republic and Poland, did sex work-

ers report low levels of violence from police officers.

Police raids, violence, intimidation

Violence against sex workers frequently occurred in the context of police raids. Sex workers variously reported that sexual violence by police occurred “every time [we were] taken to the station”; or that “police take us away and push us into the river”; or that sex workers were gang raped by police when in police custody.

In several countries, sex workers reported that raids were often part of a larger system of police extortion that is enforced through threats, detention, physical violence and rape. In such a system, police fines and arrest are often unofficial, undocumented and indistinguishable from extortion. In Kyrgyzstan, for example, sex workers reported having to pay off the police every day they worked. In many countries “fines” amounted to all the money sex workers had on them, and often included taking their jewelry or phones.

In Latvia, Kyrgyzstan and Ukraine, sex workers reported being

tested for HIV or STIs against their will after being picked up by police. Sex workers reported that the threat of such testing was an additional tool that was sometimes used by police to leverage extortion money.

Sex workers repeatedly denounced the “lawlessness of police” and their experiences of being illegally detained, framed for crimes they did not commit, forced to clean the police station, or outed as sex workers, as gays or as trans.

Sex workers reported that raids could often result in homelessness and family separation. This occurred when sex workers couldn't afford paying police extortion money and had to resort to give up their homes; when they were imprisoned for long periods; when they were deported following a raid; or when their family learned of their occupation due to a raid and threw them out.

In one case, a sex worker was forced to sell her home in a hurry under the threat that she would be incarcerated if she did not pay a large amount of extortion money ... only to have her home bought by the police!

Link between police violence and general violence

The study found that fears of police violence, extortion or arrest often pushed sex workers into hiding and forced them to work in isolated areas where they are more vulnerable to general violence.

Sex workers reported that police violence and mistreatment severely compromises their ability to report violence against them. The most frequent reasons cited for not reporting violence to the police were fears of police mistreatment, being arrested and being “outed” to police.

Sex workers reported that their lack of access to police protection results in a climate of impunity for crimes against them and has made them easy and frequent targets for aggressors.

Increased vulnerability to HIV infection

Police raids and violence increase sex workers’ vulnerability to HIV in a number of ways:

- The violence is often accompanied by coercion not to use condoms.
- Condoms can be used as evidence of prostitution during a police raid, so sex workers may be reluctant to carry them.
- When police confiscate condoms, sex workers no longer have these condoms at their disposal.
- The financial burden of police fines and extortions can result in sex workers sacrificing condom use in an attempt to attract more clients.
- The threat of police violence or extortion can force rushed nego-

tiations with clients, which can lead to unsafe sex.

- Raids and violence can render sex workers homeless or can push them into hard-to-reach and unsafe areas where they have no access to HIV and support services.

Recommendations

This study demonstrates that one cannot fight HIV without fighting violence against sex workers. We therefore recommend that, in line with U.N. Secretary-General Ban Ki-Moon’s recommendation to Asian countries, governments should decriminalize sex work.

We also recommend that police raids on sex workers be stopped. SWAN’s survey found a direct correlation between the absence or low frequency of police raids, violence and abuse (in countries such as Czech Republic and Poland) and the willingness of sex workers to report crimes to the police and seek their protection.

Governments and U.N. bodies must explicitly oppose HIV or sex work policies that are implemented through police raids or that give police more power to extort sex workers, to test sex workers for HIV or other STIs against their will, or to use physical or sexual violence against sex workers.

We also recommend:

- that laws and policies be enacted to advance the human rights of sex workers; and that sex workers be involved in a meaningful way in this process;
- that organizations by-and-for sex workers that promote sex workers’ rights and health be funded;

- that partnerships be fostered between sex workers and various ministries, including the police, with a goal of decreasing policy violence; and
- and that mainstream human rights groups and other NGOs be supported to collaborate with sex worker groups and projects to document and confront violence by state and non-state actors.

– A.-L. Crago, A. Rakhmetova,
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This article presents results from only 12 jurisdictions, even though the study was actually conducted in 13. Due to safety concerns, data from one country had to be removed. Following public statements by sex workers denouncing violence, members of the local SWAN group administering the survey received death threats and faced the possibility of the government closing down their centre and seizing their confidential medical records. The data from their country paints a stark portrait of generalized routine sexual and physical violence by law-enforcement officers. The authors dedicate this article to the 20 sex workers who risked so much to tell their story, even though it cannot be shared at this point.

A full report on the study, with individual country results, was expected to be posted by the end of 2008 at www.swannet.org, where readers can also sign on to receive SWAN News, a monthly newsletter in English and Russian.

Violence against sex workers by police and military in Democratic Republic of Congo

Sex workers in the Sud-Kivu district of the Democratic Republic of Congo (DRC) are regularly subjected to sexual and other forms of violence. In this article, based on a presentation at a concurrent session at the conference, Alphonse Mihigo Ombeni and Anna Louise Crago describe the negative impacts of this violence on the sex workers' health and working conditions. Many have become HIV-positive.

Sex workers face systematic violation of their human and socio-economic rights, including their right to work. They also face alarmingly high rates of physical and sexual violence from the police and military.

Under the pretexts of “fighting HIV” or “fighting sexual exploitation,” a number of sex work establishments have been raided and shut down by authorities, and the sex workers have been arrested.

Sex workers may be detained in legal jails. However, there also exists a parallel system of illegitimate hide-outs owned and operated by certain police commanders and soldiers.

At times, sex workers have been detained at a police commander's own home.

The sex workers who are illegally detained — essentially kidnapped — are usually released one to two weeks later, after having been submitted to repeated sexual violence and torture.

Between February and July 2007, Action pour la lutte contre l'ignorance du SIDA (ALCIS) documented cases of violence against sex workers by the army, the police and the general public, as well as the impact of the violence on sex workers' health and working conditions. The work was done in collaboration

with 10 solidarity committees of sex workers from different areas of the country.

During this time, 15 sex workers were kidnapped and subjected to sexual violence by military officers; 14 sex workers were illegally detained, tortured and subjected to sexual violence for periods of up to two weeks; and 39 sex workers were subjected to sexual violence by other actors.

The following examples illustrate the common dynamics of these attacks:

- On 16 February 2007, a group of military officers doing night patrols arrested four sex workers from Kadutu in Bukavu. They were raped and tortured.
- On 13 July 2007, after having pillaged four sex workers' homes in Nyamigo, soldiers raped and tortured the victims.
- At the beginning of March 2007, in Kamanyola, three sex workers were placed under arrest, kidnapped and raped by police for three days. All of their valuables were stolen.

In the words of Solange, who is part of the Kavumu sex worker solidarity committee:

I was taken by four soldiers during their night patrol.... These men all raped me and then let me go, barely alive. Now, I have a pregnancy I do not want. I do not want to give birth to this child, whose father submitted me to such incredible pain and tragedy. And my latest test has shown that I am now HIV-positive.

During this period, ALCIS helped 63 sex workers who were victims of sexual violence to receive medical assistance. Of these women, 43 tested positive for STIs and 27 tested HIV-positive. Prior to the attacks, all but four of the sex workers had tested HIV-negative.

The effects on sex workers

Violent attacks against sex workers by police and military have created a climate where it is considered “okay” for anyone to commit such violence. There has been an increase in general violence against sex workers. Sex workers fear police and fear that reporting violence will put them in worse danger.

Sex workers' working conditions have deteriorated substantially. Many sex workers are forced to contend with the psychological violence and

constant threat of regularly seeing their perpetrators as they wander free or patrol sex worker areas.

Fearing raids and violence, many sex workers have resorted to working or living in hidden or remote areas. This has negatively impacted them on many levels:

- Remote areas are often less safe than where the sex workers used to work.
- The sex workers have to contend with fear and isolation, which can impact on their power of negotiation with clients.
- The long distance between homes and health centres can interrupt access to treatment for trauma or injury related to HIV or sexual violence. As a result of this, six sex workers who were attacked have died.

Many sex workers have lost their source of livelihood and their homes as a result of brothel closures, attacks or the need to flee aggressors. As of December 2007, 66 sex workers with whom ALCIS was in contact, and who were previously victims of violent attacks, lacked housing, food and medical care for them and their children.

In addition, 26 sex workers who were incarcerated in prisons had no legal assistance or proper defense. Those who were HIV-positive faced the prospect of treatment interruptions.

The stigma of having been raped as well as, in some cases, being HIV-positive — when combined with the strong stigma against sex workers — create powerful barriers to sex workers accessing health services. As a result, many sex workers never received any form of health care following attacks and suffered alone at home.

Fear of being seen in public and of subsequent attacks have diminished the number of sex workers willing to attend meetings of the sex worker solidarity committees. In this way, the violent attacks have taken a strong toll on sex worker solidarity, so crucial for maintaining sex workers' health and working conditions.

Sex workers have begun speaking out against rape. In 2007, ALCIS published a number of urgent action alerts denouncing cases of violence and sexual violence and started petition campaigns. Along with sustained advocacy on sex workers' rights, ALCIS has begun meeting with police and military to address the issue. It has also pursued medical and legal support for sex workers and visits to sex workers in detention.

Recommendations

To address the problem of sexual violence against sex workers, the authors advance the following recommendations:

- UN agencies and donors should emphasize the crucial role that

preventing violence against sex workers, in particular by police and military, plays in limiting HIV epidemics.

- In order to eradicate violence against sex workers, sex work must be recognized as legitimate work.
- Projects that rely on sex worker-leadership and solidarity to advocate for sex workers' human rights must be supported, morally and financially.
- Efforts to combat and redress state and non-state violence against sex workers from a sex workers' rights perspective must receive adequate funding.

– *Alphonse Mihigo Ombeni and Anna Louise Crago*

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People with disabilities and the AIDS pandemic: making the link

People with disabilities are at a heightened risk of contracting HIV, yet they are not being reached by prevention and treatment campaigns.¹ In this article, based on a presentation made at a concurrent session at the conference, Shonali Shome and Myroslava Tataryn examine the ways people with disabilities are excluded from HIV/AIDS programs; what is being done to address the gap; and what remains to be done.

People with disabilities remain among the most stigmatized, poorest and least educated citizens. All of the risk factors associated with HIV are increased for individuals with disability: poverty, limited access to education and health care, lack of information to ensure safer sex, lack of legal protection, increased risk of violence and rape, vulnerability to substance abuse, and stigma.

