

HIV/AIDS POLICY & LAW REVIEW

Criminalization confusion and concerns: the decade since the *Cuerrier* decision

In 1998, the Supreme Court of Canada ruled that a person living with HIV could be found guilty of aggravated assault if he or she did not disclose his or her HIV-positive status and exposed another person to a “significant risk” of HIV transmission.¹ The notorious case — *R. v. Cuerrier* — involved an HIV-positive man and two women with whom he had intimate relationships involving unprotected intercourse. At the time the ruling, which imposed full legal responsibility for HIV prevention on people living with HIV/AIDS (PHAs), raised many questions. Ten years later, many of those questions remain unanswered. In addition, a host of new issues have been added to the debate.

Introduction

Since *Cuerrier*, there has been a marked upswing in the frequency of prosecutions. More than 70 people in Canada have been criminally charged for not disclosing their HIV-positive status.

The uproar over the criminalization of HIV exposure reached a new pitch in 2008 when the trial of Johnson Aziga began in Ontario. Aziga is the first person to be tried for murder for not disclosing his HIV-positive status, after two women he allegedly infected through unprotected sex subsequently died.

Within Canada, some police forces are becoming aggressive in their pursuit of so-called “HIV criminals,” and several lawsuits have been filed against police and various government authorities for failing

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

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Criminalization confusion and concerns: the decade since the *Cuerrier* decision

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to warn women that they might be exposed. At the same time, ever more advocates, in Canada and internationally, are becoming more vocal in expressing their apprehensions about criminalization trends.

So where are we now in terms of the law around the duty to disclose HIV-positive status? What new trends and practices are emerging in the enforcement of the duty to disclose? What progress has been made in terms of understanding the social impacts of the criminalization of HIV exposure? What opportunities exist to lever positive change in the coming months and years?

Escalating charges

Of the more than 70 people who have been charged for not disclosing their HIV-positive status in the last decade, a remarkably high number (32) were charged in the last three years (from the beginning of 2006 through to the time of this writing, February 2009).² Of these 32 people, 20 were charged in Ontario alone.

In addition, an increasing number of defendants are facing charges of aggravated sexual assault (which carries a maximum penalty of life imprisonment), as opposed to the lesser charges of aggravated assault or criminal negligence causing bodily harm. Furthermore, several high-profile cases involving multiple complainants and violent or exploitative circumstances have gone to trial in the last couple of years.

For example, Carl Leone pled guilty to 15 counts of aggravated sexual assault in April 2007. Five of the female complainants contracted HIV.³ Newspapers reported that some of the complainants were given alcohol or pills before blacking out, and only discovered later that Leone had had unprotected sex with them.⁴

Clato Mabior was convicted in July 2008 of six counts of aggravated sexual assault, as well as one count each of invitation to sexual touching and sexual interference.⁵ One of the complainants was only 12 years old at the time of her contact with Mabior; police said he was luring runaway girls to his home with the promise of intoxicants and a place to stay.⁶

Finally, Johnson Aziga is facing 11 counts of aggravated assault and two counts of first-degree murder for allegedly not disclosing his HIV-positive status to sexual partners.⁷ As of the time of this writing, the case remains before the trial-level courts. For Aziga to be convicted of murder in these circumstances, the Crown must overcome considerable hurdles with respect to evidence and legal argument on intent and causation. But whether or not the Crown is successful, this case marks a further escalation in the legal stakes for non-disclosure of HIV-positive status.

Media frenzy

The media has taken to covering these cases with great vigour, quoting

extensively from complainants about how they would never have become sexually involved with the accused had they been aware of his or her status and how they have suffered as a result of their exposure to HIV. In fact, the majority of the coverage about HIV/AIDS and people living with HIV that an average Canadian reads in the local newspaper or hears on the radio is about persons facing criminal charges for non-disclosure.

Several high-profile cases involving multiple complainants and violent or exploitative circumstances have gone to trial in the last couple of years.

The reporting on charges against one particular woman living with HIV was especially striking, involving such headlines as: “HIV woman strikes again,”⁸ “Woman admits AIDS assault; petite redhead pleads guilty to trying to sexually infect CFB Borden with HIV,”⁹ and “She tried to pass HIV: woman guilty of attempting to infect CFB Borden soldier.”¹⁰ Not only is this type of coverage sensational, suggesting devious

criminality, it also misrepresents the legal charges. In this particular case, the accused was charged for allegedly not disclosing her HIV status to sexual partners; intent to infect others was never alleged.

“Have you been in contact with this person?”

Police across Canada have the authority to release information to the media and the public about persons charged with or convicted of a crime, including their name, description, date of birth, address, the alleged offence(s), and other information related to the charges.¹¹ The use of this power has resulted in photographs of persons accused of not disclosing their HIV-positive status appearing in the media, along with their HIV status and warnings that sexual partners should seek medical advice and/or contact the police.¹²

The police issue these advisories to keep the public informed about law enforcement and judicial or correctional processes, to locate victims and witnesses to alleged crimes, and to protect the public. However, disclosing personal information about a person who is under investigation challenges the presumption of innocence.¹³ It could also result in negative consequences for the accused person in terms of the person’s job and personal or family relationships.

The publication of these advisories by police has arguably contributed to the stigma and discrimination experienced by people living with HIV. They fuel the media frenzy around these cases and contribute to a perception that people living with HIV pose a threat to the community at large and act in a deviant, criminal manner.

Concerned about the possible negative consequences for PHAs of the

public disclosure of individuals’ HIV status in media advisories, the British Columbia Person with AIDS Society (BCPWA) made formal complaints to the Vancouver Police Service Board and the Office of the Information and Privacy Commissioner for British Columbia, in June 2006 and June 2007 respectively.¹⁴

The complaints concerned a Vancouver Police Department media advisory of 30 March 2006. The media release included the accused’s photograph, age and HIV-positive status, and stated that “[i]t is alleged that he had unprotected sex with two Vancouver men denying that he was HIV positive.”¹⁵

In response, the Vancouver Police Board indicated that it did not find any fault in its policies on releasing information or in the specific case that was the subject of the complaint. The Board said that “[n]o less privacy intrusive investigative technique could have been employed to the same effect to identify further victims.”¹⁶

Furthermore, the Board stated that “it was essential that the accused’s HIV positive status, and his denial thereof, be disclosed. If the disclosure had not been made, others who had consensual unprotected sex with the accused would not have been able to identify themselves as victims.”¹⁷

A duty to warn?

Within the past few years, several multi-million dollar law suits have been launched, each alleging that the PHA accused in a criminal case and various government agencies failed to warn the complainant that he or she was at risk of HIV infection. These lawsuits have emerged in the context of HIV and AIDS being reportable illnesses in every Canadian province

and territory, meaning that public health authorities may be aware of a person’s HIV-positive status before his or her sexual partners.

One such lawsuit was filed by the ex-husband of a woman who was found guilty of aggravated assault in January 2007 for not disclosing her HIV-positive status to him.¹⁸ The claims in this lawsuit are far-reaching. From his ex-wife, the plaintiff is claiming \$11 million in damages, alleging intentional failure to disclose her HIV-positive status, intentional negligence in transmitting HIV, fraud in securing his sponsorship for immigration to Canada, and intentional infliction of emotional distress.¹⁹

Several multi-million dollar law suits have been launched, each alleging that the accused in a criminal case and various government agencies failed their “duty to warn.”

The suit also seeks \$9 million in damages from the woman’s employer (the strip club where she worked). Finally, the suit claims \$13 million from the Government of Canada (including Citizenship and Immigration Canada) and a declaration that the sponsorship agreement is void. Also named in the suit are the Government of Ontario and the City of Toronto Public Health Department.

The allegations against the Governments of Canada and Ontario include negligently or intentionally

failing to warn the plaintiff of his wife's HIV-positive status; allowing him to enter into an immigration sponsorship contract without full disclosure; failing to perform their duties and engaging in a subsequent conspiracy to cover up their knowledge of her HIV-positive status and their negligence; failing to administer proper medical examinations; and complicity with the fraud perpetrated by his ex-wife.²⁰

Two lawsuits have also been launched against Carl Leone. The first was filed by a woman who claims to have met Leone through an internet chat room when she was sixteen. She was allegedly infected with both herpes and HIV during their two-year relationship.²¹

In addition to suing Carl Leone, the woman is suing four members of his family and the Windsor Police Services Board for \$10 million dollars. The suit alleges that each of the defendants knew, or ought to have known, that harm to her was the reasonably foreseeable consequence of their failure to warn her of Leone's HIV-positive status or to take measures to ensure her safety.²²

A second suit by two of the other complainants in the criminal case was filed in January 2009. They each seek \$10 million in damages from the Windsor Police Services Board, the Windsor Essex County Health Unit and Leone.²³ They allege that the police did not carry out a reasonable investigation when allegations were first made against Leone. They further allege that the health unit did not take steps to protect them and other members of the public, and that it failed to report Leone to the police although it knew or should have known that he was engaged in a criminal offence.²⁴

Finally, a similar suit was filed in the Aziga case in August 2008. The plaintiff alleges that public health staff and police knew she was having sex with Johnson Aziga, whom they knew to be HIV-positive, but did not warn her. Her suit alleges that officials withheld the information in order to arrest him and therefore "used her for bait."²⁵

These lawsuits raise important questions about whether public officials — including police, public health staff, and immigration officials — have a legal obligation to "warn" sexual partners who may be at risk of HIV infection and to report potentially criminal contact to the police.

Provincial and territorial public health laws give public health officials the authority to conduct partner notification, which involves contacting the sexual or injection-drug partners of a person infected with a sexually-transmitted infection to advise them that they may have been exposed and should seek testing.

Generally, the healthcare worker doing the notification does not reveal the name or other identifying information of the "index case."²⁶ Is this the full extent of notification requirements under Canadian law or, as these lawsuits assert, is there a broader "duty to warn"?

As discussed above, police have claimed legal authority to issue advisories to the public in relation to cases under investigation. Hospitals, psychiatrists, social workers and police have all been found by courts to have a duty in some circumstances to warn someone they can identify as being at risk of harm, but none of the relevant cases in Canada were HIV-related.

Moreover, it is unclear whether counsellors have a legal obligation to disclose confidential information

about a client in order to prevent harm to another person. Counsellors do, however, have the *discretion* to do so where: (a) there is a clear risk of harm to an identifiable person or group of persons; (b) there is a significant risk of serious bodily harm or death; and (c) the danger is imminent.²⁷

When, if at all, does this discretion become a legal obligation? And who carries such an obligation? What protections are (or should be) in place to ensure that such warnings are not inappropriately used and to ensure that privacy rights, and the potential harms that could result to the person living with HIV whose privacy is violated, are properly weighed in the decision-making? How the courts answer these questions could have considerable impacts on public health and policing practice throughout Canada.

Continuing legal uncertainties

In *Cuerrier*, the Supreme Court of Canada addressed the question of when non-disclosure of HIV-positive status to a sexual partner may amount to a "fraud" that vitiates that partner's consent, thereby rendering the sexual intercourse a sexual assault.²⁸

Specifically, Justice Cory, writing for the majority, stated that there are two elements the Crown must prove in order to establish such a fraud. First, there must be a "dishonest representation" consisting of either deliberate deceit about HIV status or non-disclosure of that status. Second, the Crown must prove that the dishonesty resulted in some "deprivation" to the complainant:

The second requirement of fraud is that the dishonesty result in a deprivation

vation, which may consist of actual harm or simply a risk of harm. Yet it cannot be any trivial harm or risk of harm that will satisfy this requirement in sexual assault cases where the activity would have been consensual if the consent had not been obtained by fraud.... In my view the Crown will have to establish that the dishonest act (either falsehoods or failure to disclose) had the effect of exposing the person consenting to a significant risk of serious bodily harm. The risk of contracting AIDS as a result of engaging in unprotected intercourse would clearly meet that test.²⁹

What was not clear in *Cuerrier* is where the line should be drawn between activities requiring disclosure and those not requiring disclosure.

The majority judgment was clearly not imposing a blanket obligation on persons living with HIV to disclose their status in every sexual encounter. What was *not* clear is where the line would be drawn between activities requiring disclosure and those not requiring disclosure. For example, Justice Cory contemplated that disclosure might not be required with respect to intercourse for which a condom was used, but did not make an explicit ruling on the issue.³⁰

To date, the exact contours of the criminal law in Canada regarding non-disclosure of HIV-positive status remain uncertain, particularly with

regard to lower-risk practices (e.g., protected sex, oral sex) and undetectable viral load. In a handful of cases, trial courts have suggested that non-disclosure of HIV-positive status to a sexual partner would not vitiate consent because the risk of a particular activity does not rise to the level of being legally “significant.”