In a global survey of disability advocates, 87 percent of the organizations surveyed reported that HIV/AIDS is of immediate concern to the disabled populations that they serve.²

In spite of these heightened risk factors, HIV/AIDS organizations often erroneously assume that people with disabilities are non-sexual, and thus exclude them from prevention and outreach efforts. A lack of qualitative data regarding people with disabilities and HIV/AIDS also makes it difficult to obtain funding or to develop programming.

Gender inequality further compounds the problem for women, who are affected disproportionately by both HIV/AIDS and disability. They comprise 74 percent of people with disabilities in developing countries, yet receive just 20 percent of all rehabilitation assistance worldwide.³

Women with disabilities are esti-

mated to be three times more likely to be raped than non-disabled women.⁴ A dearth of marriage or employment prospects forces many women with disabilities to turn to sex work to survive, further increasing their risk of infection.

Compared to men, women with disabilities are less likely to be educated and more likely to live in unstable relationships, both of which also increase their risk of infection. The global literacy rate for women with disabilities is estimated to be one percent.⁵

Once infected, people with disabilities face hardships such as impeded physical access to health services and stigma from health professionals. Many may be reluctant to disclose their HIV status for fear of compounding the discrimination they regularly face.

The disabled peoples' organizations and AIDS organizations highlighted below are addressing the intersection of disability and AIDS in holistic, gender-sensitive and integrated ways. One organization is doing this work in the midst of a conflict zone; all three organizations work in under-resourced areas. They demonstrate both what is possible and what is necessary to fully address the HIV/AIDS pandemic as well as the human rights of people with disabilities.

Gulu District, Northern Uganda

The violent conflict and subsequent displacement that has ravaged Gulu and surrounding communities for the past 20 years has led to increased rates of physical impairments as well as higher HIV infection rates.

Within this context, a courageous group of women with disabilities disclosed their HIV-positive status following an AIDS and disability awareness campaign sponsored by the National Union of Persons with Disabilities of Uganda.

Many of the women have lost their livelihoods because of HIV-related illness and are no longer supported by their partners because of the stigma related to their HIV-status and their disability. They formed the Gulu District Association of Women with Disabilities, which has grown to over 45 members. The group develops income-generating activities and gathers to discuss treatment side effects and challenges at home, and even to counsel family members.

Kamwokya in Kampala, Uganda

The urban slum of Kamwokya in Kampala, Uganda is home to an impressive mental health clinic

launched by Kamwokya Christian Caring Communities (KCCC), an organization providing accessible HIV/AIDS testing and treatment services.

The field of mental health continues to be marginalized even within the disability rights movement. KCCC's inclusion of mental health in every one of its programs allows all patients to benefit from its full range of services, such as educational support for at-risk youth and income-generating initiatives.

The mental health clinic is now well-known and has become an entry point for patients who then access other services; over 200 cases have now been referred from the mental health clinic to the main clinic providing HIV/AIDS services.

Nairobi, Mombassa and Kisumu, Kenya

In Kenya, the Disability Programme at Liverpool VCT, Care and Treatment is bringing the services of a well-established voluntary counseling and testing (VCT) centre to people with disabilities and the deaf community. The Disability Programme is run entirely by deaf staff, and is completely integrated into Liverpool's overall structure.

All staff members are exposed to the challenges faced by the deaf community and people with disabilities, and they are trained to provide affirming, non-stigmatizing care. Hearing clients attending the VCT centre work through an interpreter, inverting the norm of having deaf clients always be the ones to rely on interpretation. A new project within the Disability Programme will address gender-based violence within the deaf community.

Remaining challenges: linking AIDS and disability

These are examples of creative and successful initiatives taking place on a local level, but a coordinated global response is required to fully address this issue. While the disability movement expands to address HIV/AIDS, the ongoing neglect of disability issues from the international AIDS community is nearly universal.

The annual UNAIDS reports, which provide data on the epidemic's developments as well as analysis of other high-risk populations such as sex workers and injection drug users, do not track or address disability issues anywhere in their text.

The word "disability" is not included in any of the United Nations Millennium projects relating to poverty, health or HIV status. The Mexico conference was the first International AIDS Conference to address the issue.

We have yet to witness a true global response to HIV/AIDS amongst people with disabilities. To address this problem, we offer the following recommendations:

- Implementers of HIV/AIDS programs should partner with disabled people's organizations to ensure that people with disabilities are included in all aspects of programming
- Funders should make consideration of disability issues a required condition for all HIV/AIDS proposals.
- Governments should ratify the *Convention of the Rights of Persons with Disabilities* and the *Optional Protocol*⁶ and ensure that national legislation addresses the rights of people with disabilities.

- U.N. agencies should include disability as a vulnerable group in their programming and should monitor the ongoing challenges people with disabilities face in accessing HIV/AIDS services.

The World Health Organization reports that one person in every ten, 650 million individuals, lives with a disability significant enough to make a difference in their daily lives. This does not include the millions of people that may become disabled by AIDS in their lifetime. The global fight against HIV/AIDS will not be sustainable unless and until the rights and needs of people with disabilities are addressed.

– Shonali Shome and Myroslava Tataryn

Shonali Shome and Myroslava Tataryn are staff members at AIDS-Free World (www.aids-free-world.org), an international advocacy organization that works to promote more urgent and effective global responses to HIV/AIDS.

¹ N. E. Groce, *HIV/AIDS and Disability: Capturing Hidden Voices — The World Bank/Yale Global Survey on HIV/AIDS*, The World Bank, 2004.

² Ibid.

³ Human Rights Watch, *Women and Girls with Disabilities*, online at <http://hrw.org/women/disabled.html>.

⁴ N. E. Groce, "HIV/AIDS and individuals with disability," *Health and Human Rights* 8(2) (2005).

⁵ Ibid.

⁶ Adopted by the U.N. on 13 December 2006; came into force on 3 May 2008.

Coerced and forced sterilization of HIV-positive women in Namibia

Thirteen cases of coerced and forced sterilization of HIV-positive women have been documented in Namibia. In this article, based on a presentation at a concurrent session at the conference, Jennifer Mallet and Veronica Kalambi explain that this is just the tip of the iceberg. The authors provide details of the 13 cases and describe how this procedure violates numerous laws and international obligations. At least two of the women have filed lawsuits in the High Court.

Thirteen cases of HIV positive women who were subjected to coerced or forced sterilization at public hospitals in Namibia have been documented. The sterilizations occurred at Katutura State Hospital, Central State Hospital and Oshakati State Hospital.

The relevant documentation was forwarded to Namibia's Deputy Minister of Health and Social Services by the International Community of Women Living with HIV/AIDS (ICW), the Legal Assistance Centre (LAC) and the Southern Africa Litigation Centre (SALC).

"Coerced sterilization" is generally defined as the use of coercion in obtaining the necessary informed consent for the sterilization procedure. "Forced sterilization" refers to instances where the woman is unaware that she would be undergoing a sterilization procedure at the time of the surgery and only learned of the sterilization after the fact.

Female sterilization can occur either via a hysterectomy (the removal of the uterus) or through a tubal ligation (restricting the Fallopian tubes such that a woman's egg does not reach her uterus). Both are serious surgical procedures and are considered permanent. Both often occur while a woman is undergoing a caesarian section.

The thirteen documented cases are the tip of the iceberg. Of the 230 HIV-positive women in education programs run by ICW in Namibia, 40 have indicated they were subjected to coerced or forced sterilization. The ICW is continuing to work on providing documentation of additional cases.

At least two of the women subjected to coerced or forced sterilization have filed cases before the High Court alleging violations of their right to life, human dignity and equality, and the right to be free from cruel, inhuman and degrading treatment. They are represented by LAC.

In all of the documented cases, informed consent was not adequately obtained due to one or more of the following reasons: consent was obtained under duress; consent was invalid as the women were not informed of the contents of the documents they signed; or medical personnel failed to provide full and accurate information regarding the sterilization procedure.

In at least six of the cases, consent was obtained by medical personnel in situations of duress. In a number of cases, women were asked to sign consent forms while they were in labour or on their way to the operating theatre. In other cases, women were told or given the impression that

they had to consent to sterilization in order to obtain another medical procedure such as an abortion or caesarian section.

In at least six of the cases, the women were asked to sign a consent form for sterilization without being informed of the contents of the form.

In all of the cases, the medical personnel failed to provide the women with a full description of the nature of the procedure and its effects, consequences and risks. No medical personnel informed the women of the irreversible nature of the procedure, or provided them information on alternative forms of birth control and family planning. In addition, no information was provided on the potential side effects of sterilization.

In many cases, women's continuing trauma of being subjected to coerced or forced sterilizations is compounded by the discriminatory treatment they experienced. In one of the documented cases, nurses at the Oshakati State Hospital refused to touch the patient and made disparaging remarks about her.

Coerced or forced sterilization violate numerous rights guaranteed under the Namibian Constitution and Namibia's obligations under international and regional law, including the right to be free from cruel, inhuman and degrading treatment; the right

to liberty and security of person; the right to health and family planning; the right to privacy; the right to equality and to be free from discrimination; and the right to life.

To ensure that these rights are not violated, doctors are required to obtain the informed consent of patients before they undertake any sterilization procedure, including a tubal ligation or a hysterectomy. This requires that the patient be fully informed and that her consent be

obtained freely without any coercion. This did not occur in the documented cases.

Namibia's neighbour, South Africa, has enacted legislation mandating that consent be obtained prior to any sterilization and, further, that consent be "given freely and voluntarily without any inducement." No such legislation exists in Namibia.

In forwarding the documentation to the Deputy Minister of Health of Namibia, ICW has drawn attention

to the numerous violations of rights involved in forced and coerced sterilization. ICW continues to engage in research and advocacy with partner organizations in order to put an end to this practice.

– Jennifer Mallet and
Veronica Kalambi

Jennifer Mallet (namibia@icw.org) and Veronica Kalambi are with ICW in Namibia.

Using strategic litigation to strengthen rights in southern Africa

Litigation can be a useful tool for achieving policy and legal change, but only if accompanied by broader advocacy and education efforts. In this article, based on her oral poster presentation at the conference, Priti Patel describes the approach of the HIV/AIDS Programme at the Southern Africa Litigation Centre (SALC).

With the exception of South Africa, there have only been a handful of judicial decisions in the southern African region on HIV-related cases. In Namibia, the AIDS Law Unit of the Legal Assistance Centre successfully challenged a Namibian military policy of denying employment to HIV-positive individuals regardless of their individual physical health.

In Botswana, the courts have issued a few decisions, primarily on workplace discrimination. In the rest of the region, courts have yet to issue a single significant legal decision in an HIV-related case.

The HIV/AIDS Programme at SALC was established in 2007 to respond to the paucity of legal cases in the region. SALC works in Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe.

The HIV/AIDS Programme provides technical and monetary assistance to lawyers, legal non-profit organizations and community organizations to bolster the use of strategic litigation in domestic courts — in order to strengthen the rights of people living with HIV and

groups which are most vulnerable, particularly women and children. Technical assistance ranges from providing strategic input on legal cases, to drafting key legal documents, to providing legal research on specific issues.

The HIV/AIDS Programme only works on cases that have the potential for broader policy or legal impact beyond the actual litigants in the case itself. Examples of broader impact include a change in governmental policy, a legal change, or the potential to eliminate or reduce illegal practices.

The HIV/AIDS Programme stresses the use of strategic litigation as an advocacy tool for achieving significant policy and legal change. Therefore, in all cases, we work with community organizations and local lawyers to ensure that the legal challenge is part of a broader multifaceted advocacy campaign.

Litigation can often be a useful avenue for advocating for change, but the issuance of a favorable judgment, in and of itself, does not translate immediately into a change in the reality on the ground. Such change requires (a) continued efforts and monitoring by local community organizations to ensure that the judicial decision is being applied at all relevant levels — and, if it is not — (b) actions by local lawyers to continue accessing the courts to ensure implementation of the judgment.

For example, in Malawi the HIV/AIDS Programme, together with Women and Law in Southern Africa-Malawi (WLSA-Malawi) and a local lawyer in private practice, are considering a legal challenge to the narrow definition of jointly-held property as it applies in marriages. We are asking the court to expand the current common law definition of “jointly-held” to include property to which a person has made significant non-monetary contributions.

Given that in most cases women tend to contribute to a household and property through non-monetary means, the expansion of the definition is critical to providing women with further economic autonomy. But even if a court were to expand the common law definition, there would still be a need for WLSA-Malawi and other local community organizations to inform women of their rights and monitor lower court proceedings to

ensure implementation of the judicial decision.

Another core component of the HIV/AIDS Programme’s methodology is to use human rights and HIV issues addressed in the litigation to raise public awareness and discourse in the country and region.

In Zambia, we are working with Zambian AIDS Law, Research and Advocacy Network (ZARAN) and the Legal Resources Foundation—Zambia to challenge the dismissal of two former Zambian Air Force employees due to their HIV status. We are asking the court to provide the clients with redress for their dismissal. We also are asking the court to require the Air Force to provide an individualized assessment of health, including taking into account the impact of antiretroviral treatment on health prior to a dismissal.

Though the legal case focuses primarily on the dismissal of the two former employees, we continue to use the case to raise public awareness of the military’s discriminatory policy by publishing opinion pieces in local newspapers and, more generally, by discussing the case in a wide range of fora.

In Namibia, we are working with the International Community of Women Living with HIV/AIDS—Southern Africa (ICW—Southern Africa) and the Legal Assistance Centre (LAC) on a legal challenge to the coerced sterilization of HIV-positive women at public hospitals.

At least three cases have been filed in the High Court by the LAC. These cases allege violations of the women’s constitutional rights to life, liberty and human dignity; to be free from cruel, inhuman and degrading treatment; to equality and freedom from discrimination; and to found a family.

The cases seek redress for the specific plaintiffs, but we will use other advocacy tools — including community mobilization and governmental advocacy — to ensure an end to the practice.

Litigation can be a powerful tool for changing policy, law and social attitudes. It can also provide a public platform on which the voices of those generally silenced can not only be heard but actually magnified. However, litigation must be pursued in tandem with other advocacy tools, including public education, legislative and governmental advocacy, and community mobilization to ensure real change in the reality of people’s lives.

— Priti Patel

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Civil society strategy for the compulsory licensing of lopinavir/ritonavir: the Brazilian case

The flexibilities in the TRIPS Agreement (Trade Related Aspects of Intellectual Property) have been very useful in lowering the prices of antiretrovirals (ARVs) in Brazil. In this article, based on several presentations made at the conference, Marcela Fogaça Vieira et al describe recent developments in Brazil, including the granting of a compulsory licence for efavirenz.

Until 1996, intellectual property legislation in Brazil did not grant patents for pharmaceutical products and processes. Even though the TRIPS Agreement gave developing countries until 2005 to incorporate its provisions, Brazil went ahead and adopted a new intellectual property law in 1996.

This change had a great impact in the Brazilian public health system, overhauling the existing legal regime that permitted medicines to be produced locally at affordable prices. Prior to the new law, Brazil had adhered to a policy of universal free access to antiretroviral drugs, made possible especially through national production of generic drugs.

Other challenges threatened the country's policy of universal access to ARV. The greatest challenges have been the increase in the cost of treatment, caused by new patented drugs, required to substitute for, or complement, previous treatments; and an increase in the number of patients receiving treatment. This constant increase in the cost of antiretroviral treatment has put the sustainability and universality of this healthcare policy in jeopardy.¹

Against this backdrop, the TRIPS flexibilities become necessary. The

flexibilities include mechanisms intended to mitigate the adverse effects of the rights conferred on patent holders, with a view to restoring the balance between intellectual property rights and the right to access new knowledge. Compulsory licensing, permitted under Article 31 of TRIPS Agreement, can be issued for a number of reasons, including cases of national emergency or public interest.

Since 2001, the threat of compulsory licensing has been the main strategy employed by Brazil to pressure drug companies to lower prices for ARVs. The state's pharmaceutical laboratory, Farmanguinhos, was able to advise the Ministry of Health on acceptable prices to assist them in their negotiations with drug companies.

In addition, Farmanguinhos' capacity to produce the drugs locally gave the government considerable leverage in its negotiations. In response, drug companies have preferred to lower the price of their products rather than have their intellectual property rights "infringed."² However, since the Brazilian government had never actually issued a compulsory license, this negotiating strategy grew increasingly less effective.

In 2005, during a round of negotiations with the drug company Abbott to lower the price of lopinavir/ritonavir (Kaletra®) — used at the time by 17 000 people in Brazil and responsible for approximately 30 percent of the National STD/AIDS Program's expenditure on medicines — the Brazilian government took a step towards a compulsory license by declaring that the medicine was of public interest.

It was estimated that the drug could be locally produced at a third of the price set by Abbott.³ However, after months of talks, the Ministry of Health struck a deal with Abbott. Many civil society groups considered it to be a bad deal, and one that was clearly "TRIPS-plus," since it included clauses that are more restrictive than those included in TRIPS.⁴

The failure to issue a compulsory license in this case prompted member organizations of the Working Group on Intellectual Property (GTPI) of the Brazilian Network for the Integration of Peoples, in conjunction with the Public Defender Office, to file a civil public action (or a class action) — the first of its kind in Brazil — to compel the federal government to issue a compulsory license for lopinavir/ritonavir.

A preliminary decision on the case went against the plaintiffs, on the grounds that issuing a compulsory license would trigger retaliation by developed countries and possible shortages of the drug, due to doubts about the capacity of domestic industry to produce the medicine.

In response, in 2006, the GTPI enlisted domestic and international specialists to assess the technical capacity of four Brazilian pharmaceutical firms (two public and two private) to produce antiretroviral medicines. The specialists determined that the Brazilian firms did indeed have the capacity to produce both first-line and second-line antiretroviral drugs.⁵

These results were corroborated by two additional studies conducted simultaneously in Brazil by the Clinton Foundation and the United Nations Development Programme (UNDP).⁶ These arguments were employed in the ongoing civil public action; the final judgment is expected by the end of 2008.

Meanwhile, a compulsory license was issued the first time in Brazil in 2007, for the drug efavirenz, commercialized by Merck and used by 80 000 people in the country. On the international market, some prices were twice as low as those being charged in Brazil.

After lengthy negotiations with Merck, the only offer the company made was to reduce prices by two percent, which was considered unacceptable by the Brazilian government. Brazil declared efavirenz to be of public interest in April 2007 and

the compulsory license was issued a month later.

While preparations for local production are underway, the generic version of the drug has been imported from India through international organizations, which has resulted in an immediate saving of US\$30 million per year for Brazil.⁷ Recently, Farmanguinhos applied for sanitary registration of its generic version of efavirenz, which should be in production in 2009.⁸

The compulsory license in Brazil caused a great change in the national scenario, bringing new elements for the civil public action presented in 2005, and thus having considerable potential to influence its final decision.

(There are implications beyond the borders of Brazil. The compulsory license issued in Thailand for lopinavir/ritonavir led Abbott to reduce the price of medicine for middle-income countries. This is a case of a local decision having a global effect. And the use of India as a supplier of cheaper generic alternatives highlighted the flexibilities of TRIPS and the urgent need for countries to develop capacity for local production of essential medicines.)

In conclusion, Brazilian civil society groups believe that the courts should be used even more as a channel for defending collective rights, principally because it is a means of: (a) finding alternatives inside the current patent system in force in Brazil; (b) raising public awareness about the negative impacts that intellectual property rights have on access to

health; and (c) involving the judiciary in the adoption of measures to pressure the executive branch of government to use TRIPS flexibilities for the protection of public health.

– *Marcela Fogaça Vieira, Renata Reis and Gabriela Chaves*

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¹ Brazil, National STD/AIDS Program, *A sustentabilidade do acesso universal a anti-retrovirais no Brasil*, Brasília, 2005.

² J.A.Z. Bermudez, M.A. Oliveira, G.C. Chaves, "O Acordo TRIPS da OMC e os desafios para a saúde pública," in J.A.Z. Bermudez, M.A. Oliveira, A. Esher (eds.), *Acceso a Medicamentos: derecho fundamental, papel del Estado*. Rio de Janeiro, ENSP/Fiocruz, 2004, pp. 69–90.

³ National AIDS Agency, *Técnicos da Saúde, Indústria e Comércio analisaram proposta da Abbott referente ao Kaletra*, 19 August 2005.

⁴ GTPI, *Acordo do Governo Brasileiro com a Abbot Frustrada Expectativas dos Brasileiros*, 13 July 2005.

⁵ J. M. Fortunak, O.A.C. Antunes, *A produção de ARV no Brasil — uma avaliação*, Rio de Janeiro, ABIA/MSF, 2006.