In *R. v. Nduwayo*, the judge instructed the jury that the accused had a legal duty to disclose his HIV-positive status to his sexual partner if he had unprotected sexual intercourse, but that there was no legal duty to disclose if he used condoms at all times.³¹ Similarly, in *R. v. Smith*, the judge stated his understanding that to find the accused guilty he had to satisfy himself beyond a reasonable doubt that the sex was unprotected.³² And in *R. v. Edwards*, the judge noted that the Crown acknowledged that performing unprotected oral sex on an HIV-positive man would not trigger a legal duty to disclose.³³

However, in a more recent Manitoba decision, the trial judge stated the law rather differently. The decision criminalized non-disclosure even when condoms were used.³⁴ This case was also the first to directly examine the issue of low viral load and its relevance in terms of “significant risk.”

The judge ruled that *both* an undetectable viral load *and* the use of a condom would reduce the risk of transmission below the level that would be considered a “significant risk.” Neither condom use nor low viral load on its own would suffice to remove the obligation to disclose one’s HIV-positive status, in this judge’s interpretation.³⁵ (As of this writing, a notice of appeal had been filed in the case, but no further steps had been taken.)

In the intervening period since the Supreme Court established the “significant risk” threshold for liability, considerable medical and scientific advances have been made in the understanding of HIV transmission and treatment. These cases epitomize the challenge courts face in keeping pace with medical and scientific advances and applying them to the diverse circumstances of individuals’ real-life sexual encounters.

Protecting women

Almost two-thirds of the charges laid in relation to HIV non-disclosure in the last three years involved male defendants and female complainants, with multiple female complainants in several cases. It is not surprising, therefore, that some proponents see criminal charges as appropriate punishment for dishonest men who are selfishly putting women’s health and lives at risk. But do criminal charges for non-disclosure protect women from harm?

Criminally charging a man after the fact for not disclosing his HIV-positive status to a prospective female sexual partner may punish the person for not being forthright, but it does not protect against exposure. She has already been exposed. Therefore, the only potentially protective function that criminal charges could play would be as a deterrent — namely, if someone aware of his or her HIV-positive status who otherwise would not reveal that status were compelled to do so because of the risk of criminal prosecution for not disclosing.

Yet there is little evidence to suggest much, if any, deterrent effect of this sort. In general, the deterrence value of criminal prosecutions is minimal with respect to sexual

practices — and particularly if alcohol, drugs or domestic violence are involved. The one study to date that has attempted to measure the deterrent effect of the criminal law on HIV non-disclosure to sexual partners (not a Canadian study) has found little impact. The authors concluded that they had

failed to refute the null hypothesis that criminal law has no influence on sexual risk behavior. Criminal law is not a clearly useful intervention for promoting disclosure by HIV-positive people to their sex partners. Given concerns about possible negative effects of criminal law, such as stigmatization or reluctance to cooperate with health authorities, our findings suggest caution in deploying criminal law as a behavior change intervention for seropositives.³⁶

If the objective is to protect women against HIV infection, criminal charges for HIV non-disclosure are a poor substitute for empowering women to take control of their own sexuality, ending violence against women and addressing the root causes of gender discrimination and subordination.

Criminal charges distract from the larger task of ensuring comprehensive sexual health information and services for everyone. As long as women are dependant on their partners (or on public health or the police) to disclose potential harms to them, women will never be equal or empowered in their relationships.

To be clear, men who assault or exploit women should be prosecuted with the full force of the law (notably, the conviction rate for sexual assault is extremely low in Canada). But sexual assault is already a criminal act. The offender's knowledge

that he had HIV at the time of the attack may be an aggravating factor, but it is not the essence of the crime.

Furthermore, an increasing number of women in Canada are living with HIV. What are the consequences of criminally prosecuting non-disclosure for these women, including women in abusive relationships or who are economically dependent on a partner?

Criminal charges distract from the larger task of ensuring comprehensive sexual health information and services for everyone.

A recent case in Montreal is revealing in this regard. In February 2008, a woman was found guilty of aggravated sexual assault for not disclosing her HIV-positive status to her boyfriend when they began dating.³⁷ A few months into their five-year relationship she disclosed to him. They broke up, and the man was charged with assault following complaints of domestic violence against the woman and her son; in retaliation, he alleged that she had failed to disclose her HIV-positive status before they had had unprotected sex.

The woman testified that they had used condoms from the beginning of their relationship, but the court concluded that the couple had unprotected sex at least once prior to her disclosure.³⁸ In a bitter irony, he was given an absolute discharge with no criminal record despite being found guilty of assaulting her and her son.

In circumstances such as these, are women protected through the criminalization of non-disclosure and HIV exposure? And as ever more women are infected, in particular aboriginal women and women who inject drugs or whose partners use drugs, will women be protected and empowered through criminalization, or will more women find themselves behind bars?

The way forward — where to next?

Although there has been a trend in Canada over the past ten years to ever more expansive and frequent use of the criminal law in cases of HIV exposure, we have reached a moment where perhaps some significant changes can be achieved if advocates take strategic advantage of emerging opportunities. Several specific interventions may be particularly pertinent:

- Increase public information and debate on the criminalization of HIV exposure and its impacts.
- Develop a legal defence strategy, including materials for defence lawyers and expert witnesses.
- Work with Attorneys-General's offices to develop prosecutorial guidelines to limit the ongoing attempts by prosecutors to expand the scope of the criminal law.³⁹
- Build a base of evidence on the impacts of criminalization of HIV exposure, including published research studies.

Canada currently has the unsettling (dis)honour of being a world leader in criminalizing HIV exposure. Perhaps in the next post-*Cuerrier* decade, we will be able to advance a more rights-based, evidence-informed approach to sexuality and HIV pre-

vention, such that criminal charges for otherwise consensual sex are no longer seen as warranted.

– Alison Symington

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¹ *R. v. Cuerrier*, [1998] 2 SCR 371.

² The Canadian HIV/AIDS Legal Network tracks criminal charges for HIV non-disclosure using media reports, legal databases and information received from AIDS service organizations, lawyers and people living with HIV. While such a tracking can never be completely comprehensive, the Legal Network believes its records capture most of the cases that have been brought forward in Canada. Unless otherwise noted, the observations made in this article are based on the Legal Network's tracking.

³ "Guilty of exposing women to HIV, Ontario man faces life sentence," *Sudbury Star*, 28 April 2007, p. A8.

⁴ For example, see D. Schmidt, "'I'm clean,' he told victims; some given pills and blacked out," *Windsor Star*, 28 April 2007, p. A1.

⁵ *R. v. Mabior*, 2008 MBQB 201.

⁶ P. Turenne, "Sex menace sentenced; HIV-infected man lured runaway girls with drugs," *Winnipeg Sun*, 11 October 2008, p. 5.

⁷ D. Peat, "Accused lied about HIV, Crown says; but defence argues it wasn't murder; it was cancer," *Toronto Sun*, 21 October 2008, p. 5.

⁸ T. McLaughlin, "HIV woman strikes again; cops; charged with having unprotected sex," *Toronto Sun*, 28 February 2007, p. 4.

⁹ T. McLaughlin, *Toronto Sun*, 26 November 2005, p.4.

¹⁰ Front page, *Toronto Sun*, 26 November 2005.

¹¹ This authority is contained in various pieces of provincial and federal legislation, including privacy legislation and police acts. See G. Betteridge and T. Katz, "Ontario: Police disclose HIV status of accused under Police Services Act," *HIV/AIDS Policy & Law Review* 9(3) (2004): 22–24.

¹² For example, in March 2007 Toronto Police Service released a photograph of Robin St. Clair in a news release, noting that she was 26 years old, charged with sexual assault, and alleging that "she deliberately failed to disclose to a sexual partner her HIV status" and that "she deliberately withheld information from other sexual partners in order to have sex with them." The news release indicated that police were releasing a picture of Ms St. Clair in an effort to encourage anyone who has had sexual contact with her to seek medical advice; and that police were seeking the public's assistance locating victims or witnesses. (Toronto Police Service, 32 Division, news release, 22 March 2007.)

¹³ G. Betteridge and T. Katz.

¹⁴ Letters on file with author.

¹⁵ Media advisory, on file with author.

¹⁶ Memo dated 13 December 2006, from Volker Helmuth, Director, Planning and Research Section, to Service & Policy Complaint Review Committee, Vancouver Police Board, p. 2. [on file with author].

¹⁷ *Ibid.*

¹⁸ *Whiteman v. lamkhong et al*, Statement of Claim, Ontario Superior Court of Justice [on file with author].

¹⁹ *Ibid.* at para. 4.

²⁰ *Ibid.* at para. 5.

²¹ *Jane Roe v. Carl Desmond Leone et al*, Statement of Claim, 18 April 2005 [on file with author]

²² *Ibid.* at paras. 28–34.

²³ T. Wilhelm, "Leone victims launch \$20M lawsuit," *Windsor Star*, 29 January 2009 (online).

²⁴ *Ibid.*

²⁵ N. Macintyre, "They used me as HIV 'bait'; woman sues for more than \$6m in damages," *Hamilton Spectator*, 13 August 2008.

²⁶ Canadian HIV/AIDS Legal Network, *Public Health Laws and HIV Prevention*, Criminal Law and HIV Info Sheets, 2008.

²⁷ *Smith v. Jones*, [1999] 1 SCR 455 (Supreme Court of Canada).

²⁸ *Criminal Code*, ss. 265(3)(c) and 273(1).

²⁹ *R.v. Cuerrier*, [1998] 2 S.C.R. 371 at para. 128.

³⁰ *R.v. Cuerrier*, [1998] 2 S.C.R. 371 at para. 129.

³¹ *R. v. Nduwayo*, [2006] B.C.J. No. 3418 at paras. 7–8. See also: *R. v. Nduwayo*, Charge to the Jury, pp. 625–626.

³² *R. v. Smith*, [2007] S.J. No. 166 (Sask. P.C.) at para. 59.

³³ *R. v. Edwards*, 2001 NSSC 80 at para. 6.

³⁴ *R. v. Mabior*, 2008 MBQB 201 at para. 116.

³⁵ *Ibid.* at para. 117.

³⁶ S. Burris et al, "Do criminal laws influence HIV risk behavior? An empirical trial," *Arizona State Law Journal* 39 (2007): 467.

³⁷ *R. c. D.C.*, District of Longueuil, Chambre criminelle, 505-01-058007-051, 14 février 2008. See also: "1 year sentence for HIV-positive woman guilty of assault; sentence to be served in community because of women's health, court says," *CBC News* (online), 9 July 2008.

³⁸ *Ibid.*

³⁹ For example, a Legal Guidance (for prosecutors and caseworkers) and a Policy Statement (for a more general readership) on prosecutions to the sexual transmission of infections were published in March 2008 by the Crown Prosecution Service of the United Kingdom. See Y. Azad, "Developing guidance for HIV prosecutions: an example of harm reduction?" *HIV/AIDS Policy & Law Review* 13(1) (2008): 13–19.

“Patients, not criminals”?

An assessment of Thailand’s compulsory drug dependence treatment system

Since the enactment of a new law on addiction treatment in 2002, Thailand has sharply increased the number of people in compulsory drug treatment programs. This article provides an overview of the system, particularly the custodial programs. It also provides some preliminary observations on the implementation of the legislation on its own terms — namely, that people who are dependent on drugs should be “treated as patients and not criminals.” While diverting people with drug dependence from the criminal justice system is important, this stated approach is undermined in a number of ways by the law’s implementation. This article is based on a longer report released by the Canadian HIV/AIDS Legal Network in 2009.¹

Introduction

Historically, Thailand’s drug policy has prioritized the criminalization and imprisonment of people who use drugs in attempts to make the country “drug free.” While still aimed at the same objective, the *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* (“the Act”) provides alternatives to incarceration for some drug offences:

Drug addicts [sic] rehabilitation has been considered as an important task in [the] criminal justice system in Thailand. Previously drug users/ drug addicts used to be charged as offenders. Since March 2, 2003 onwards drug users/drug addicts has [sic] not been arrested as “offenders” but “patients.” Instead of being prosecuted, they will be diverted to rehabilitation under appropriate plans. If they are successful, they will be acquitted. On the other hand, if they fail, they will finally be prosecuted in [the] criminal justice system.²

In a speech in 2004 to celebrate the U.N.’s annual “International Day Against Drug Abuse and Illicit Trafficking,” Thailand’s then-

Minister of Justice, Phongthep Thepkanjana, declared that

the national policy on solving the problem of drug abuse and addiction is clearly stated that drug addicts are considered as “Patients”, not criminals. Emphasizing the importance and effectiveness of drug treatment is one of our major strategic approaches.³

Methodology

During two visits to Thailand in 2008, over the course of about three weeks in total, the author met with officials in various government departments and agencies, and visited seven custodial centres run by various entities, including branches of the armed forces. These centres included both “intensive” and “less intensive” centres, as well as a centre for women and a centre for juveniles. Where possible, information provided by officials cited here was cross-checked against information provided by other officials. The author also conducted detailed, semi-structured interviews with 15 people who had been detained in Thailand’s compulsory drug treatment centres.⁴

Limitations of this research include the relatively small number of people interviewed about their experiences in compulsory treatment centres, the large number of such centres in Thailand and the different approaches towards treatment among the different agencies that run the centres. Nevertheless, this research is among the first to assess Thailand’s recent system of compulsory drug treatment. It also captures some of the experiences and opinions of people who have passed through the centres, perspectives that are all too frequently ignored.