⁶ Clinton Foundation, *Relatório sobre a visita da Fundação Clinton a Farmanguinhos & LAFEP — Produção de antiretrovirais: análise de custos e competitividade internacional, 2006; and Programa das Nações Unidas para o Desenvolvimento — PNUD, Projeto: Avaliação da capacidade de produção de ARV no Brasil, 2006.*

⁷ Brazil, *Chega ao Brasil 1º lote de efavirenz genérico usado no tratamento da AIDS*. Brasília, Radiobrás, 2 July 2007.

⁸ MS pede registro do Efavirenz à ANVISA. Notícias do Programa Nacional, 17 September 2008.

Abuses of women's rights in sexual and reproductive health-care settings

For many years, the intersection between HIV/AIDS and sexual and reproductive rights focused on the prevention of the epidemic. The violations to reproductive rights that HIV-positive women face were not visible. However, this has begun to change. In this article, which is based on her presentation in the Human Rights Networking Zone at the conference, Ximena Andión Ibañez describes six areas where women's reproductive rights have been violated. The author advocates the use of litigation as a tool for advancing these rights.

HIV-positive women suffer violations of their reproductive rights in myriad forms. The nature and impact of the violations depend not only on the positive status of the woman, but also on intersecting characteristics, such as age, race, ethnicity, class and sexual orientation.

Mandatory testing

Providing adequate and accessible HIV testing and counselling is the first step in enabling HIV-positive women to fully exercise their reproductive rights.¹ HIV testing must be grounded in an approach that protects human rights and respects ethical principles — meaning that it should be confidential, accompanied by counselling and only done with informed consent.²

However, there is a growing trend to make testing mandatory. For instance, Kenya has specific regulations requiring informed consent, but only half of its public health facilities and 15 percent of its maternity facilities follow them.³

Requiring pregnant women to be tested for HIV can discourage them from seeking prenatal care. Mandatory testing requirements may also put women at risk of physical abuse, abandonment, neglect or even

ostracism by their husbands, partners or community. Mandatory testing is often accompanied by violations of the right to confidentiality and privacy.⁴

Prevention of mother-to-child transmission (PMTCT)

The benefits of PMTCT programs are immense, yet it is crucial that governments implement them with keen awareness of the experiences of all women living with HIV/AIDS and with respect for their human rights.⁵ The traditional focus of PMTCT programs as prevention programs for infants ignores the needs of women living with HIV/AIDS. The result is that often pregnant women cannot access antiretroviral drugs. PMTCT programs have a duty to care for the woman being treated, and to respect the rights of these women as patients.⁶

Women's participation in PMTCT programs should be voluntarily, and women's access to other reproductive services should not be conditional on their participation in these programs. Women's human rights are undermined when women are denied the opportunity to provide informed consent to treatment, when their con-

fidentiality is not respected and when their participation in the programs subjects them to stigma and discrimination associated with HIV.⁷

Adequate counselling must be a precondition to women's participation in PMTCT programs. To ensure an informed decision, women must be counselled on the risks and benefits of taking antiretroviral medication; the likelihood of transmission of HIV to their fetus; and the possible pain, impact and side effects of the treatment.

Coerced sterilization

Coerced sterilization of women living with HIV/AIDS, which is becoming more frequent in some regions of the world, is a violation of women's reproductive rights.⁸

One of the ways that coerced sterilization of HIV-positive women occurs is when health providers sterilize a woman when performing other medical procedures. For example, Andrea, a young Chilean woman, was sterilized while recovering from the delivery of her first child. She was not informed about the procedure. At 22, her reproductive life was over. Vivo Positivo, an organization of people living with HIV, is litigating the case before the national courts.

In many instances, consent to sterilization is not free and informed. Health care providers do not give women full information about the risk of mother-to-child transmission and available treatments; or they make the provision of other reproductive health services conditional on the woman accepting sterilization.

Instances of coerced sterilization have been documented in Chile by *Vivo Positivo*, and are being documented in South Africa and Namibia by the International Community of Women Living with HIV/AIDS (ICW).

States must ensure that coerced sterilization does not take place in any public or private health facilities. Women may be offered the option of sterilization, but the offer must be accompanied by adequate information and counselling, and the woman must provide her consent.

Access to safe and legal abortion

Only a few countries explicitly allow HIV-positive women to terminate their pregnancies,⁹ but even in these countries it remains unclear whether pregnant HIV-positive women receive complete and unbiased counselling about abortion and the risks of pregnancy for both the woman and the fetus.

The World Health Organization (WHO) has stated that a pregnant woman who tests HIV-positive should be counselled on the options of continuing or terminating her pregnancy in countries where abortion is legal. States must liberalize their abortion laws. States with restrictive abortion laws must, at a minimum, regard HIV-positive status as grounds for a legal abortion. Specific coun-

selling should be devised for women who discover their HIV status once they are already pregnant and are seeking ante-natal care.¹⁰

Denial of reproductive health services

HIV-positive women are sometimes denied access to reproductive health services; or, if they do have access, they may be mistreated by the health care providers. Many providers reprimand them for bearing children, turn them away from public-health care facilities, and refer them to private facilities specializing in HIV/AIDS (where costs are usually higher).

Gita Bai, an HIV-positive pregnant woman in India was denied access to health care because of her HIV status. She gave birth on the street and died. Her death was certainly a consequence of the lack of health care.

In Kenya, research has shown that counselors in family planning centres are usually reluctant to discuss contraceptive options and even refuse to provide contraception to HIV-positive women. Many health care providers assume that a woman that is living with HIV/AIDS is not sexually active.¹¹

The way forward

This article has described only some of the rights violations faced by HIV-positive women. We must continue documenting these situations and developing strategies to hold governments accountable. The Center for Reproductive Rights (CRR) uses, and advocates the use of, national and international litigation to hold governments accountable, and to produce changes in laws and policies to protect women's reproductive rights. In

our experience, legal advocacy strategies have proved effective in advancing women's reproductive rights.

– Ximena Andión Ibañez

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¹ United Nations Population Fund (UNFPA) and World Health Organization (WHO), *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and Their Children in Resource-Constrained Settings*, 2006.

² Ibid.

³ Ibid.

⁴ CRR, *HIV/AIDS: Reproductive Rights on the Line*, 2002.

⁵ CRR, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, 2005.

⁶ Ibid.

⁷ Ibid.

⁸ According to the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, programs targeting pregnant women "often emphasize coercive measures directed towards the risk of transmitting HIV to the fetus, such as mandatory ... testing followed by coerced abortion or sterilization." OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006 consolidated version.

⁹ Ibid.

¹⁰ See WHO, *Fact Sheet 10: Women and HIV and Mother to Child Transmission*, 2000.

¹¹ Federation of Women Lawyers (FIDA-Kenya) and CRR, *At Risk: Rights Violations of HIV-Positive Women in Kenyan Health Facilities*, 2008. At www.reproductiverights.org/publications.html.

Drawing conceptual linkages: property rights and HIV

An understanding of the impact of HIV/AIDS epidemic on broader social development necessitates a closer scrutiny of the relationship between HIV/AIDS and economic productivity. In this article, which is based on her presentation at a concurrent session at the conference, Priya Nanda describes the relationship between the widespread exclusion in developing countries of land ownership by women and their vulnerability to HIV and the effects of HIV. The author calls for more research on the complexity and diversity of land tenure systems and property laws.

For agriculture-dependent economies, land is the single most important economic asset that affects households' ability to enhance livelihood, adapt to shock or survive. Lack of property or land and other capital can therefore lead individuals into a downward spiral of poverty and deprivation, especially in the context of coping with HIV/AIDS. Conditions of poverty and efforts to ensure survival lead individuals to make choices that place them at a higher risk of contracting HIV.

Conversely, the ownership of land and other assets have the ability to protect individuals and families against the devastating effects of HIV and AIDS and also protect against contracting the disease.

Widespread exclusion of women in developing countries from owning or controlling property, and customs concerning their access to and use of property, affects their ability to protect themselves and their families from the consequences of HIV/AIDS.¹ The lack of ownership of assets and property also heightens women's vulnerability to sexual violence and increases their inability to refuse or negotiate safe sex with intimate partners. An inability to refuse unwanted sex or negotiate protected sex among intimate partners could contribute to HIV infection or re-infection.²

At the same time, the epidemic leads to new social and economic burdens upon the death or debilitation of a male earning member — often borne by women and girls — that can stretch household safety nets to the breaking point. While the disease itself affects women's ability to be productive, it also erodes their assets base by dispossessing land upon the death of a spouse or dissolution of marriage.³

Although the risk of HIV is increasing disproportionately among women, the reverse is true for their ownership of land. For women, land is fraught with customary and gender inequitable and patriarchal norms that lead to disproportionate ownership being conferred to men.

In Pakistan, women own less than three percent of the plots they till; and in Cameroon, women do 70 percent of agricultural work but own less than 10 percent of the land. In sub-Saharan Africa, the ownership is an abysmal one percent.

The inverse relationship between ownership of land and gender in many countries is due to customary laws that dominate statutory law when it comes to deciding issues of property and inheritance. In many countries in Sub-Saharan Africa, women acquire land mostly through

the institution of marriage and kinship structures.

Women often do not own the property that they till, which increases their dependency on male partners, places them at risk of domestic violence, and leaves them with little negotiating position in their households.

These and countless other situations add to the magnitude of distress women face at the hand of customary laws and practices. In a recent study from Southern Africa, experiences of HIV-positive women reaffirm that they are evicted from their homes and land, and forced into destitution — while having to cope with illness and having to care for themselves and their families.⁴ Coupled with the stigma associated with the disease, this can lead women down a livelihood spiral.

Conversely, households that are affected by HIV and own land are better able to cope as the land provides a secure resource base that can generate income and perhaps compensate for the loss of earnings of those who are ill.

From conceptual to evidence-based arguments

Ownership of land and property offers the possibility of social mitiga-

tion through conferring the power to deal with HIV-related stigma, negotiate sexual relationships and manage or escape violent relationships. Evidence from South Africa suggests that women sometimes engage in transactional sex because of lack of property, both as shelter and as a productive asset.⁵

Recent studies have also identified women's property ownership as one of the critical factors that helps reduce women's risk of violence.⁶ Alternatively, other evidence suggests that when women attempt to assert their ownership rights, they experience violence.⁷ Research by the International Center for Research for Women (ICRW) does not demonstrate a strong association between tenure insecurity and women's ability to negotiate intimate partner violence; however, it is difficult to collect data on the timing of violence with property ownership.

In terms of economic mitigation, land confers the ability to rent or sell property and liquidate other assets land in order to pay for antiretroviral treatment.⁸ It also helps households achieve food security. (However, land ownership is not the only factor; women may still not be able to afford seeds and equipment, or may not have the labor and time due to sickness and death.)

Overall it is difficult to ascertain the protective aspect of property rights, due to a lack of detailed information on the source of HIV infec-

tion and tenure status at the time of infection.⁹ For example, while data from UNAIDS reveal that at the global level, women represent fully 50 percent of all adults living with HIV/AIDS and continue to face fast-growing infection rates,¹⁰ and women represent 60 percent of the infected adult population in sub-Saharan Africa — we have virtually no gender-disaggregated statistics on the female share of land ownership.

It is difficult to ascertain evidence in absence of data. This remains an area of critical research, with the conceptual understanding and recognition that women's control of productive assets is essential if they are to be part of the adaptive strategies to address poverty and disease.¹¹

The risk of over-interpreting weak data and therefore undermining a serious issue leads to the conclusion that there is a need for collecting more robust data on women's ownership of, access to, and control of land, housing and other property. The complexity and diversity of land tenure systems and property laws in various countries also need to be better understood before any serious analysis can be done on women's property ownership and HIV.

At the same time, there is also a concomitant need to reform and harmonize customary laws. Even if that were to happen, the judicial sector's capacity to uphold women's rights and provide effective litigation would also have to be enhanced.

Lastly, there need to be more efforts to promote legal literacy and public awareness of women's rights, and to support organizations and network that facilitate land claims.

— Priya Nanda

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¹ R. Strickland, *To Have and To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa*, International Center for Research on Women (ICRW), 2004.

² ICRW, *Women's Property Rights, HIV and AIDS and Domestic Violence: Research Findings from Two Districts in South Africa and Uganda*, 2008.

³ Centre on Housing Rights and Evictions (COHRE), "Placing women's inheritance rights on the agenda in sub-Saharan Africa," *COHRE Newsletter* 1(1) (2003): 6.

⁴ K. Izumi, "Gender-based violence and property grabbing in Africa: a denial of women's liberty and security," *Gender & Development* 15(1) (2007): 11–23

⁵ ICRW.

⁶ N. Bhatla, S. Chakraborty and N. Duvvury, *Property Ownership and Inheritance Rights of Women as Social Protection from Domestic Violence: Cross-Site Analysis*, ICRW.

⁷ L.W. Karanja, "Domestic violence and HIV infection in Uganda," *Human Rights Dialogue* (10) (2003):10–11.

⁸ S. Drimie, *The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa*, a synthesis report prepared for the Southern African Regional Office of the Food and Agricultural Organization of the United Nations, 2002.

⁹ ICRW.

¹⁰ UNAIDS, *2007 AIDS Epidemic Update*.

¹¹ C.D. Deere and M. León, "The gender asset gap: land in Latin America," *World Development* 31(6) (2003): 925–947.

Measuring for change: a new research initiative by and for people living with HIV

Several organizations have banded together to create the People Living with HIV Stigma Index. In this article, which is based on a presentation at a concurrent session at the conference, Lucy Stackpool-Moore and Anandi Yuvaraj describe the purpose of the index and how it was developed. The authors believe that the index provides a real opportunity to measure, understand and advocate effectively to improve policies and programs and to make a real difference in the lives of people living with HIV.

Introduction

Stigma limits access to health services by silencing discussions about taboo issues that are integral to HIV vulnerability — such as race, poverty, gender relations, sexuality and drug use.¹ Stigma reveals itself not only in issues that are scandalized or reported inaccurately, but also in what is left unsaid and in voices that are not heard.² It is both what is talked about and how, as well as what is silenced and why, that fuel this vicious cycle linking stigma and marginalization.

Much of what we know about the stigma attached to HIV, and the resulting discrimination towards people living with the virus,³ is anecdotal or fragmented. Existing surveys show that while much is known about the influence of stigma there is no clear picture of its actual magnitude, complexity or ability to compare across many domains.⁴

Stigma and accompanying discrimination are widely recognized as significant barriers to HIV prevention, treatment and care services reaching those who need them most.⁵ Without concerted action to eliminate stigma, the goal of universal access to these vital services will be impossible to achieve.⁶

People Living with HIV Stigma Index

To address this lack of evidence, a measurement tool, the People Living with HIV Stigma Index, has been developed.⁷ The survey is the result of a partnership between the International Planned Parenthood Federation (IPPF), UNAIDS, the Global Network of People Living with HIV (GNP+) and the International Community of Women living with HIV/AIDS (ICW).

This global initiative has also received financial support from GTZ, the German international technical cooperation agency, UNAIDS and the (U.K.) Department for International Development (DfID), with the key objectives of (a) increasing advocacy and building the evidence base; and (b) operationalizing the Greater Involvement of People Living with HIV (GIPA) principle.

The tool has been developed to help us measure stigma and discrimination, to measure the impact of our interventions, and to document the well-being of people living with HIV over time.

Some of the key areas explored in the research process include the causes of stigma and discrimination;

“People are really keen to implement the index because they recognize it has been created by and for positive people, and that it can ultimately benefit their communities.”

— *Kate Thomson, Chief of Civil Society Partnership Team, UNAIDS.*

access to work and services; internal stigma; rights, laws and policies; effecting change; disclosure and confidentiality, treatment; having children; and overcoming stigma. Better evidence will contribute to more insightfully directed and improved programs, stronger advocacy efforts and better-informed policies.

Because it is an initiative that is by and for people living with HIV, the process is just as important as

the product. It puts into practice the GIPA principle.

The process includes referrals (to a variety of services, materials and sources of support) and follow-up support for all involved. The interviewers are people living with HIV themselves, interviewing other people living with HIV, and they adopt a “side-by-side” approach in the interview to make it as comfortable, empathetic and empowering as possible.

Like other studies that collect data from people, the index must observe certain standards with regard to ethical issues and data protection. In each country where this survey is carried out, those responsible for conducting the study ensure that it conforms to that country’s ethical and data protection requirements.

Two issues of particular importance are informed consent (every person interviewed must be fully informed about the nature of the study and then give their consent); and confidentiality (ensuring that the information participants have disclosed and their identity are kept in confidence).

Strengthening regional capacity

During 2008, the important process of preparing for the roll-out of the index commenced by strengthening the capacity of networks of people living with HIV and building in-country partnerships.

From 50 countries across Asia and the Pacific, Africa, the Caribbean and Latin America, 87 HIV positive people representing 66 organizations have been trained as trainers or team leaders.

UNAIDS Regional Support Teams and UNAIDS Country Coordinators,

as well as regional partners of IPPF, ICW and GNP+, have been working together to implement these workshops.

“I have spoken out against stigma. But I have been struggling with the evidence to quantify it. As a researcher and as an advocate, I now have the missing link.”

– Beatrice Were, Uganda

National implementation

The index has been developed in collaboration with community leaders, activists, researchers and human rights advocates around the world. It has been piloted in Kenya, Lesotho, Trinidad and Tobago, India and South Africa. The first full-scale national implementation of the index is underway in the Dominican Republic. Findings and initial analysis were scheduled to be published towards the end of 2008.

There are two key initial findings so far:

1. Very few people living with HIV responding to the questionnaire actually understand what stigma and discrimination looks like on a daily basis (in their own lives).
2. More information and advocacy is needed about rights, laws and policies that may exist nationally

and internationally to support people living with HIV.

– Lucy Stackpool-Moore
and Anandi Yuvaraj

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¹ R. Parker et al, *HIV/AIDS Related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action*, Horizons Program and Population Council, 2002.

² K. Morrison, *Breaking the Cycle: Stigma, Discrimination, Internal Stigma and HIV*, POLICY Project, 2006.

³ **Stigma** is a process of producing and reproducing inequitable power relations, where negative attitudes towards a group of people, on the basis of particular attributes such as their HIV status, gender, sexuality or behaviour, are created and sustained to legitimize dominant groups in society. The stigma associated with HIV is often based upon the association of HIV with already marginalized and stigmatized behaviours, such as sex work, drug use and same-sex and transgender sexual practices. Stigma relating to HIV affects people living with HIV and — through association — their partners, children, households and others in their communities. **Internal or self stigma** refers to the way people living with HIV feel about themselves and specifically if they feel a sense of shame about being HIV positive. Internal stigma can lead to low self-esteem, depression or can result in a person living with HIV withdrawing from social and intimate contact. **Discrimination** is a manifestation of stigma. Discrimination consists of actions (or lack of actions) directed towards individuals who are stigmatized. Discrimination occurs at many different levels, for example within a family or community setting, in an institutional or educational setting, and/or in national policies or laws. (These definitions are taken from GNP+ and the Asia-Pacific Network of People Living with HIV (ANP+), *NGO Code of Good Practice: Self-Assessment Checklist: Stigma and Discrimination*, at www.hivcode.org/silo/files/stigma--discrimination-.pdf).

⁴ L. Nyblade and K. MacQuarrie, *Can We Measure HIV/AIDS-Related Stigma and Discrimination? Current Knowledge about Quantifying Stigma in Developing Countries*, POLICY Project, 2006.

⁵ P. Brouard, and C. Wills, *A Closer Look: The Internalization of Stigma Related to HIV*, POLICY Project, 2006. See also Asia Pacific Network of People Living with HIV/AIDS, *AIDS Discrimination in Asia*, APN+, 2004.

⁶ DfID, *Taking Action Against HIV Stigma and Discrimination*, 2007. See also S. Clay; C. Chiyi and M. Chonta, *Understanding and Challenging HIV Stigma: Toolkit for Action: Module 1 — Children and Stigma*, International HIV/AIDS Alliance and Pact, 2007; and R. Kidd and S. Slay, *Understanding and Challenging HIV Stigma: Toolkit for Action*, ICRW and the CHANGE Project, 2003.

⁷ See www.stigmindex.org.

Continued challenge posed by HIV-related restrictions on entry, stay and residence

Restrictions on entry, stay, and residence for people living with HIV/AIDS violate international human rights law and cannot be justified by public health rationales. In this article, based upon his presentation in a concurrent session at the conference, Joe Amon argues that governments must immediately repeal these laws and policies.

The issue of national restrictions on entry, stay and residence for persons living with HIV/AIDS (PLWHAs) has recently received renewed public attention, as international organizations, non-governmental organizations and even some national governments have called for a repeal of these laws and policies.