Thailand’s drug laws and HIV risk

Despite the passage of the 2002 Act, the *Psychotropic Substances Act B.E. 2518 (1975)*, the *Narcotics Control Act B.E. 2519 (1976)* and the *Narcotics Act B.E. 2522 (1979)* remain in force. These acts prohibit and control the unauthorized production, consumption, possession and sale of a wide range of drugs, including cannabis, heroin, cocaine and amphetamine-type stimulants.

(Methamphetamine, commonly known as *ya ba* or *ya ma*, is one of the principal drugs used in Thailand.⁵)

Penalties for drug offences can range from fines of several hundred thousand Thai baht to up to 20 years in prison — and, in the case of “disposal” (i.e., trafficking), or possession for this purpose, of even the smallest amounts of certain drugs (e.g., heroin, amphetamine-type stimulants), the penalty can include life imprisonment. The death penalty may be imposed for offences involving more than 20 g of these substances.⁶

The policy that people who use drugs should be “treated as patients, not criminals” is contradicted by existing laws that continue to criminalize mere consumption.

While the 2002 Act creates a legal regime to divert people from incarceration for some drug offences, people continue to be arrested and charged for offences under the other acts, including consumption and possession of illegal drugs. Thus, the policy that people who use drugs or are dependent on drugs should be “treated as patients, not criminals” is contradicted by existing laws that continue to criminalize mere consumption.

Many people who use drugs in Thailand are incarcerated at some point. From 1992 to 2000, the number of persons jailed for drug use and possession only (i.e., not traf-

ficking) more than doubled.⁷ Despite diversion into compulsory treatment, Thailand had over 100 000 people in prison on “drug-related cases,” and more than one-fifth of such cases were cases of drug consumption (as opposed to drug trafficking or other drug-related offences), as reported in 2004 by the U.N. Office on Drugs and Crimes (UNODC).⁸

Incarceration has been a known risk factor for HIV infection among people who inject drugs in Thailand for more than a decade.⁹ Illegal drugs continue to be available in some Thai correctional facilities, resulting in some people continuing to use injection drugs while incarcerated.¹⁰ Research has revealed HIV prevalence as high as 40 percent among injectors who had been jailed.¹¹

People in custody are also exposed to other infectious diseases. Tuberculosis prevalence in prisons is several times that in the population as a whole.¹² High rates of incarceration among young methamphetamine users in Thailand have been associated with a range of HIV risk behaviours, including injection drug use.¹³

Research has also found significant risks of HIV infection related to syringe-sharing in pre-trial detention facilities.¹⁴ As of the end of 2008, opioid substitution therapy for people dependent on opioids was not available in prisons in Thailand, there was no access to HIV prevention materials in Thai prisons, and community-based HIV education groups had limited access to prisons.

Compulsory treatment: legal procedures

Arrest and court

The diversion scheme established by the 2002 Act can apply to people

charged with drug consumption alone, or drug consumption plus one or more of the following charges: possession, possession for “disposal” (i.e., trafficking), or disposal.¹⁵ The amounts of drugs involved must be small in order to qualify the person for diversion (e.g. less than 100 mg of heroin or 500 mg [5 tablets] of methamphetamine).¹⁶

After a person’s arrest for one of these offences, a court determines whether to “transfer such alleged offender for the identification of narcotics consumption or narcotic addiction” to a Sub-Committee for assessment.¹⁷ In practice, this decision turns on whether the person’s urine tests positive for drugs. When the case is transferred to a Sub-Committee, the prosecution is temporarily suspended.¹⁸

Detention for assessment

The accused is then detained for an assessment of drug-dependence by Department of Probation officials.¹⁹ Assessment usually involves a urine test and a criminal record check. The probation officer might also interview the person and will often investigate the person’s relationship with family, level of education and employment, which may involve interviews with family members or employers.

The officer will also investigate the person’s medical history and history of drug treatment. If the assessment finds the person ineligible for diversion into treatment, the case is returned to the Public Prosecutor; if the person is eligible, the probation officer’s report recommends a particular form of treatment.

According to the Act, assessment should happen within 15 days, a period which can be extended by up to a maximum of 30 days where there

is necessary cause.²⁰ However, being detained for the full 45 days appears to be routine, rather than exceptional. According to people interviewed, on occasion some people are detained for longer than 45 days.

During this period, individuals are held in prison. Thus, despite the Act's stated purpose of diverting people from incarceration, people dealt with under the Act are effectively incarcerated for extended periods of time. Although separated from other prisoners, those being detained for assessment of drug-dependence are subject to the same poor conditions.²¹

Despite the Act's stated purpose of diverting people from incarceration, people have been incarcerated for extended periods of time.

Sub-Committees and treatment orders

Usually Sub-Committees make decisions very quickly, such as a brief deliberation of a minute or two. Most decisions follow the recommendations contained in the probation officers' reports.

The Sub-Committees will order compulsory drug treatment in either custodial or non-custodial programs.²² Custodial programs are commonly described as either "intensive" (higher security) or "less intensive" (lower security).

According to officials, a person who uses drugs but is not dependent

is likely to be ordered into a (non-custodial) out-patient treatment program. A person who is dependent is likely to be sent to a (custodial) less intensive program. A person considered severely dependent — e.g., daily use and a prior record of compulsory treatment — is likely to be sent to a (custodial) intensive program.

According to data from the Department of Probation, in any given year between 2003 and 2008, 25 to 50 percent of people in the compulsory drug treatment system were ordered to attend custodial programs.²³ Over the same five-year period, almost 84 percent of people undergoing compulsory drug dependence treatment were methamphetamine users.²⁴

Initial treatment orders may be for up to six months, although the Sub-Committee has authority under the Act to extend treatment for further periods of up to six months at a time, to a maximum duration of three years. If the Sub-Committee determines that the outcome of treatment is "satisfactory," the person is released without further prosecution. If it deems the outcome "not satisfactory," the Public Prosecutor will revive the criminal prosecution.²⁵

Custodial treatment programs

While the system is overseen by the Department of Probation, the actual custodial centres are run by the military (the Royal Thai Army, Navy and Air Forces), the Ministry of Public Health, the Ministry of Interior, the police force and the Bangkok Metropolitan Administration.²⁶

Since the Act was adopted, the number of compulsory drug treatment centres has been expanding rapidly: in 2004, there were 35 centres; by 2005, there were 49;²⁷ by the end

of 2008, there were 84.²⁸ There are plans for the Army to establish an additional 14 centres by 2009.²⁹

The centres run by the Army are of the less intensive variety, while the centres run by the Air Force are intensive. For its part, the Navy runs both intensive and less intensive centres. Typically, the military centres hold 100–400 patients, except the Air Force centres which hold 30–60 patients. The centres run by the Ministry of the Interior are also smaller (30–50 patients).

Included in these figures are a number of centres for women and for juveniles. As of the end of 2008, there were 11 centres for women — eight less intensive centres and three intensive centres — and one centre for juveniles. These centres follow the general treatment approach of other centres, but with some adaptations. For example, a centre for juveniles might have general education classes each morning. A centre for women might have less vigorous physical exercises and different types of vocational training.

The Thanyarak Institute on Drug Abuse is responsible for training the centres' personnel. The Department of Probation is responsible for assessing the centres every three years. Assessment is not compulsory; the centres themselves must request assessment.

"Patients not criminals"?

Despite the stated intention, there are a number of ways in which people in Thailand's compulsory drug treatment system are not, in practice, treated as patients rather than criminals.

Detoxification

Detoxification will often be the first phase of drug treatment programs.

According to UNODC, “[t]he main goal of detoxification programs is to achieve withdrawal in as safe and as comfortable a manner as possible.”³⁰ UNODC notes that

[d]ependent users of psychostimulants, in particular amphetamines and cocaine, may also require medical supervision during the acute withdrawal phase following cessation of use. While there may be no direct physical withdrawal effects (and no prescribing of an agonist to minimize discomfort), the individual may have severe psychological problems (including induced psychosis) and sleep disturbance that may be managed by prescribing suitable medication.³¹

The people who enter custodial treatment programs have no right to choose their treatment or have input into their treatment plan.

Methamphetamine addiction is the most common form of drug dependence among those in Thailand's compulsory treatment system. The severity of withdrawal is generally greater in people who are older, who are more dependent and who have been using methamphetamine longer.³²

Yet the current process under Thailand's compulsory drug treatment system means that most people who are drug-dependent undergo detoxification while detained for

assessment in prison, as opposed to in a health care setting.

Thailand's prisons are poorly equipped and poorly resourced to supervise the process of detoxification and manage the complicated symptoms of withdrawal. There is little or no medical supervision or medication available to drug-dependent people being detained for assessment. None of the people interviewed for this research had received medication to help manage withdrawal symptoms in prison.

Opioid substitution therapy — maintenance or tapering — for those dependent on opioids does not exist in Thai prisons.³³ While proper nutrition, rest and exercise are particularly important during methamphetamine withdrawal,³⁴ these conditions are not present in Thailand's prisons. No psychosocial interventions (such as counselling) were available to the people who went through detoxification in prison and who were interviewed in the course of this research. There is little or no attention to mental health problems that are common among people who use drugs.

Drug treatment

Following the period of detention for assessment, custodial treatment programs initially involve four months in treatment centres, followed by a two-month “re-entry” program outside the centre.

The treatment provided in the treatment centres is a modified therapeutic community, involving a highly-structured residential environment with group psychotherapy and practical activities.³⁵

For custodial treatment, the centres run by the Royal Thai Army, the Royal Thai Navy, the Department of Probation and the centres under the

Ministry of Public Health employ the FAST model of drug treatment, a variant of the therapeutic community approach developed by the Thanyarak Institute on Drug Abuse.

FAST is an acronym that stands for Family (e.g., family visits, activities for family members), Alternative activities (e.g., group activities such as music or gardening), Self-help (e.g., physical training) and Therapeutic community work (e.g., group work, group evaluation).

In the intensive treatment centres, the Royal Thai Air Force employs a similar treatment approach (called *jirasa*), which places greater emphasis on discipline and physical activities (such as military drills) and a focus on Buddhist morality and practice.

A typical four-month period in a centre might be divided into:

- an “inception period” for the first month, during which the emphasis is on building motivation to stop drug use and preventing relapse;
- a “treatment period” for the second and third months, with an emphasis on group work, work therapy (e.g., cooking and cleaning the centre) and vocational training (e.g., agricultural work, mechanics and woodworking for men; hair-dressing, making artificial flowers or silk-screening for women); and
- a pre-release “re-entry” period for the fourth month, intended to prepare people to go back into the community and involving activities outside the centre (e.g., field trips or community service such as street cleaning).³⁶

The patients might be assessed by staff of the centres twice during the

four-month period (usually after 90 days and then again after 120 days in the centre). They are assessed on the basis of their cooperation with the system and their development in self-care skills and psychological well-being. Urine testing for drug use may be carried out in the centres.

Some people who were interviewed over the course of this research said that their time in treatment centres was generally better than their experiences waiting for assessment in prison, noting that the centres had such things as scheduled activities and better food. Other people interviewed were more critical of the treatment in the centres, explaining that they were bored during their time in the centres and that the treatment was ineffective.

The people who enter custodial treatment programs have no right to choose their treatment or have input into their treatment plan, although this is both an ethical requirement and improves treatment outcomes, according to the World Health Organization (WHO) and UNODC.³⁷

Discipline

The treatment centres follow a standardized approach, though the rules can vary from one centre to another. These rules are explained to the patients on entry into the camp and are displayed prominently around the centre. They typically comprise the following:

- No possessing or consuming drugs
- No escaping
- No stubbornness
- No stealing
- No quarrelling
- No sexual relationships
- No unauthorized possessions

According to the Act, a director has the power to punish a person who fails to follow the rules of a treatment centre by imposing probation; suspending visiting or communication rights for up to three months; or imposing solitary confinement for up to 15 days at a time.³⁸

Some interviewees who had been detained in the centres reported instances of cruel, inhuman and degrading forms of punishment, such as beatings or being made to roll on gravel.³⁹ These forms of punishment are not permissible under the Act.⁴⁰

Some people detained in the centres reported instances of cruel, inhuman and degrading forms of punishment, such as beatings and being made to roll on gravel.

Follow-up

Although not required by the Act, the Department of Probation attempts to undertake follow-up one year after treatment is completed. It may involve an appointment to see a Department of Probation officer or staff at the Thanyarak Institute. It might also involve a home visit, if there is sufficient staff to carry this out. Alternatively, it might also involve indirect follow-up, such as a telephone call or a questionnaire sent by mail.

Some people who had been in the compulsory drug treatment system

reported completing the requirement of follow-up visits. However, according to both officials and people who had been through the centres, for a considerable number of people follow-up is not possible. Given that drug consumption itself is illegal in Thailand, it is not surprising that some people will avoid follow-up, as this may reveal their continued drug use to authorities.

Evaluating treatment efficacy

The Act does not require an assessment of the efficacy of compulsory treatment programs. Both officials and people who have been in such programs frequently said that 70 percent of people who go through the system will not relapse, which suggests that the other 30 percent will use drugs again. The Department of Probation's publication notes that between 2003 and 2008, among all those who underwent compulsory drug treatment, the result was satisfactory in 75 percent of cases and unsatisfactory for 15 percent, with 10 percent categorized as "others."⁴¹

Attempts to assess drug treatment programs are inherently difficult. The task of evaluating efficacy is complicated by the fact that considerable numbers of people do not attend follow-up appointments. Thus, the statement that roughly 70 percent of people who go through the system will not relapse is unreliable.

The approach to assessing "success" in treatment is biased: it includes those who voluntarily return for an appointment, but ignores the many who do not, including those that do not return for follow-up because they fear the consequences of reporting ongoing drug use.⁴² Some officials expressed frustration

at not being able to evaluate the efficacy of treatment using more reliable data.

It is notable that there has been no research into the comparative efficacy of the different forms of treatment offered by different custodial centres. There is robust research from outside Thailand showing strong associations between periods of treatment in therapeutic communities and subsequent reductions of drug use.⁴³ However, key distinguishing characteristics of Thailand's system — such as its compulsory nature, or that it is delivered through a diverse collection of entities including those with a military and law enforcement background — call into question whether such findings extend to Thailand's system.

Not all forms of compulsory treatment will be effective. Some research from outside Thailand indicates that external motivators (such as being legally mandated into treatment) may increase internal motivation or interact with it to produce better outcomes.⁴⁴ However, this has been contradicted by other research that suggests that a lack of internal client motivation in treatment may undermine positive outcomes.⁴⁵

Thailand is not alone in not basing its system on rigorous evidence. Research has highlighted that, in many cases, there is a lack of proper evaluation of the efficacy of compulsory drug dependence treatment.⁴⁶ Specifically with relation to treatment for methamphetamine dependence, some research has shown that compulsory treatment has been associated with higher rates of relapse than voluntary treatment.⁴⁷

The people interviewed revealed a wide variety of perspectives on the quality of treatment. Some people had remained abstinent following

compulsory treatment. Some interviewees were appreciative of the treatment they received in the treatment centres, while noting that they did not remain abstinent after being released. Other interviewees were more critical of the effectiveness of the compulsory treatment system, noting that it is up to the individual whether to give up drugs or not.

Recommendations

To realize better the intention of the Act, namely that people with drug dependence be treated as patients, not criminals, action is needed to:

- minimize use of pre-treatment detention, including in prisons;
- develop and enforce minimum standards of care for drug dependence treatment;
- create mechanisms for patient input into programs and into measures to address any abuses; and
- accurately evaluate the efficacy of compulsory drug treatment, while expanding access to voluntary treatment services.

— Richard Pearshouse

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¹ R. Pearshouse, *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*, Canadian HIV/AIDS Legal Network, 2009, online via www.aidslaw.ca/drugpolicy.

² Department of Probation, *Department of Probation*, 2005, p. 20 [original in English].

³ Keynote address by H.E. Mr Phongthep Thepkanjana, Minister of Justice of Thailand, 26 June 2004, U.N. Conference Centre, Bangkok.

⁴ Excerpts from those interviews can be found in the full Legal Network report.

⁵ Literally, *ya ba* means "crazy drug," referring to the limited cases when a methamphetamine consumer might display "crazy" behaviour; possibly due to a drug-induced psychosis, while *ya ma* means "horse drug," referring to its effects on the consumer's energy level. The latter term is often preferred among people who consume methamphetamine as being less stigmatizing.

⁶ *Narcotics Act B.E. 2522 (1979)*, s. 66(3).

⁷ C. Beyrer et al., "Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand," *AIDS Behaviour* 7 (2003): 153–161.

⁸ UNODC, *Drugs and HIV/AIDS in South East Asia: A Review of Critical Geographic Areas of HIV/AIDS Infection Among Injecting Drug Users and of National Programme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*, 2004, p. 42.

⁹ K. Choopanya et al., "Incarceration and risk for HIV infection among injection drug users in Bangkok," *Journal of AIDS* 29(1) (2002): 86–94.

¹⁰ *Ibid.*

¹¹ C. Beyrer et al.; H. Thaisri et al., "HIV infection and risk factors among Bangkok prisoners," *BMC Infectious Diseases* 3 (2003): 25.

¹² See, e.g., S. Nateniyom, "Implementation of the DOTS strategy in prisons at provincial level, Thailand," *International Journal of Tuberculosis and Lung Disease* 8(7) (2004): 848–854.

¹³ N. Thomson et al., "Correlates of incarceration among young methamphetamine users in Chiang Mai, Thailand," *American Journal of Public Health*, 2008 (in publication).

¹⁴ See, e.g., A. Buavirat et al., "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: case-control study," *British Medical Journal* 326 (2003): 308–326; K. Choopanya et al.

¹⁵ *Narcotic Addict Rehabilitation Act, B.E. 2545 (2002)* (hereinafter in these notes, "2002 Act"), s. 19.

¹⁶ For more details, see the full report by the Legal Network.

¹⁷ 2002 Act, s. 19.

¹⁸ *Ibid.*

¹⁹ Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand*, undated [original in English], on file with the author: Probation officers undertaking the assessment (on which treatment decisions are based) are not trained medical professionals, nor is it clear whether they apply established assessment tools to assess the severity of addiction (such as the *Addiction Severity Index [ASI]*). There is, therefore, a risk that the process of decision-making about whether a person is to be subject to compulsory treatment, and for what period, is not clinically driven.

²⁰ 2002 Act, s. 21.

²¹ Note that, according to Article 10(1) of the ICCPR, "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

²² 2002 Act, s. 23.

²³ Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand*.

²⁴ *Ibid.*

²⁵ 2002 Act, s. 33.

²⁶ Department of Probation, *Department of Probation & the Compulsory Drug Treatment System in Thailand*.

²⁷ UNODC, *HIV/AIDS and Custodial Settings in South East Asia: An Exploratory Review into the Issue of HIV/AIDS in Custodial Settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam*, 2006, p. 46.

²⁸ Personal communication by the author with the Department of Probation, December 2008.

²⁹ *Ibid.*

³⁰ UNODC, *Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide*, 2003, p. IV.2, online at www.unodc.org/pdf/report_2003-07-17_1.pdf.

³¹ UNODC, *Drug Abuse Treatment and Rehabilitation*, pp. IV.2–IV.3.

³² C. McGregor et al., "The nature, time course and severity of methamphetamine withdrawal," *Addiction* 100(9) (2005): 1320–1329.

³³ Forced, abrupt opioid withdrawal can cause profound mental and physical pain and may be considered a violation of human rights obligations to protect detainees from inhuman or degrading treatment: R. Bruce and R. Schleifer, "Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," *International Journal of Drug Policy*, 19 (2008): 17–23.

³⁴ J. Obert et al., *A Physician's Guide to Methamphetamine: Developed from Matrix Institute & UCLA Integrated Substance Abuse Programmes*, 2005.

³⁵ [U.S.] National Institute on Drug Abuse, *Research Report Series: Therapeutic Community*, 2002, p. 1. Opioid substitution treatment is not available for patients dependent on opioids in treatment centres, yet a new policy of the Thai government is that such treatment will become available in the community under Thailand's universal health care scheme. Thus, while the Act is intended to

treat people with opioid dependence as patients, not criminals, they are effectively denied an established form of treatment available outside the centres.

³⁶ This period should not be confused with the non-custodial 're-entry period' of an additional two months following completion of custodial treatment.

³⁷ UNODC, WHO, *Principles of Drug Dependence Treatment: Discussion Paper*, pp. 5, 9. See also: [U.S.] National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide*, 1999, online at www.nida.nih.gov/PODAT/PODATIndex.html.

³⁸ 2002 Act, s. 32.

³⁹ U.N. standards state that "[c]orporal punishment ... and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences"; *United Nations Standard Minimum Rules for the Treatment of Prisoners*, 1955, U.N. Doc. E/5988 (1977), para. 31. Note that according to Article 7 of the ICCPR: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." This right is absolute and non-derogable. WHO and UNODC note that "[i]nhumane and degrading practices and punishment should never be part of treatment of drug dependence"; UNODC/WHO, *Principles of Drug Dependence Treatment: Discussion Paper*, 2008, p. 9.)

⁴⁰ Punishment must always be determined "by the law or by the regulation of the competent administrative authority" and "no prisoner shall be punished except in accordance with the terms of such law or regulation...": *United Nations Standard Minimum Rules*, paras. 29–30.

⁴¹ Department of Probation, *Department of Probation & The Compulsory Drug Rehabilitation System in Thailand*.

⁴² Similar methodological challenges are present in other assessments of drug dependence in Thailand. For example, see V. Verachai et al., "The results of drug dependence treatment by therapeutic community in Thanyarak Institute on Drug Abuse," *Journal of the Medical Association of Thailand (Chotmaihet thangphaet)* 86(5) (2003): 407–

414 [original in English]. The study reports that "[a]fter they completed the program, the clients were followed-up for five years. 203 cases (73.0%) were abstinent from drugs." However, the data is based on the 278 cases that completed the program of drug dependence treatment by therapeutic community from 1986 to 2000, not the 2881 cases that joined the therapeutic community during this period.

⁴³ See, e.g., S. Wilson, "The effect of treatment in a therapeutic community on intravenous drug use," *Addiction* 73(4) (2006): 407–411; J.-R. Fernández-Hermida et al., "Effectiveness of a therapeutic community treatment in Spain: a long-term follow-up study," *European Addiction Research* 8(1) (2002): 22–29.

⁴⁴ See, e.g., G. De Leon et al., "Circumstances, motivation, readiness and suitability (the CMRS scales): predicting retention in therapeutic community treatment," *American Journal of Drug Abuse*, 20(4) (1993): 495–515; G. Joe et al., "Retention and patient engagement models for different treatment modalities in DATOS," *Drug & Alcohol Dependence* 57 (1999): 113–125. Note that whether involuntary treatment complies with human rights requirements is a separate matter from its effectiveness.

⁴⁵ T. Wild et al., "Perceived coercion among clients entering substance abuse treatment: structural and psychological determinants," *Addictive Behaviours* 23(1) (1998): 81–95; J. Platt et al., "The prospects and limitations of compulsory treatment of drug addiction," *Journal of Drug Issues* 18(4) (1988): 505–525; A. Stevens et al., "Quasi-compulsory treatment of drug dependent offenders: an international literature review," *Substance Use and Misuse* 40 (2005): 269–283.

⁴⁶ T. Wild et al., "Compulsory substance abuse treatment: an overview of recent findings and issues," *European Addiction Research* 8 (2002): 84–93.

⁴⁷ M.-L. Brecht et al., "Coerced treatment for methamphetamine abuse: differential patient characteristics and outcomes," *The American Journal of Drug and Alcohol Abuse* 31 (2005): 337–356.

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. The articles for this issue were written by David Garmaise.

B.C. medical officers of health seek more supervised injection facilities

The Health Officer's Council of British Columbia, which is made up of the province's medical officers of health, has passed a resolution asking all health authorities in B.C. to develop supervised injection facilities (SIFs) where needed.¹

Medical officers said that they passed the resolution partly to make it clear where they stand in the federal appeal of a recent court case involving Insite, the SIF in Vancouver's Downtown Eastside, and partly because they are grappling with soaring rates of injection drug use and

infections in some B.C. communities, especially in the north.