On 5 August 2008, speakers at the XVII International AIDS Conference in Mexico City — including representatives from UNAIDS, Human Rights Watch, the United States Congress, and the government of El Salvador — demanded an end to HIV-related restrictions on entry, stay, and residence in countries around the world.

Three months earlier, at the U.N. General Assembly High-Level Meeting on HIV/AIDS, U.N. Secretary General Ban Ki-Moon proclaimed that “[i]n the world as a whole, I call for a change in laws that uphold stigma and discrimination — including restrictions on travel for people living with HIV,” both because stigma “drives the virus underground, where it can spread in the dark; [and] as important, it is an affront to our common humanity.”¹

As of August 2008, at least 67 countries placed special restrictions on entry, stay, or residence on PLWHAs.² While the majority of the countries in the world placing restrictions on non-nationals based

on HIV status do so only for longer term stays (generally greater than three months),³ there are 14 countries with have HIV-related restrictions for short-term stays or which categorically refuse entry of PLWHAs.⁴

These restrictions broadly violate international human rights law provisions banning discrimination and upholding equality before the law. The *International Covenant on Civil and Political Rights* guarantees all persons the right to equal protection of the law without discrimination.⁵ The U.N. Commission on Human Rights has interpreted this provision to include discrimination based on HIV/AIDS.⁶

Additionally, governments have committed in the 2001 *Declaration of Commitment on HIV/AIDS*, and in subsequent declarations, to enact appropriate legislation to eliminate all forms of discrimination against PLWHAs.⁷

Justifying such restrictions on public health grounds would require evidence that such measures were effective and the least restrictive measure necessary.⁸ However, HIV-related restrictions on entry, stay and residence are too broad and coercive to be the least restrictive means to achieve this end,⁹ and do not actually protect public health.¹⁰

These restrictions may, in fact, negatively impact public health

because they contribute to and reinforce stigma and discrimination against migrant PLWHAs¹¹ by lending credibility to the idea that non-nationals are a danger from which the national population must be protected,¹² and by prejudicially implying that PLWHAs will act irresponsibly in transmitting the infection. The restrictions make it difficult to conduct HIV prevention and treatment programs in migrant communities,¹³ and create the false impression that only migrants are at risk for HIV.¹⁴

An increasing awareness of the discriminatory nature and negative effects of these laws has begun to prompt some change. In 2004, El Salvador made the decision to remove entry and residence regulations.¹⁵ In advance of the International AIDS Conference in Toronto in 2006, Canada eliminated requirements of disclosure of HIV status for short-term stays. China¹⁶ and the United States¹⁷ have also suggested a willingness to move in the direction of eliminating these restrictions, though they have not yet done so.

However, despite some successes and the attention noted above, complete elimination of these restrictions is not imminent and will require unrelenting work on the part of advocates: As some countries have been relaxing their restrictions, others have

moved in the direction of tightening.¹⁸ Human rights and HIV/AIDS organizations must continue to demand that these restrictions be immediately and decisively repealed.

– Joe Amon

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³ UNAIDS and International Organization for Migration (IOM), *UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions*, 2004, p.4.

⁴ Deutsche AIDS-Hilfe, p. 5. These 14 countries are Brunei, Egypt, Iraq, Yemen, Malaysia, Oman, Qatar, Singapore, Sudan, South Korea, Tunisia, Turks & Caicos Islands, United Arab Emirates and the United States of America.

⁵ *International Covenant on Civil and Political Rights*, GA res. 2200A (XXI), 21 U.N. GAOR Supp. No. 16 at 52, U.N. Doc. A/6316 (1966), art. 26.

⁶ Commission on Human Rights, "The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)," Resolution 1995/44, adopted without a vote, 3 March 1995.

⁷ G.A. Res. S-26/2, para. 58, U.N. Doc. A/RES/S-26/2 (Aug. 2, 2001), available at www.un.org/ga/aids/docs/ares262.pdf.

⁸ United Nations, Economic and Social Council, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, Annex, UN Doc E/CN.4/1984/4 (1984).

⁹ Office of the United Nations High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006, para. 105; UNAIDS

and IOM, pp. 6–7.

¹⁰ This principle was first stated by the World Health Organization (WHO) in 1987, and has been restated by other international organizations on numerous occasions. See WHO, *Report of the Consultation on International Travel and HIV Infection*, WHO/SPA/GLO/787.1 (1987); UNAIDS and IOM, p. 8.

¹¹ International AIDS Society, *IAS Policy Paper: Banning Entry of People Living with HIV/AIDS*, 2007, p. 1.

¹² All-Party Parliamentary Group on AIDS, *Migration and HIV: Improving Lives in Britain: An Inquiry into the Impact of the UK Nationality and Immigration System on People Living with HIV*, 2003, p. 18.

¹³ UNAIDS and IOM, p. 2.

¹⁴ All-Party Parliamentary Group on AIDS, p. 28.

¹⁵ Deutsche AIDS-Hilfe, p. 8.

¹⁶ "HIV/AIDS travel ban to be lifted," *Financial Times Daily*, 6 August 2008; see also "China to relax law on HIV for foreigners," *New York Times*, 13 November 2007.

¹⁷ Letter from Rep. Barbara Lee et al. to President George Bush, 10 September 2008.

¹⁸ Deutsche AIDS-Hilfe, pp. 8–9. See also, "HIV patients not welcome, says PM," *Herald Sun*, 13 April 2007; and "Kyrgyzstan tightens regulations on AIDS tests for foreigners," BBC Monitoring Service, 14 February 2007.

Putting the right back into sexual and reproductive rights

There are numerous barriers to the achievement of sexual and reproductive health rights (SRHR), particularly for people living with HIV (PLHIV). In this article, which is based on his presentation at a concurrent session at the conference, Shaun Mellors, who is living with HIV, discusses the need for PLHIV to help lead efforts to ensure that their SRHR are addressed. The author also describes specific actions that donors can take to support the SRHR of PLHIV.

In Cairo in 1994, at the International Conference on Population and Development (ICPD), the international community agreed on a broad definition of reproductive health that included the recognition that reproductive health is not just about health

but is also a human rights issue.¹

However, "sexual rights" is not recognized terminology in some international consensus documents. And some donors do not recognize reproductive rights and only support reproductive health initiatives for

PLHIV. These realities have implications both for the SRHR of PLHIV and for policy development and program design.

Reproductive rights embrace certain human rights that have been recognized in national laws, interna-

tional human rights documents and other consensus documents, including the following:

- the rights of men and women to have the highest attainable standard of sexual and reproductive health;
- the right to decide the number and spacing of their children;
- the right to services and information on safe and effective methods of family planning; and
- the right to make decisions about their reproductive lives free from violence, coercion and discrimination.

These rights do not currently include sexual rights. Can a definition of reproductive health and rights be comprehensive if it excludes sexual rights?

Although the ICPD Programme of Action did not recognize sexual rights, states did agree to provide conditions for a “satisfying and safe sex life.”² Similarly, in the Beijing Declaration and Platform for Action of the Conference on Women in 1995,³ the international community recognized the existence of sexual rights (without employing that exact term) and echoed what the ICPD had said by stating that “reproductive health implies that people are able to have a satisfying and safe sex life”⁴ and that “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality.”⁵

In 2004, the World Health Organization (WHO) developed a working definition of sexual rights which stated that

[s]exual rights embrace human rights that are already recognised in national

laws, human rights documents and other consensus documents, which include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, including access to SRH services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life.⁶

Barriers to SRHR

SRHR are far from being achieved. Legal reform and implementation are being compromised by ideological and moral barriers. These barriers result in resistance to fully respect non-discrimination on the basis of sexual orientation; to recognize aspects of sex and sexuality outside of conception and marriage; and to set up comprehensive sexual and reproductive health services that include birth termination interventions, in particular for adolescents.

HIV-positive people should have the fundamental right to access sexual and reproductive health services without fear of being stigmatized or judged for their sexual and reproductive health choices. However, sadly, we know that many PLHIV still face stigma and discrimination when trying to access appropriate services. The discrimination can take the form of:

- forced abortions and sterilization of women living with HIV;
- pressure from health care workers discouraging PLHIV from having sex, let alone children;

- lack of safe abortion services for those who need and choose them;
- misconceptions among about sexual activity: from health care workers, community workers, counsellors and PLHIV themselves, exacerbated by lack of appropriate information, pertinent services and supplies; or
- laws and policies that directly violate the human rights of PLHIV, including criminalizing HIV transmission, and forced abortions for pregnant positive women.⁷

Sexual rights of PLHIV

PLHIV have the right to pleasurable and enjoyable sexual life, to intimacy, to have children and to love. SRHR imply that the choices and decisions regarding our sexuality and reproduction should be ours to make — free of coercion and stigma.

The sexual and reproductive health desires of PLHIV are as varied as the epidemic itself. The PLHIV community is not a homogenous community, and the needs of different sectors — including women, youth, LGBT, sex workers, and drug users — need to be taken into account when planning programs and services.

To ensure that the sexual rights of PLHIV are addressed, change has to begin on the individual level — as PLHIV, we need to understand and believe that we have rights when it comes to expressing and enjoying our sexuality. We need to be educated to understand those rights and be empowered to demand them.

HIV, sex and reproduction are intimately linked. Acting on these linkages is not the sole mandate of the sexual and reproductive health movement. The HIV community — par-

ticularly networks and associations of PLHIV — need to embrace and guide this agenda. It is important that HIV-positive people help to lead this “linkages” agenda and to proactively shape the content.

Turning policy into action

Prioritizing the sexual and reproductive health needs of PLHIV will necessitate a shift in donor priorities. People living with HIV need to guide this process for two reasons: (1) to avoid the “cherry-picking” approach that dominates the current agenda for many donors; and (2) to clearly articulate what this agenda encompasses.

The following are actions that donors can take to support the SRHR of PLHIV:

Political pressure and accountability.

Donor governments should use political and diplomatic means to exert pressure on other governments to ensure they meet their human rights obligations and amend laws that are discriminatory to PLHIV or that compromise their SRHR. Also, donor governments and U.N. member states should work to improve human rights mechanisms and processes so that they can be used as instruments for holding national governments accountable.

Support governments’ efforts.

Through political dialogue, donors should ensure that national plans include targets for reform and imple-

mentation of SRHR, and that people living with HIV are meaningfully engaged in the design, implementation and monitoring of these plans. They can make money available to turn SRHR into costed, budgeted, implemented and monitored programmatic priorities and activities.

Support PLHIV and the greater involvement of PLHIV (GIPA).