The federal government is appealing a May 2008 decision by the B.C. Supreme Court that ruled that Insite was exempt from federal drug laws because to deny drug users access to the health services provided by

Insite would constitute a violation of the Canadian Charter of Rights and Freedoms.²

Meanwhile, B.C. Health Minister George Abbott revealed that the province will intervene in the court case. In a statement to *The Globe and Mail*, Abbott said:

Our government appreciates the role of the Health Officer's Council of British Columbia in advocating for preventive health services for British Columbia. We believe that Insite is an important part of the continuum of care and look forward to a positive response from the courts so that we can consider the further use of this service to British Columbia's health care system.³

The federal appeal is scheduled to be heard in April 2009.

Forum in City of Ottawa debates merits of SIFs

Proponents and opponents of an SIF for the City of Ottawa presented their views at an open forum organized by the Ottawa Coalition on AIDS on 12 February 2009.⁴

A police officer was booed when he expressed his force's opposition to the idea of opening an SIF. Staff

Sergeant Uday Jaswal said that "a safe injection site is a conflict for us, it leads to ethical dilemmas that would be difficult to remedy."

University of Ottawa researcher Lynne Leonard said that Ottawa has a huge needle problem which could be helped by an SIF. "If we could build it, they would most certainly come," she said.⁵

There are an estimated 3000 to 5000 drug addicts in Ottawa. A survey in 2007 of 405 drug users uncovered alarming rates of infection: 10 percent were HIV-positive and 61 percent carried the hepatitis C virus.⁶

Other surveys in Ottawa revealed that 43 percent of drug users interviewed said they had overdosed at least once, with the average being four times.⁷

There are 70 SIFs worldwide, in six European countries, Vancouver's Downtown Eastside and Australia.

They provide clean injection equipment in a clinical setting, where individual cubicles have two-way mirrors so nurses can observe addicts as they inject. The sites offer health care, counselling, education and referrals.⁸

¹ "Medical officers seek more injection sites," *The Globe and Mail* (online), 18 February 2009.

² See S. Chu, "Vancouver's supervised injection facility granted constitutional exemption from federal drug law," *HIV/AIDS Policy & Law Review* 13(2/3) (2008): 28-29.

³ "Medical officers seek..."

⁴ B. Johnston, "Cops spike safe injection site; Ottawa policy under fire for drug stance at policy form," *The Ottawa Sun*, 13 February 2009, p.5.

⁵ Ibid.

⁶ K. Egan, "Adding up damage done by drugs; but is Ottawa ready for safe injection site," *The Ottawa Citizen*, 13 February 2009, p. F1.

⁷ Ibid.

⁸ B. Johnston.

Human rights complaint filed against Ontario College of Physicians and Surgeons over methadone program

A Toronto doctor is leading a fight with the Ontario College of Physicians and Surgeons over the college's practice of collecting personal health information from patients receiving methadone by prescription. He is protesting what he calls a double standard, discrimination and a violation of civil liberties. Other patients are not required to provide the college with personal health information.¹

Dr Philip Berger, chief of family and community medicine at St. Michael's hospital, and a prominent Toronto physician, has filed complaints with

Ontario Human Rights Tribunal and the Office of the Information and Privacy Commissioner. He has also asked Barbara Hall, chief commis-

sioner of the Ontario Human Rights Commission, to order the college to stop what he calls intrusive information gathering.

“The college is supposed to regulate doctors, not patients,” Berger said. According to Berger, doctors who refuse to open their patients’ files to audits can be stripped of their ability to prescribe methadone.²

Wade Hillier, manager of the college’s methadone program, said that the requirements are in place to reduce risks of overdosing and to prevent “double-doctoring” — i.e., obtaining drugs from multiple physicians.

Hillier said that the college’s authority to collect and store patient information comes from an agreement with the provincial government, which asked the college to administer a methadone maintenance program in 1996. Medical charts are examined only to ensure doctors comply with the guidelines, and patients’ names are removed from any reports sent to the college, Hillier said.³

In his letter to Ms Hall, Berger said that his “fundamental concern” regarding the methadone program established by the college is that “it singles out for special attention and control patients who are opioid substance dependent and being treated with methadone.”⁴

In his letter to Information and Privacy Commissioner Ann Cavoukian, Berger says that the college has no legal authority under the *Regulated Health Professions Act, 1991* to collect and use personal health information, and that the practice is outside the legislative protections established by the *Personal Health Information Protection Act*.⁵

There are an estimated 20 000 patients in Ontario receiving methadone by prescription.⁶

The college’s methadone guidelines also require patients to submit

to weekly urine tests in the presence of a clinic worker or security camera. Giving doctors the discretion to decide when tests should be done could save the province millions of dollars, and spare patients much indignity, Berger said.⁷

¹ T. Tyler, “Addicts protest ‘double standards’; methadone users say physicians’ regulator requires personal data other patients don’t have to provide,” *Toronto Star*, 14 February 2009, p. A08.

² Ibid.

³ Ibid.

⁴ Letter from Philip Berger to Barbara Hall, 16 October 2008, on file with the Legal Network.

⁵ Letter from Philip Berger to Ann Cavoukian, 16 October 2008, on file with the Legal Network.

⁶ Ibid.

⁷ T. Tyler.

More money for Vancouver drug court, but future funding for all drug courts uncertain

The federal government is providing an additional \$200,000 to support the pilot drug treatment court project in Vancouver, B.C.¹ The drug court is an alternative to criminal courts for people who commit crimes to support their drug use. People who plead guilty and promise to abstain from drugs qualify for the drug treatment court.

The additional funds will be used to continue to pay the salary of a staff person who helps people passing through the drug court find supported housing; and to top-up funds that welfare recipients have to pay for rent.

Federally funded drug courts now operate in six Canadian cities: Vancouver, Edmonton, Regina, Winnipeg, Toronto and Ottawa. Their goal is reduce crimes associated with drug dependency through

treatment, drug testing and support services.

Meanwhile, officials in two other cities are pushing for drug courts to be established in their jurisdictions. The Halifax, N.S., police chief

Frank Beazley said that his city needs a drug court because “so many of Halifax’s crimes are committed by drug addicts.”²

In Hamilton, Ontario, the police board has asked federal Justice Minister Rob Nicholson for a drug court.

The federal government spends \$3.4 million a year on the six existing drug courts. Funding for the programme is scheduled to run out in March 2010. The Justice Department is expected to complete a review of the programme this summer, and to make a recommendation concerning whether to continue the current programme and, possibly, expand it to other municipalities.

The programme has both supporters and critics. Supporters call it “one of the best programmes in the justice system,” offering an innovative way to turn “drug-addicted criminals” into “healthy responsible citizens.”³

For the 20–30 percent of people who make it through the programme, it is well worth it, according to John Gibbons, an Ottawa police constable. “If you get somebody off the streets, you get them housed, you get them into a tax-paying member of society,” this is an incredible savings,” he said.⁴

But Dr Thomas Kerr, of the B.C. Centre for Excellence in HIV/AIDS, says that the drug courts are more popular than effective. Addiction is a medical problem, not a criminal issue,

he said, whereas the drug courts are “just prolonging [users’] exposure to the criminal justice system.”⁵

The Review recently carried a feature article on drug treatment courts. See D. Werb et al, “Drug treatment courts in Canada: an evidence based review,” *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 12–17, online via www.aidslaw.ca/review.

¹ L. Culbert, “Feds pump more money into drug court,” *The Vancouver Sun*, 18 November 2008.

² “Halifax police chief proposes drug court,” *The (Halifax) Chronicle Herald*, 19 February 2009.

³ “Drug treatment courts’ future up in the air,” *CBC News* (online), 10 March 2009.

⁴ *Ibid.*

⁵ *Ibid.*

Survey reveals need to combat stigma, improve education, find new treatments

Twenty-five years into the epidemic, a large majority of Canadians living with HIV still feel stigmatized and believe that improvements are required in education and treatment. These are the key findings of the HIV+25 Survey released on 24 November 2008.¹

The web-based survey asked 381 people living with HIV about the impact of the disease on their lives, and explored their level of knowledge and their satisfaction with health care and current treatments.

The survey was conducted by P/S/L Research Canada in collaboration with the Canadian AIDS Society (CAS), the Canadian Aboriginal AIDS Network (CAAN), the AIDS

Committee of Toronto (ACT), the Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-Sida), and AIDS Community Care Montreal (ACCM). The survey was funded by Merck Frosst Canada.

More than eight out of 10 respondents said that they faced stigma associated with their HIV status. Just over half said that the stigma

impacts their ability to find a job. In addition, 44 percent said that their co-workers were not aware of their HIV status; 55 percent said that they feel depressed; and 45 percent reported feeling isolated as a result of living with HIV.

David, a person living with HIV, said, “I always hesitate to tell anyone I am HIV-positive because I know the reaction will often be negative....

It impacts almost every area of my life.”

“These findings demonstrate the need for further and continuing education to eradicate stigma attached to being HIV-positive,” said Stephen Alexander, programs consultant with CAS.

The survey showed that persons living with HIV need to be better educated about treatments. More than half of the respondents said they were somewhat, not very or not knowledgeable about the treatments available. One out of three said they were not fully informed about the complexities of the disease.

The survey found that the less knowledgeable persons living with

HIV are about HIV and treatments, the less likely they were to adhere to their treatment regime. This can have a negative effect on treatment outcomes.

Although half the respondents said they wanted to be more involved in their treatment decisions, the majority were not aware of the latest classes of antiretroviral medications. Yet, respondents were clearly worried about HIV becoming resistant to currently available treatments. More than nine in 10 said they wanted a treatment developed that attacked the virus in new ways to counteract resistance.

Respondents were also concerned about side effects. More than two-

thirds cited fatigue. Sleep disturbances and diarrhea were mentioned by about half of the persons surveyed. These findings reinforce the need for research on new treatments.

Results of the survey are considered accurate to within five percentage points, 19 times out of 20. The researchers said that additional research is required to further explore the needs of the different sub-groups in the survey.

¹ HKDP Communications and Public Affairs, “HIV+25 Survey asks where we are in Canada twenty-five years after discovery of the virus,” news release, Ottawa, 24 November 2008.

In brief

Federal government tries again to set mandatory minimum sentences for some drug offences

The federal government has re-introduced legislation establishing mandatory minimum sentences for “serious” drug offences.¹ Bill C-15,² which received first reading in the House of Commons on 27 February 2009, is similar to Bill C-26, which was tabled in the previous session of Parliament, but which died on the

order paper when Parliament was dissolved in September 2007.³

Bill C-15 includes:

- a one-year mandatory prison sentence for dealing drugs for organized-crime purposes or when a weapon or violence is used;
- a two-year minimum term for dealing harder drugs such as cocaine and methamphetamines to youth, or dealing near a school;
- two years minimum for running a pot grow-op with at least 500 plants;
- an increase to the maximum term for producing marijuana to 14 years, and
- stiffer sentences for trafficking in so-called date-rape drugs.⁴

Critics of mandatory minimum sentences point out that the burden of such sentences falls on people involved in small-scale, street-level drug distribution and consumption to support addictions; that it is bad public health policy to increase the incarceration rate of people who use drugs; and that evidence from the U.S. indicates that mandatory minimum sentences do not work for drug offences, resulting in the incarceration of large numbers of non-violent drug offenders while doing nothing to curb drug-related crime or problematic drug use.⁵

A previous attempt in 2006 (Bill C-9) to impose mandatory minimum sentences for drug offences failed when the bill was amended in committee.

Ontario judge scolded for ignorance of HIV

Justice Jon-Jo Douglas, an Ontario judge who mandated the use of face masks and rubber gloves in a trial involving a witness who was HIV-positive, has been given a “dressing-down” by Ontario’s Chief Justice, Anne-Marie Bonkalo, and ordered to spend a day at Casey House, a Toronto hospice for people living with HIV/AIDS.⁶

This follows a complaint lodged with the Ontario Judicial Council by the Canadian HIV/AIDS Legal Network and the HIV/AIDS Legal Clinic (Ontario) over what they called “shockingly discriminatory thinking and practice” on the part of the judge.⁷

The council decided against a public inquiry; instead, they sent the case to the Chief Justice. In a letter which Judicial Council Registrar Marilyn King sent to the complainants, she said that Justice Douglas “now fully understand the concerns with his conduct” and “has learned from his experience.” The letter went on to say that

[t]he Chief Justice advised that that Justice Douglas has expressed his apologies for his conduct, with sincere regret for any harm his behaviour may have caused to the witness in the proceedings or to others with HIV/AIDS, and for any impacts that his behaviour may have had upon the public.

The Judicial Council also recommended that judges in Ontario be better educated about HIV.

The complainants said that the outcome was a step in the right direction. “The bigger picture here is making sure that judges do have appropriate information and they

don’t approach their jobs with misinformation about HIV,” said Richard Elliott, executive director of the Canadian HIV/AIDS Legal Network.

Groups oppose proposed police crackdown in Downtown Eastside

HIV/AIDS and civil rights advocates have reacted angrily to a plan from the police to crack down on street crime, drug dealers and chronic offenders in Vancouver’s Downtown Eastside (DES).⁸

In January 2009, Vancouver Police Chief Jin Chu presented a draft business plan for 2009 which includes proposals to increase the number of street patrols in the DES. It also aims to reduce petty crimes by ticketing chronic offenders and seizing drugs from dealers, rather than spending more time formally arresting and processing them. The plan would have to be approved by the city’s police board.

A coalition of six HIV/AIDS-related organisations⁹ plus the B.C. Civil Liberties Association, sent a letter to Chief Chu and Vancouver Mayor Gregor Robertson saying that police sweeps and aggressive ticketing would threaten the health and safety of residents of the DES.

The letter said that if low-income offenders were unable to pay their fines, they could be barred from the DES and, in the process, lose access to essential services, including health care and drug treatment programs. The letter added:

Our overall concern is that the Vancouver Police department’s planned activities in the Downtown Eastside, whose population is dis-

proportionately disabled, aboriginal, HIV-positive and hepatitis C-positive, will increase transmission of HIV and hepatitis, limit access to critical health services and will not achieve the desired goals.¹⁰

Douglas King, a lawyer with the Pivot Legal Society, said that the proposed police crackdown is an unwanted remnant from the previous city council’s controversial Project Civil City programme that aimed to reduce major street disorder by ticketing petty street-level crimes.

“If the VPD wants to give out hundreds of tickets,” King said, “then they’d better be prepared for their officers to spend hundreds of hours in court.”¹¹

One city councillor said that a desire to clean up the streets prior to the 2010 Winter Olympics (which Vancouver is hosting) is ultimately behind the crackdown.¹²

Punitive laws and policies put sex workers at risk

Forcing prostitutes out of populated areas and into back alleys and dark streets increases violence and the spread of HIV, according to a new study conducted in Vancouver and published by the B.C. Centre for Excellence in HIV/AIDS.¹³

The research showed that one in four sex trade workers were pressured into having unprotected sex, and that the most vulnerable were women who had been “displaced to outlying areas due to policing or prostitution or drug charges.”

Dr Kate Shannon, author of the study, said that Canadian prostitution laws and drug policies increase the risk of sexually transmitted diseases

and violence in open, street-level sex work markets.

“Our findings showed that the policing and enforcement of prohibitive sex work legislation had a direct and negative relationship with female sex workers’ ability to negotiate condom use with their clients,” she said.

Health care costs in prisons rising fast

The cost of providing health care to federal inmates is rising quickly, according to information from Correctional Service of Canada (CSC) obtained by the Sun Media through an access-to-information request.¹⁴

Health care costs in penitentiaries was nearly \$150 million last year, compared to \$132 million the year before. The average cost of caring for inmates is now 2.4 times higher than the costs for the average Canadian living outside prison. CSC says that the costs of treating mental health problems, substance abuse and infectious diseases like HIV and hepatitis C partially explains the rising costs.

Craig Jones, the executive director of the John Howard Society of Canada, said that the Conservative government has unwisely rejected public health initiatives such as needle exchange and clean tattoo programs that could help stop the

spread of blood-borne diseases. This ideologically-driven approach in preference to “evidence based solutions” does nothing to reduce harm and actually leads to increased health care costs, he said.

Richard Elliott, executive director of the Canadian HIV/AIDS Legal Network, called the CSC’s zero tolerance policy for drugs misguided and impractical. “Let’s take some pragmatic steps to prevent some of these health problems,” he said.

The rate of HIV is ten times higher in prisons than in the general population — and 20 times higher for hepatitis C.

Manitoba: New AIDS drugs added to provincial formulary

In December 2008, the Manitoba Government announced that four new AIDS drugs would be added to the provincial formulary in early 2009, and provided free of charge to people living with HIV/AIDS.

The four drugs — Truvada, Atripla, Isentress and Intelence — are more efficient and powerful versions of existing medicines.

Mike Payne, executive director of Nine Circles Community Health Centre, said that the new drugs would benefit patients who have built up immunity to existing drugs; and would contribute to a reduced pill

burden for some patients. Truvada, for example, combines two existing medications into one pill.

¹ S. Merti, “Conservatives would impose mandatory sentences on drug dealers, grow-ops,” Canadian Press (online), 27 February 2009.

² *An Act to Amend the Controlled Drugs and Substances Act and To Make Related and Consequential Amendments to Other Acts*. The text of the bill is available online via www.parl.gc.ca/LEGISINFO/index.asp?Language=E&query=5739&Session=22&List=toc.

³ See A. Symington, “Legislation imposing mandatory minimum sentences for drug offences passes second reading,” *HIV/AIDS Policy & Law Review* 13(1) (2008): 25–27.

⁴ S. Merti.

⁵ A. Symington, “Legislation imposing...”

⁶ M. O’Toole, “Ont. Judge browbeaten for HIV comments,” *National Post*, 10 January 2009; T. Tyler, “A judge confronts his fear of AIDS; Jon-Jo Douglas once made witness don mask,” *Toronto Star*, 10 January 2009; K. Makin, “Judge who told witness to wear mask censored,” *The Globe and Mail*, 10 January 2009.

⁷ A. Symington, “Complaint filed concerning judge’s conduct,” *HIV/AIDS Policy & Law Review* 13(1) (2008): 30–31.

⁸ “Downtown Eastside advocates vow to fight police crackdown,” *CBC News* (online), 17 February 2009.

⁹ The six organizations are AIDS Vancouver; the B.C. Positive Women’s Network, Youthco AIDS Society, the Asian Society for the Intervention of AIDS, the B.C. Persons with AIDS Society and the Canadian HIV/AIDS Legal Network.

¹⁰ M. Howell, “AIDS agencies pan street police plan,” *Vancouver Courier*, 18 February 2009.

¹¹ “Downtown Eastside advocates...”

¹² *Ibid.*

¹³ D. Spalding, “Isolating prostitutes unsafe, study finds,” (Nanaimo) *Daily News*, 6 February 2009.

¹⁴ K. Harris, “Sick inmates costly; loss of needle-exchange programs behind prison care costs, access documents show,” *The Calgary Sun*, 17 December 2008, p. 28.

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 David Garmaise, managing editor of the *Review* at dgarmaise@gmail.com. All of the articles in this section were written by David Garmaise.

U.N. adopts historic declaration on economic, social and cultural rights

On International Human Rights Day, 10 December 2008, the U.N. General Assembly adopted a landmark document, the *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*.

The Optional Protocol would establish several procedures to enable people who experience violations of economic, social and cultural

rights to seek remedies and to hold those responsible to account for their actions. Similar mechanisms are already in place to redress violations

of civil and political rights. At least 10 member states of the U.N. have to ratify the Optional Protocol for it to enter into force.

The 36 Special Rapporteurs and Independent Experts of the U.N. issued a joint statement welcoming the adoption of the Optional Protocol and adding that

[t]he decisive action of the General Assembly today makes it clear that economic, social and cultural rights, including the rights to adequate housing, food, health, education and work, are not a matter of charity, but rather rights that can be claimed by all without discrimination of any kind.¹

The experts said that the combination of a petitions mechanism, an inquiry procedure and the possibility of interim measures will contribute to a body of jurisprudence around rights, thereby helping states to ensure their implementation.

“Allowing individuals and groups of individuals to submit complaints on alleged violations to the Committee on Economic Social and Cultural Rights represents a promising tool for all victims of violations of these rights to speak out and be heard,” the experts stated.

The experts said that they sincerely hoped that views adopted by the Committee under the Optional Protocol procedures will be used by the human rights community to assist states in taking concrete steps to realize the rights of all and to reach out to the most marginalized and disadvantaged.

“This marks an essential step towards the establishment of a long-

awaited mechanism that reinforces the universality, indivisibility, interdependence and interrelatedness of all human rights, and the guarantee of dignity and justice for all,” the experts said.

The experts emphasized that the new complaint and inquiry mechanism will also play a role in enhancing protection of other rights. “Widespread violations of economic, social and cultural rights are often root causes of social unrest and conflict which can lead to massive violations of civil and political rights,” they stated.

An NGO coalition said that the adoption of the Optional Protocol “represents an historic advance for human rights.” In a news release, the coalition said that the Optional Protocol “has been appropriately described by Louise Arbour, the previous High Commissioner for Human Rights, as ‘human rights made whole.’”²

The new Optional Protocol was the result of five years of intensive work, followed by intensive consultations, according to Portugal’s representative, the main sponsor of the draft resolution on the issue. This work was carried out by a U.N. body, the Third Committee (Social, Humanitarian and Cultural).

Although the Third Committee agreed on the text of the Optional Protocol by consensus (i.e., without a vote), a number of representatives expressed concerns over whether eco-

nomics, social and cultural rights were sufficiently suited to an individual complaints mechanism, and whether those responsible for violations could be held to account in the same way as civil and political rights.³

The text of the Optional Protocol is available via www.opicescr-coalition.org/.

¹ “UN human rights experts welcome the adoption of the *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* by the General Assembly,” joint statement, 10 December 2008, online at www.unhcr.ch/hurricane/hurricane.nsf/view01/C5486C42747EC60BC125751B005B08B3?opendocument.

² NGO Coalition for an *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, “NGOs celebrate historic adoption of Optional Protocol for Economic, Social and Cultural Rights at United Nations,” news release, New York, 10 December 2008, online via www.opicescr-coalition.org/.

³ U.N. General Assembly, “Third Committee recommends General Assembly adoption of Optional Protocol,” news release, New York, 18 November 2008, online at www.un.org/News/Press/docs/2008/gashc3938.doc.htm.

Uganda: Proposed bill would criminalize HIV transmission, force partners to reveal HIV-positive status

The Uganda government has introduced in Parliament an omnibus AIDS bill which aims to criminalize the “intentional or willful” transmission of HIV, introduce “routine” HIV testing for pregnant women, and require disclosure of one’s HIV-positive status to one’s spouse or partner. The bill also contains measures to protect the rights of people living with HIV/AIDS, including guaranteeing access to treatment and providing protection against discrimination.¹

Under the bill, conviction on the charge of intentionally or willfully transmitting HIV would be punishable by death.

The bill is the first formal effort by the government to criminalize behaviour that could lead to HIV transmission. It comes at a time of growing anxiety among public health specialists over the stagnation of the country’s HIV prevalence rate at around 6.5 per cent and evidence of rising year-on-year infections.

There has been a recent public outcry over media reports of HIV-positive individuals infecting minors, which has gained support for the bill.

HIV/AIDS advocates have expressed opposition to the provisions criminalizing HIV transmission. They said that applying criminal law to HIV-risk behaviour was likely to undermine prevention efforts and, rather than encouraging people to know their status, would actually deter them from seeking HIV testing.

“If you push for ... punishment because someone is infected, you are discriminating and undermining the rights of people living with HIV,” said Beatrice Were, a leading HIV-positive campaigner.²

Stella Kentutsi, program manager at the National Forum of

PLWHAs Networks in Uganda (NAFOPHANU) asked, “How do you know who infects intentionally and wilfully and who does not? What makes it intentional or wilful?”³

“We should avoid creating scenarios where people living with HIV/AIDS are looked at either criminals or potential criminals,” a statement by NAFOPHANU said. “Rather than introducing laws criminalising HIV exposure and transmission, legislators must reform laws that stand in the way of HIV prevention and treatment.”⁴

The proposed legislation calls for routine HIV testing for both pregnant women and their partners, as well as couples planning to marry.

Dr David Apuuli Kihumuro, head of the Uganda AIDS Commission, said that the provision that HIV status disclosure would be mandatory for couples planning to marry should be changed (along with certain other sections of the bill). “We have to think about the repercussions of this in a male-dominated society,” Kihumuro said, noting that many women were afraid of their husbands’ reactions once they revealed their HIV status.⁵

At least three women in Uganda have been killed by their husbands

in 2008 because they were HIV-positive.

Kentutsi said that medical practitioners usually had no way of knowing how a spouse or other sexual partners might react, and should therefore not be permitted to reveal an infected person’s HIV status.⁶

Although the bill provides for voluntary testing and counselling, it would also require mandatory testing for people charged with drug abuse, illegal possession of medical instruments, sexual offences and commercial sex work. As well, sexual assault survivors would undergo routine HIV testing.

The bill encourages HIV-positive people to inform their partners about their status, and follow prevention and treatment measures to prevent transmission of the virus; and recommends that health workers notify the sexual partners of people who test positive for HIV if the individual “has been given reasonable opportunity to inform their partner(s) of their HIV-positive status and has failed to do so.”⁷

In addition, the draft law would permit a court to order an individual to undergo an HIV test.

HIV/AIDS advocates have expressed concern about the disclo-

sure requirements of the proposed legislation, claiming that the provisions could eliminate the confidentiality of voluntary testing and contribute to increased transmission of HIV.