Donors should support networks and organizations of PLHIV in their efforts to support HIV-positive people to know and claim their rights; and to enable the networks and organizations to play the roles of watchdog, implementer, advocate and decision-maker on policies and programming supporting SRHR for PLHIV.

Support the role of civil society.

Donors should adopt funding policies and mechanisms that support civil society to implement evidence- and rights-based approaches.

Conclusion

People living with HIV should lead the advocacy effort to change policy and strategy, and to develop appropriate and accessible sexual and reproductive health programmes and interventions. Ensuring that the targets for sexual and reproductive health and rights of people living with HIV are met will require that stigma be challenged in all its forms.

— Shaun Mellors

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¹ Programme of Action of the International Conference on Population and Development, 1994, c.VII.

² Ibid, c.VII, art. 7.2.

³ Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995.

⁴ Ibid, para. 94.

⁵ Ibid, para. 96.

⁶ WHO, “Sexual health — a new focus for WHO,” *Progress in Reproductive Health Research* 67 (2004).

⁷ International Community of Women Living with HIV/AIDS and Global Coalition on Women and AIDS, *Sexual and Reproductive Health and Rights*, fact sheet, undated. At [www.icw.org/files/SRHR-ICW fact sheet-06.doc](http://www.icw.org/files/SRHR-ICW_fact_sheet-06.doc).

Yogyakarta Principles: Applying existing human rights norms to sexual orientation and gender identity

International human rights apply to all people, including lesbian, gay, bisexual and transgender persons. But up until recently, there was no document that explained these rights specifically as they relate to sexual orientation and gender identity. In this article, based on his presentation at a concurrent session at the conference, Boris Dittrich describes the development of the Yogyakarta Principles, which not only list the rights involved, but also provide recommendations to states (and others) concerning how the rights should be implemented.

Lesbian, gay, bisexual and transgender (LGBT) people the world over face discrimination simply because their sexual orientation or gender identity does not fit the “mold” of the majority of society. The discrimination can come from family members, other individuals or state authorities.

Legislators have made homosexuality a capital crime in seven countries. In about 85 other jurisdictions, homosexuality is criminalized with prison sentences up to 10 years.¹ Even in countries where homosexuality is no longer a crime, homophobia is still widespread.²

Most states have signed human rights treaties. But often they treat human rights like a menu in a restaurant: They pick and choose what they like. For example, some states may say that they are in favour of human rights, but not for men having sex with men (MSM). This is a violation of the basic concept of human rights, which are universal and indivisible, and thus apply to all human beings.

The Yogyakarta Principles

Inspired by a meeting with the former U.N. High Commissioner for Human Rights, Louise Arbour, in 2006 a group of experts on international

human rights law convened in the Indonesian city of Yogyakarta and developed the Yogyakarta Principles.

In all, there are 29 Principles on the application of international human rights law in relation to sexual orientation and gender identity. Each principle is accompanied by detailed recommendations to states and other stakeholders.

In developing the principles, the experts took language from existing international treaties and jurisprudence, and applied the language to sexual orientation and gender identity. Thus, nothing was invented. The Yogyakarta Principles are not a wish list; they are existing legal rights.

For example, Principle 18 addresses the right to be protected from medical abuse. It is clear that all people generally have the right not to be forced to undergo any form of medical or psychological treatment, procedure, testing or be confined to a medical facility. So it is evident that this right also applies to LGBT people.

Principle 2 proclaims the right to equality and non-discrimination. The document recommends that states repeal criminal laws that prohibit consensual sexual activities between

people of the same sex who are over the age of consent.

Link to HIV/AIDS

Principle 17 says that “Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.” This is highly relevant to the AIDS epidemic, because in countries where LGBT people are stigmatized, as is particularly the case in Russia and other Eastern European countries, AIDS workers will find it harder to reach vulnerable groups like MSM. This is because the men are afraid to come out of the closet. They do not want to incriminate themselves or to become outcasts in their society.

In communities where homosexuality is not accepted, many MSM also have sex with women while living their clandestine lives. In some cities in Central and Eastern Europe, one third of men in gay venues reported having both male and female partners.³ So, it is clear that stigma directed at MSM also places women and girls at risk.

UNAIDS has said that recognition of the rights of people with

different sexual identities both in law and practice, combined with sufficient, scaled-up HIV programming to address HIV and health needs are necessary and complementary components for a successful HIV response.⁴

Recommendations

The following are some of the recommendations included in the Yogyakarta Principles document:

- Governments should allow the LGBT community to organize, to express their opinion, to express their sexual orientation without repercussions, and to grant them freedom of assembly and movement.
- Organizations involved in planning global and regional HIV responses (such as country coor-

inating mechanisms and national AIDS committees) should ensure that HIV-related services are available to MSM and that funds dedicated to these services at the national level are proportional to the impact of HIV on MSM in that country.

- MSM should be included in national surveillance and independent epidemiological and behavioural research studies.

It is important to remember that lesbians, gay men, bisexuals and transgendered people — like sex workers and injection drug users — are distinct groups, each with its own history and social codes, and each requiring different approaches.

Reducing discrimination of people on the basis of their sexual orientation or gender identity will improve

not only their health but also the health of the broader society.

— Boris O. Dittrich

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Copies of the Yogyakarta Principles are available in all six U.N. languages at www.yogyakartaprinciples.org/.

¹ D. Ottosson, *State-Sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity Between Consenting Adults*, International Lesbian and Gay Association, 2008.

² European Union Agency for Fundamental Rights, *Annual Report 2008*.

³ F. Hamers and A. Downs, "HIV in Central and Eastern Europe," *Lancet* 361: 1035–1044.

⁴ From remarks made by Miriam Maluwa in the occasion of the launch of the Yogyakarta Principles at the U.N. in New York on 17 November 2007.

Rejecting the evidence: Russia's drug dependence treatment system

In at least three regions of Russia, the drug treatment system fails to respond to the needs of injection drug users seeking treatment for their addiction. In this article, based on his presentation at a concurrent session at the conference, Diederik Lohman describes the results of research conducted by Human Rights Watch (HRW). The author explains that the Russian medical establishment ignores overwhelming scientific evidence that treatment substitution programs are both safe and effective.

In a country like Russia, where around a million people live with HIV and injection drug use drives the epidemic, drug dependence treat-

ment must play an important role in both HIV prevention and treatment. Scientific evidence has shown conclusively that drug dependence treat-

ment can be an effective prevention intervention, can facilitate access for drug users to antiretroviral treatment (ART), and can increase adherence

rates. Unfortunately, Russia's drug dependence treatment system is not playing that role today.

Research conducted by HRW in three regions in Russia in 2007 showed that every step of the way the system fails drug users who want treatment.¹ Drug treatment in Russia is largely ineffective. Various studies show that more than 90 percent of people who get treatment relapse within a year.² One 2007 study showed that 35 percent of patients relapsed within a week of leaving the clinic.³ The treatment system fails to seize opportunities to educate drug users on the prevention of HIV and other health risks. It plays little role in facilitating access to ART for drug users, and no role in supporting adherence.

The tragic result is (a) continued drug use by people who otherwise might have successfully entered into treatment programs; (b) new infections with HIV, hepatitis C, tuberculosis (TB) and overdose deaths that could have been prevented; and (c) ART and TB treatment failures because some drug users are unable to adhere to the drug regimens.

The primary reason for this bleak situation is the stubborn refusal on the part of Russian authorities to accept scientific findings and introduce evidence-based practices into the Soviet era drug treatment system that is still in use. As a result, practices that have no foundation in science continue to be the basis for Russia's drug treatment system.

Russia's refusal to allow substitution treatment, the most effective form of drug treatment available, best illustrates the problem. As UNAIDS, the World Health Organization (WHO) and the United Nations Office on Drugs and Crime

(UNODC) have pointed out, substitution treatment is safe; and it is effective in treating drug dependence, preventing HIV transmission and supporting HIV treatment efforts.⁴ Yet, at the East European and Central Asian AIDS Conference in Moscow in May 2008, a top Russian ministry of health official stated that his colleagues are still not convinced that substitution treatment is effective.

Russian law expressly prohibits the use of methadone for the treatment of drug dependence — whether for maintenance treatment or even tapering. Top officials frequently demonstrate an almost visceral hostility to the concept of substitution treatment. In February 2008, at a drug treatment conference in Moscow, Russia's chief drug treatment doctor said that everyone was getting "so annoyed" with the issue of methadone and that only a group of "dissenters" continued to advocate for it.⁵

Advocating for substitution treatment is impossible in Russia. Anyone who discusses the advantages of substitution treatment risks being accused of promoting the use of drugs by both politicians and the prosecutors' office.

On the other hand, opponents of substitution treatment have free reign. No matter how outlandish the arguments advanced against methadone, few people are willing to risk criminal sanction for pointing out inaccuracies in these arguments. Those who are willing to take that risk lack a platform to make their case as no established medical publication will agree to publish their articles.

The most brazen attack on substitution treatment occurred in 2005 when Russia's chief drug treatment doctor and several other top health

officials published a memorandum entitled "No to Methadone" in two leading Russian drug treatment publications.⁶

The document completely misrepresented scientific evidence on substitution treatment. It selectively cited a few isolated studies — some more than 30 years old — that raised concerns about the effectiveness and safety of substitution, while ignoring the hundreds of studies that have found that substitution was both safe and effective. Neither of these two publications ever published a rebuttal of the memorandum.

But the failure to adopt evidence-based practices runs far deeper than just the refusal to allow substitution treatment.

Best practice standards emphasize the need for low threshold services.⁷ Drug users who want to get treatment should be able to enter treatment programs immediately and without undue barriers. In Russia, however, people who voluntarily seek treatment but cannot pay for it are put on a drug user registry and are restricted in some of their rights. Thus, voluntarily seeking treatment is not rewarded but punished.

Drug users who want treatment must present to the clinic with a series of health certificates before they can be admitted. Collecting these certificates takes several days, thus forcing drug users who have resolved to get treatment to either continue to use while they collect the certificates or go into withdrawal until they can be admitted.

Best practice standards also emphasize the need to keep people in treatment for a sufficient amount of time.⁸ The U.S. National Institute for Drug Abuse advises that three months is the minimum period of time

required for treatment to have a real impact on treatment success. Yet, in two thirds of Russia's regions there are no government rehabilitation clinics. As a result, the vast majority of users spends 10 days in detoxification and then go home without any kind of rehabilitation. This results in high treatment failure rates.

Best practice standards recommend actively engaging patients during detoxification to motivate them for rehabilitation treatment, teach them about HIV, overdose prevention and other health issues.⁹ In Russia, however, drug users are routinely heavily sedated in detoxification clinics and spend most of their time there in a semi-comatose state. Not only is this unnecessary from a medical perspective, but it also makes it impossible to engage users in the treatment

process, which again leads to treatment failure.

Russia's failure to introduce evidence-based practices into the drug treatment system is bad public health policy. It also violates human rights. The Russian government urgently needs to examine and address the problems of its drug dependence treatment system. The international community must continue to support advocates of evidence-based approaches and pressure Russia's leadership to conduct the necessary reforms.

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² N.N. Ivanets and M.A. Vinnikova, *Heroin Dependence — Disease Characteristics and Treatment of the Post-Abstinent Syndrome (Geroinovaya zavisimost — klinika i lechenie post-abstinentnogo sindroma)* (Moscow: Medpraktika-M, 2001); and V.V. Chirko and M.V. Demina, *The Characteristics of Clinical Narcology — Drug Dependence and Toxicomania: Disease Characteristics, Development, Therapy (Ocherki klinicheskoi narkologii — narkomanii i toksikomanii: klinika, techenie, terapiya)* (Moscow: Medpraktika-M, 2002). Both monographs are cited in M. Zobin and E. Egorov, "Remission with opioid dependence," published at www.narcom.ru/cabinet/online/107.html.

³ Draft report on a survey conducted by the Penza Anti-AIDS Foundation, on file with HRW.

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⁵ "Russia scorns methadone for heroin addiction," *New York Times*, 22 July 2008.

⁶ N.N. Ivanets et al, "Say No to Methadone Programs in the Russian Federation," *Medical Newspaper (Meditsinskaya gazeta)*, 30 March 2005.

⁷ National Institute on Drug Abuse, *Principles of Effective Drug Addiction Treatment: A Research-Based Guide*.

⁸ *Ibid.*

⁹ *Ibid.*

U.N. guidance note on HIV and sex work "reworked" by activists

In 2007, UNAIDS issued a guidance note on HIV and sex work, the tone and contents of which angered sex workers, activists and public health workers worldwide. In this article, based on presentations at the conference, M. Seshu et al describe the problems with the guidance note, discuss the reaction to its publication, and explain how a group of activists got together to develop a reworked version of the guidance note.

In 2007, UNAIDS published a guidance note that took a different approach to all previous U.N. policy on sex work.¹ In earlier documents, UNAIDS described programs that demonstrated the effectiveness of sex worker empowerment and peer-based

program management for HIV prevention and treatment.

However, the guidance note addresses vulnerability to sex work and recommends reduction of demand for sex work as a strategy to reduce HIV transmission among sex

workers and their clients. It devotes an inordinate amount of space to the subject of the provision of life choices and occupational alternatives to sex work.

Unfortunately, the guidance note does not address improving occu-

pational conditions of workers or empowerment of sex workers, which are key to preventing and treating HIV/AIDS in this population.

UNAIDS convened global consultations before preparing the guidance note. Sex workers were well represented in these consultations, but the final product clearly did not reflect the input from the sex worker community.

In fact, the input from sex workers was rejected in favour of arguments advanced by organisations committed to conflating sex work, trafficking and sexual violence, which is the basis of the anti-prostitution pledge which the U.S. government made a condition for development funding on HIV/AIDS.

The guidance note is at odds with the *International Guidelines on HIV/AIDS and Human Rights*, which state that

[w]ith regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.²

The UNAIDS guidance note does little to empower sex workers to protect themselves. Instead, it stigmatizes sex workers, and it makes it more likely that working conditions, which are often already poor, will become even more so.

The guidance note fails to distinguish between trafficking and informal migration, or consensual sexual activity and sexual violence. It then imports all that is negative about these globally abusive practices to an erroneous vision of sex work.

Therefore, the political and legal responses that are deemed necessary

to deal with what might be serious international and domestic crime are regarded as entirely applicable to sex work. This approach lacks sophistication and misunderstands the varied realities of sex work.

The focus in the guidance note on life skills, microfinance, girls' education and other strategies for prevention of prostitution are misguided, because the implication is that funding for these activities should come from HIV/AIDS resources. Sex workers are not against education resources being spent on girls education, but they recognize that the allocations for HIV prevention and care for sex workers are already too small; HIV/AIDS money needs to be spent on condoms, services for sexually transmitted infections, good information and community empowerment.

Finally, the guidance note reduces sex workers to targets for interventions, and ignores the critical and beneficial role of sex workers as the best educators of their male clients.

The response

There was a chain reaction to the UNAIDS guidance note. A letter of protest was sent to UNAIDS from sex worker organizations. A representative of the Asia-Pacific Network of Sex Workers attended a UNAIDS Programme Coordinating Board (PCB) meeting and worked with the NGO delegation to push for a review of the guidance. The Canadian HIV/AIDS Legal Network published a human rights critique of the guidance note.³ Many sex worker organisations published their own critiques.⁴ A group that advises UNAIDS on HIV and human rights issues called for changes to the guidance.⁵

Further, in response to the guidance note, an expert Global Working

Group (GWG) on HIV and Sex Work Policy was formed by the International Network of Sex Work Projects (NSWP). The GWG is made up of activists from the fields of sex work, public health, human rights and women's rights.

Using internet communication technologies to coordinate the contributions of sex workers, advocates, researchers and policy makers, the GWG was able to mobilize a broad-based coalition in support of evidence-informed and rights-based programming. Few sex work policy initiatives in the history of the AIDS epidemic have elicited such a global, coordinated and rapid response as that mounted by the GWG.

The NSWP and the GWG, with support from the International HIV/AIDS Alliance, produced a "reworked" version of the guidance note.⁶ In preparing the reworked version, the drafters took into account the damage done by HIV-prevention campaigns (such as many abstinence and be faithful campaigns) that promote blaming or scapegoating of sex workers for HIV.

This reworked document was then presented publicly to UNAIDS and the United Nations Population Fund (UNFPA) at Delhi, India by members of the National Network of Sex Workers, India. The Women Won't Wait campaign spoke out in support of the reworked guidance.

Conclusion

The UNAIDS guidance note abandons Jonathan Mann's legacy of rights-based policy and programming. By including in the reworked guidance note the voice and contributions of civil society neglected in the UNAIDS note, the GWG has gone some distance to achieve what

UNAIDS arguably should have done in the first place. The hope is that the reworked guidance note, as well as subsequent activities, will represent the beginning of a new era of genuine participatory dialogue between sex workers and UNAIDS.

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Work Policy for their contribution to the presentations on which this article is based.

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Sex Work (April 2007), September 2007. Available via www.aidslaw.ca/sexwork.

⁴ See, for example: Australian Sex Workers Association, letter to the 29th Meeting of the PCB, UNAIDS, 2007 (at www.scarletalliance.org.au/library/unaidspcbsub_07/file_view); and International Committee on the Rights of Sex Workers in Europe, *The Curious Sex Worker's Guide to the UNAIDS Guidance Note on HIV and Sex Work* (at www.sexworkeurope.org/site/images/PDFs/the%20curious%20sex%20worker.pdf).

⁵ UNAIDS Reference Group on HIV and Human Rights, *Recommendations Regarding the "UNAIDS Guidance Note on HIV and Sex Work (April 2007)"*. At http://data.unaids.org/pubBaseDocument/2008/20080215_rghr_statement_sexworkguidance_en.pdf.

⁶ The Global Working Group on HIV and Sex Work Policy, *Draft Reworking of the UNAIDS Guidance Note on HIV and Sex Work* (April 2007), September 2007. At <http://sexworkpolicy.wordpress.com/draft-reworking-of-the-unaids-guidance-note-on-hiv-and-sex%20work/>.

Recognize sex work as legitimate work

It is not sex work per se that makes sex workers vulnerable to HIV, but rather the policies that repress them. In this article, based on her presentation at a plenary session at the conference, Elena Reynaga, who is a sex worker, describes how these policies deprive sex workers of their rights and subject them to physical and sexual violence. The author concludes that at the heart of the problem lies the fact that sex work is not recognized as legitimate work.

In Cambodia, anti-prostitution policies have been approved under great pressure from the U.S. As a result, sex workers are being arrested under the pretense that they are victims of sexual slavery and trafficking. In order to “protect” them, sex workers are imprisoned in rehabilitation centres where they are raped by law enforcement officers and can only escape by paying off large bribes.

In Bolivia, violent raids and the public “lynching” of sex workers, drove our fellow sex workers to sew their lips together in protest.

The double stigma against HIV and sex work is used to justify police repression. In Zambia, sex workers, are publicly whipped and beaten by the police, while being yelled at that they are “bitches who are killing the nation” and “rat poison.”

Violence perpetrated by the police and other law enforcement officers is a direct risk of HIV transmission for female, trans and male sex workers.

The lack of legal protection not only allows, but also, *fuels* violence toward sex workers. Although there is no consolidated international data-

base of the number of sex workers that have been murdered, the Latin America and Caribbean Sex Worker Network recently recorded the murders of 34 sex workers in one ten-month period. Every single one of those crimes remain unpunished.

In many parts of the world, when sex workers are imprisoned for up to three months at a time, those who are HIV+ suffer treatment interruptions. Often the only way to avoid prison is to submit to rape by police, almost always without condoms, of course.

Other human rights abuses suffered by sex workers include: using sex workers as research subjects and not providing them with the results of the research; refusing to allow sex worker organizations to legally register; and sex workers not being able to access basic prevention tools such as male and female condoms and water-based lubricants.

Legitimizing sex work

If international agencies are really invested in supporting sex workers, they shouldn't impose their own agenda or their own ideology.

UNAIDS recently developed a draft guidance note on HIV and

sex work that had a strong anti-prostitution tone. For example, the guide talked about programming to promote sex workers changing to a "decent job" — as if sex work were less decent than other work!

It also suggested that people living with HIV could not engage in sex work. Based on that criteria, no person living with HIV should have sex. The problem is not sex — the problem is not using a condom!

The anti-prostitution emphasis of the draft was a major change from UNAIDS policies from 2002 and 2004 and came about due to strong pressure from ultra-conservative governments.

As sex workers, we demand that what we do be recognized as legitimate work. We will no longer hang our heads in shame. To those who say that sex work is not decent, we reply: "Indecent are the conditions in which we work!"

— *Elena Reynaga*

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