Chris Baryomunsi, vice chair of the Ugandan Parliament's Committee on HIV/AIDS and Related Matters, defended the proposed legislation, but added that his committee was open to considering amendments in order to address concerns from various groups.⁸

The bill also calls for all pregnant women who test positive for HIV to receive antiretroviral treatment and medication to prevent mother-to-child transmission of the virus;

provides for HIV testing for infants born to HIV-positive mothers; guarantees treatment, care and support for HIV-positive infants; and mandates increased safety measures in hospitals.

Under the draft law, employers would be forbidden to require mandatory HIV testing for their employees, and other officials could not require HIV tests before providing services such as credit, insurance or loans. In addition, the draft law prohibits discrimination on the basis of HIV status in schools, workplaces or in bids for public office.

For a discussion of HIV laws in west and central Africa, see R. Pearshouse, "Legislation contagion: building resis-

tance," *HIV/AIDS Policy & Law Review* 13(2/3) (2008): 1, 5–10.

¹ S. Naturinda, "Bill to force spouses to reveal HIV status," *Daily Mirror*, 12 December 2008; "UGANDA: Draft HIV bill's good intentions could backfire," *PlusNews* (online), 24 November 2008.

² "UGANDA: Draft HIV..."

³ *Ibid.*

⁴ *Ibid.*

⁵ *Ibid.*

⁶ *Ibid.*

⁷ S. Naturinda.

⁸ *Ibid.*

Zimbabwe: Collapse of the public health system has devastating consequences for HIV care

There is a health and health care crisis in Zimbabwe which is affecting HIV/AIDS patients, and which is a "direct outcome of the malfeasance of the Mugabe regime and the systematic violation of a wide range of human rights, including ... an egregious failure to respect, protect and fulfill the right to health."¹ This is one of the conclusions of a report prepared by Physicians for Human Rights (PHR) following an investigation conducted in Zimbabwe in December 2008.

The findings contained in the report show, at a minimum, violations of the rights to life, health, food, water and work. The report says that "when examined in the context of 28 years of massive and egregious human rights violations against the people of

Zimbabwe under the rule of Robert Mugabe, they constitute added proof of the commission by the Mugabe regime of crimes against humanity."²

The report says that the collapse of the public health system in Zimbabwe, which culminated in the

closure of all public sector hospitals in November 2008, is "unprecedented in scale and scope."³

The report says that transport costs have made getting to work impossible for many health care workers, even in the capital, Harare.

A rural clinic staff nurse reported that since he lived at the clinic, he had no difficulties in getting to work; however, since bus fare to get to the nearest town to collect his monthly salary cost more than the entire salary, it made no sense to collect it. He had not done so since April 2008.⁴

When asked about how the absence of healthcare workers was affecting HIV treatment, a senior government official said, “The problem is the staff and the patients cannot come due to travel costs.”⁵

The report said that agricultural output has dropped 50–70 percent over the past seven years. It said that the Mugabe government has exacerbated food insecurity for Zimbabweans in 2008 by blocking international humanitarian organizations from delivering food and humanitarian aid to populations in the worst-affected rural areas. Patients with HIV/AIDS and TB are especially vulnerable to food insecurity.

The report says that UNAIDS figures show that Zimbabwe has a severe generalized epidemic of HIV, with an overall adult HIV prevalence rate of 15.3 percent. An estimated 1.3 million adults and children in Zimbabwe were living with HIV infection in 2008. In 2007, some 140 000 Zimbabweans died of AIDS, and the current toll is estimated at 400 AIDS deaths per day.

For HIV/AIDS, the most severe threat has been the interruption of regular supplies of antiretroviral (ARV) drugs. Multiple key informants, patients, and providers told PHR that ARV supplies had become irregular due to breakdowns in drug delivery, distribution and provision, and to theft of ARV drugs by operatives of the governing party.

Most troubling were reports that some physicians were switching patients on established ARV regimens to other regimens based not on clinical need, but on drug availability.

This can lead to drug resistant HIV strains.

These dangerous practices constitute a significant threat to public health since the development and transmission of multi-drug resistant variants of HIV in Zimbabwe could undermine not only Zimbabwe’s HIV/AIDS program, but regional programs as well.

Among the recommendations contained in the report is one calling on donors to convene an emergency summit on HIV/AIDS, tuberculosis and other infectious diseases to coordinate action to address the current acute shortfalls in AIDS and tuberculosis treatment and care in Zimbabwe.

¹ PHR, *Health in Ruins: A Man-Made Disaster in Zimbabwe*, January 2009, p. 14, online via <http://phrblog.org/blog/2009/01/22/health-in-ruins/>.

² Ibid.

³ Ibid. at p.15.

⁴ Ibid. at p. 26.

⁵ Ibid.

Macedonia: Detention of sex workers sparks protest

HIV/AIDS and human rights organizations have vigorously protested the detention, compulsory medical testing and criminal prosecution of alleged sex workers in Skopje, Macedonia in November 2008.¹

On the night of 20 November 2008, police executed a large-scale raid targeting a well-known sex work zone in Skopje, arresting more than 30 people (the majority of them women alleged to be sex workers) and detaining them overnight.

The following day, those detainees accused of being sex workers were subjected to compulsory testing by police for HIV and hepatitis B and C.

Media outlets subsequently published and broadcast photos of the women being escorted from police

vans into the clinic, as well as information that they had been arrested for “involvement in prostitution.”

The Ministry of the Interior published on its website pictures of the detainees that had been taken at the police station. Furthermore, The

Minister of the Interior issued a press statement in which she declared the police action was part of the government's "fight against a sociopathological phenomenon in society and to eliminate street prostitution."

The Minister also stated the testing had been done to find out if the "arrested prostitutes" were purposefully spreading infectious diseases, and that those who tested positive would face criminal charges.

On 3 December, the Ministry of the Interior issued a news release stating that seven of the detained women had tested positive for the hepatitis C virus (HCV) and were now facing criminal charges for allegedly "transmitting an infectious disease."²

On 17 December, The Canadian HIV/AIDS Legal Network and Human Rights Watch (HRW) wrote a letter to the Minister of the Interior and other government officials "strongly condemning the police actions."

The letter stated that "the actions of the police, and of the Minister, and your Government, violate human rights protected under international law, ... are inconsistent with sound, ethical public health practice and will likely serve to undermine efforts to protect and promote public health."³ The letter was endorsed by 35 other organizations and individuals.

The letter pointed out that:

- detaining individuals in order to conduct forced medical procedures violates the right to security of the person;
- the conduct of the policy and the government violated the right to privacy of those detained, and constituted inhuman or degrading treatment or punishment; and

- forcibly testing someone for HIV or HCV is a violation of both bodily integrity and privacy.

The letter also expressed concern that seven of the women arrested face criminal charges of "transmission of an infectious disease" even though HCV is generally not considered a sexually transmitted infection, and prosecutors and police have not identified any evidence suggesting that actual transmission of HCV occurred in a circumstance involving any of those arrested.

The letter stated that

the actions of police and the Ministry of the Interior in this case — mass arrests, abusive policing, forced medical testing, violations of privacy and criminal prosecutions — undermine not only sex workers' basic human rights but also public health objectives, by impeding voluntary testing for HIV and HCV and by increasing stigma and discrimination against those most vulnerable to sexually transmitted infections.⁴

This latest crackdown and incident of forced HIV and HCV testing by police is occurring in a context of violence against sex workers (including police violence and extortion) and their unequal access to police protection.⁵ The letter stated that

police targeting of sex workers contributes to higher HIV risk in many ways, such as making sex workers reluctant to carry condoms if these will be used as evidence to support prostitution charges, forcing sex workers to rush negotiations with clients which can lead to unsafe sex, or compelling sex workers to accept unsafe sex demanded by clients in order to pay off fines or respond to police extortion.⁶

The Legal Network and HRW called upon the Macedonian Government to (among other things):

- stop forced testing of its citizens;
- ensure that all future testing for sexually transmitted infections involves informed consent, pre- and post-test counselling, and guaranteed confidentiality of test results;
- ensure access to necessary medical care for arrested sex workers who need it;
- investigate the causes, procedures and consequences of these latest arrests; and
- re-examine laws relating to the criminalization of sex workers, in light of the evidence that such criminalization undermines both health and human rights.⁷

¹ "Open Letter to the Government of Macedonia Regarding Criminal Prosecution of Alleged Sex Workers," Canadian HIV/AIDS Legal Network, HRW and 35 other organisations, 17 December 2008, online via www.hrw.org/en/news/2008/12/17/open-letter-government-macedonia.

² On file with the Legal Network.

³ "Open letter..."

⁴ Ibid.

⁵ See A.L. Crago et al., "Central and Eastern Europe and Central Asia: Police raids and violence put sex workers at risk of HIV," *HIV/AIDS Policy & Law Review* 13(2/3) (2008): 71–72.

⁶ "Open letter..."

⁷ Ibid.

Senegal: Growing intolerance towards gay men

The arrest and conviction of nine gay men in Senegal in January 2009 is part of a disturbing pattern. A largely Muslim country, Senegal has become increasingly intolerant of homosexuality in recent years, despite having a reputation for liberalism and openness.

For example:

- In February 2008, a group of men were arrested after a magazine printed photographs of what purported to be a gay wedding. One of those arrested, a popular singer, was forced to flee the country and seek asylum in the U.S.
- In August 2008, a Belgian and a Senegalese man were sentenced to two-year prison sentences for performing “unnatural acts.”
- In two separate incidents in 2008, villagers desecrated the tomb of well-known gay men, stating they did not want them buried in their area.¹

Gay men in Senegal complain of being regularly persecuted and of receiving death threats.

Paradoxically, Senegal is only one of seven African countries whose national AIDS prevention specifically focuses on men who have sex with men. According to the French organization Aides, set up to fight HIV/AIDS, Senegal has an HIV/AIDS rate of 0.7 percent for the general population, but in the gay community it is 21.5 percent.

The charges against the nine men “will have a chilling effect on AIDS programs,” said Scott Long, director of the lesbian, gay, bisexual and transgendered rights program

at Human Rights Watch (HRW). “Outreach workers and people seeking HIV prevention or treatment should not have to worry about police persecution.”

HRW has called for the immediate release of the men. HRW said that the convictions and the treatment of the men contravene civil rights declarations that Senegal has agreed to uphold. “Senegal’s sodomy law invades privacy, criminalizes health work, justifies brutality and feeds fear,” said Long.²

HRW has also expressed concern about the safety of the men, who were apparently beaten while in police custody. HRW has called for the men to be separated from other prisoners for as long as they remain in custody, and for them to receive appropriate health care, including HIV treatment if needed.

Anti-gay sentiment has been on the rise across Africa in recent years. Nigeria’s Parliament tried to pass a law last year that would restrict the rights of homosexuals to even meet to discuss their rights. Gambia’s president threatened to behead any homosexuals found in his country.

About three out of four countries on the continent have outlawed consensual sex between men. Rights campaigners, however, warn that such homophobia only fuels the spread of AIDS — on a continent

already plagued by the disease — because gay men will be reluctant to get treatment that could mark them as gay.

See additional coverage of the arrest of the nine gay men in the section on International Courts in this issue.

¹ “Senegal: Tougher jail terms signal rise of homophobia,” Agence France-Presse English (online), 16 January 2009.

² M. Carter, “Leading human rights organisation calls for release of HIV workers in Senegal,” *Aidsmap News* (online), 2 January 2009.

Israel: HIV-positive surgeon allowed to return to work

The Israeli Ministry of Health decided in January 2009 that a surgeon living with HIV may return to carrying out invasive surgical procedures, providing he or she maintains an undetectable viral load, follows infection control procedures and uses two layers of surgical gloves when operating. The Ministry also decided that prospective patients of the surgeon need not be notified of the surgeon's HIV infection because there is an extremely low risk of HIV transmission if the above conditions are met.¹

The decision marks the first time that a public health body has admitted that an HIV-positive health care worker has been cleared to carry out invasive surgical procedures since the introduction of antiretroviral therapy. The decision also emphasises the very low risk of HIV transmission from healthcare workers with HIV.

The surgeon tested positive for HIV in January 2007. He was suspended from performing operations while an expert advisory committee looked into the matter.

The hospital where he works contacted 1669 patients on whom the surgeon had operated since 1997 and offered them the opportunity to be tested for HIV. Of the 1669 patients, 545 agreed to take the test. None tested HIV-positive,² despite the fact that the surgeon had a high viral load (above 100,000 copies/ml) and a very low CD4 count at the time of diagnosis, indicating that he had been infected with HIV for some years.³

The surgeon did not report any incidents when blood exposure could have placed patients at risk.

The findings of the look-back exercise are consistent with the results of similar studies, which show that surgeon-to-patient transmission is very rare.

The Israeli expert advice that antiretroviral therapy and viral suppression are risk reduction measures for HIV transmission echoes the Swiss Federal AIDS Commission statement in January 2008, which noted that individuals with undetectable viral load on treatment cannot transmit HIV.⁴

The Israeli decision is likely to lead to pressure on bodies regulating health care institutions to review their guidance on health care workers with HIV engaging in exposure-prone, invasive procedures.

In the United Kingdom, for example, the General Medical Council and the General Dental Council require that HIV-positive health care workers desist from carrying out exposure-prone procedures — anything that involves cutting, suturing, use of needles or delivery of babies using forceps or suction.

Furthermore, all health care workers recruited to the National Health Service who will be carrying out these types of procedures are tested for HIV. Many health care workers have been forced to retire or move to other jobs within the health service as a result of the guidance.

¹ "Israeli health ministry says HIV-positive surgeon very low risk to patients; surgeon returns to work," *Aidsmap News*, 9 January 2009.

² "Getting HIV from your surgeon highly unlikely," *Reuters Health* (online), 8 January 2009.

³ "Israeli health..."

⁴ See R. Pearshouse, "Switzerland: Statement on sexual transmission of HIV by people on ART," *HIV/AIDS Policy & Law Review* 13(1): 37–38.

In brief

U.S.: Obama lifts ban on funding for international groups performing or counselling abortions

On 23 January 2009, a few days after being sworn in, President Barack Obama lifted a ban on U.S. funding for international health groups that perform abortions, promote legalizing the procedure or provide counselling about terminating pregnancies.¹

Obama issued a memorandum rescinding the Mexico City Policy (also known as the “global gag rule”) which President Ronald Reagan originally instituted in 1984, President Bill Clinton reversed in 1993 and President George W. Bush revived in 2001 (on his first day in office).

The memorandum revokes Bush’s order, calling the limitations on funding “excessively broad” and adding that “they have undermined efforts to promote safe and effective voluntary family programs in foreign nations.”²

In an accompanying statement, Obama said he would also work with Congress to restore U.S. funding support for the United Nations Population Fund “to reduce poverty, improve the health of women and children, prevent HIV/AIDS and provide family planning assistance to women in 154 countries.”³

Obama’s decision was praised by family planning groups, women’s health advocates and others for allowing the U.S. Agency for International Development (USAID) to once again provide millions of dollars to programs offering medical services, birth control, HIV prevention and other care.

Lifting the Mexico City Policy will not permit U.S. tax dollars to be used for abortions, but it will allow funding to resume to groups that provide other services, including counselling about abortions.

The anti-prostitution pledge that recipients of PEPFAR funding have to sign remains in effect. (“PEPFAR” stands for the President’s Emergency Plan for AIDS Relief.) If Obama wanted to change this policy, he would have to convince Congress to change the law. The pledge was retained by Congress when it renewed PEPFAR in 2008.⁴

Burundi: Senate rejects law criminalizing homosexuality

On 18 February 2009, the Burundi Senate overwhelmingly rejected a draft bill which would have amended the penal code to criminalize homosexuality.⁵

The bill had been approved by the National Assembly, the lower house of Parliament, in November 2008, with virtually no debate. At the time, numerous organizations — including Burundian public health officials, the Burundian Catholic Church, Human Rights Watch (HRW) and other international human rights organizations — protested the actions of the National Assembly and called on the Senate to amend the bill.⁶

“By rejecting this amendment, Senators in Burundi have protected the human rights of their people,” said Michel Sidibé, executive director of UNAIDS in a news release.

“They have also set a standard for other lawmakers around the world to follow their example in stopping laws that block the AIDS response.”⁷

Currently, 84 countries in the world have legislation that prohibits same sex behaviour.⁸

In its news release, UNAIDS stated:

Criminalization of adult sexual behaviour and violation of human rights of people living with HIV are hampering HIV responses across the world. Such measures have a negative impact on delivery of HIV prevention programmes and access to treatment by people living with HIV. Not only do they violate human rights of individuals, but further stigmatize these populations.

In the 2006 United Nations Political Declaration on HIV/AIDS, governments committed to removing legal barriers and passing laws to protect vulnerable populations. Countries that have non-discrimination laws against men who have sex with men, injecting drug users and sex workers have provided better access to HIV prevention, treatment, care and support services.⁹

Ethiopia: New law threatens human rights

On 6 January 2009, the Ethiopian Parliament passed what has been termed a “draconian law” that bans NGOs that receive more than 10 per cent of their funding from overseas from participating in work that promotes human and democratic rights, equality (including that of women), the rights of children and people

with disabilities, conflict resolution, and the efficiency of justice and law enforcement.¹⁰

The *Charities and Societies Proclamation* creates a Charities and Societies Agency and gives it very wide discretion to regulate NGOs and control their activities.

Critics of the new law are concerned that important projects will be cancelled, and valuable staff lost, because the money to fund them comes from outside the country and because it is unrealistic to expect local fundraising to make up the shortfall.

Equality Now, an organization that works for the protection and promotion of human rights for women, said that because of this law, vulnerable people will be left without assistance, including women and girls who have been subjected to sexual and other violence and who depend heavily on civil society organisations to give them legal and material help.¹¹

India: Bill criminalizing buying sex lapses in Parliament

Proposed legislation designed to criminalize the purchase of sexual services was allowed to lapse when the lower house of the Indian Parliament (*Lok Sabha*, or House of the People) was dissolved on 26 February 2009.¹²

Sex workers and advocates for the rights of sex workers, who had been vehemently lobbying against the *Immoral Traffic (Prevention) Amendment Bill, 2006* (ITPA) since it was conceived in 2005, declared a major victory. In their view, the legislation would have violated the

rights of sex workers and further marginalized them.

The effect of the proposed legislation would have been to shift legislative policy on sex work from tolerance to prohibition.

In addition to penalizing clients for visiting a brothel, the legislation would have broadened the definition of “prostitution” to include all transactional sex (as opposed to acts involving exploitation on a commercial scale); inserted a definition of trafficking for prostitution (which would have effectively criminalized poverty-induced sex work); lowered the rank of police authorized to search and raid brothels and arrest sex workers therein; and extend the period of detention for sex workers to seven years.

Modelled on legislation developed in Sweden, laws outlining the purchase of sexual services are being adopted in many parts of the world, particularly Europe and North America, but also in other parts of Asia (e.g., South Korea and Nepal).

Southern Africa: Regional model law on HIV drafted

The Southern African Development Community (SADC) Parliamentary Forum has adopted a Regional Model Law on HIV. The purpose of the model law is to provide guidance on HIV-related legislation for countries in the region that are adopting or have adopted HIV-specific laws.¹³

The model law aims to:

- provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human rights standards;

- promote the implementation of effective prevention, treatment, care and research strategies....;
- ensure that the human rights of people living with or affected by HIV are respected, protected and realised....; and
- stimulate the adoption of specific measures ... to address the needs of groups that are vulnerable or marginalised...¹⁴

U.N.: Statement condemns human rights violations based on sexual orientation and gender identity

At the United Nations, 66 nations have supported a statement affirming that international human rights protections include sexual orientation and gender identity.¹⁵ It is the first time that a statement condemning rights abuses against lesbian, gay, bisexual and transgender people has been presented in the General Assembly.

The 66 countries stated they are “deeply concerned by violations of human rights and fundamental freedoms based on sexual orientation or gender identity,” and said that “violence, harassment, discrimination, exclusion, stigmatization and prejudice are directed against persons in all countries in the world because of sexual orientation or gender identity.”

The participating countries urged all nations to end criminal penalties against people because of their sexual orientation or gender identity. It is estimated that more than six dozen countries still have laws against consensual sex between adults of the same sex.

Another 57 states signed an alternative text promoted by

the Organization of the Islamic Conference. While affirming the “principles of non-discrimination and equality,” they claimed that universal human rights did not include “the attempt to focus on the rights of certain persons.”

Asia: Rapid increase in cases of HIV among MSM

Asian health officials have warned that the region is facing a resurgence of HIV cases among men who have sex with men (MSM) that will not subside without increased government efforts. The warnings were made at a World Health Organization conference in Hong Kong on 18 February 2009.¹⁶

According to officials at the conference, discriminatory laws, stigma, low condom use, multiple sex partners and limited health care access are contributing to the spread of HIV among MSM in the region.

York Chow Yat-ngok, Hong Kong’s secretary for food and health, said that there has been a “rapid rise” of HIV cases among MSM and that HIV prevalence among this population is 10 times that of other high-risk groups, including sex workers and injection drug users.¹⁷

Shivananda Khan, a representative with the Asia Pacific Coalition on Male Sexual Health, said, “We are facing an emerging catastrophe. Unless we intervene now, the level of infection over the next 20 years will double every year....”¹⁸

¹ R. Stein and M. Shear, “Funding restored to groups that perform abortions, other care,” *The Washington Post*, 24 January 2009, p. A03.

² Ibid.

³ Ibid.

⁴ “Don’t expect a revolution,” *The Economist*, 12 May 2009.

⁵ UNAIDS, “Senators in Burundi uphold rights of men

who have sex with men,” news release, Geneva, 18 February 2009.

⁶ HRW, “Burundi: respect privacy, reject repressive law,” 16 February 2009, online at www.hrw.org/en/news/2009/02/16/burundi-respect-privacy-reject-repressive-law.

⁷ UNAIDS.

⁸ Ibid.

⁹ Ibid.

¹⁰ Equality Now, “Urgent appeal — new law threatens human rights in Ethiopia,” 10 January 2009, online at www.equalitynow.org/english/actions/action_2205_en.html.

¹¹ Ibid.

¹² T. Tandon, “Indian sex workers, repel move towards criminalisation,” statement from the Lawyers Collective HIV Unit, 27 February 2009.

¹³ “Announcing the adoption of the SADC PF Model Law on HIV,” 9 December 2008, online via www.sadcpf.org.

¹⁴ This text is from a presentation on the model law by three members of parliament from Zambia, South Africa and Mauritius, on file with the author.

¹⁵ International Gay and Lesbian Human Rights Commission, “United Nations: General Assembly statement affirms rights for all,” news release, New York, 19 December 2008, online at <http://www.iglhrc.org/cgi-bin/iowa/article/pressroom/pressrelease/826.html>. The news release contains a list of the 66 nations that endorsed the statement.

¹⁶ A. Freeda, “WHO warns of a growing male AIDS crisis,” *New Strait Times*, 19 February 2009.

¹⁷ T. Chui, “Asia faces gay sex AIDS explosion,” *The Standard*, 19 February 2009.

¹⁸ Ibid.

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. All of the articles in this section were written by Ms Chu.

Federal Court orders judicial review of decision on Mexican's refugee application

On 6 November 2008, the Federal Court allowed an application for judicial review of the Refugee Protection Division's decision that Jose Fernando Rodriguez Diaz, a citizen of Mexico, was neither a Convention Refugee nor a person in need of protection.¹

Diaz claimed protection on the grounds of a fear that his brothers would kill him and that he would be persecuted in Mexico because he was gay and HIV-positive. Diaz was

diagnosed with HIV in 1991 while living in Mexico. He claimed that his employer discovered his illness and dismissed him; and that in 1995 he was dismissed again from another

job because his employer discovered his sexual orientation and illness.

Diaz also claimed that when his stepfather passed away, he shared equally in the estate which included

a sugar plantation, a coffee plantation and a house. In 1996, one of his brothers threatened to kill him if he did not leave Mexico. As a result, Diaz gave his sister power of attorney to deal with the family properties and left for the U.S., where he remained until April 2005, when he returned to Mexico for several days before travelling to Canada.

Shortly after his arrival in Canada, Diaz applied for refugee protection. On 9 October 2007, the Refugee Protection Division of the Immigration and Refugee Board held that adequate state protection was available and there was a viable internal flight alternative to Mexico City. Diaz requested that the decision be set aside and the matter referred back to a newly constituted panel of the Board for redetermination.

According to the Federal Court, there were two issues that were not

adequately considered relating to a reasonable finding of a viable internal flight alternative for the applicant. First, the Board failed to address the suggestion that negative stigma towards HIV-positive Mexicans affected the delivery of treatment and medication by medical staff in Mexico, which was an issue particular to Diaz's circumstances.

Second, the Board failed to adequately address whether, on a balance of probabilities, Diaz had proven that systemic barriers associated with HIV testing and employment amounted to persecution. The interrelated aspects of Diaz's socio-economic status and HIV-positive status were important considerations that the Board overlooked.

The documentary evidence suggested that in Mexico, families of HIV-positive Mexicans played an important role in caring for people in

Diaz's position because of societal discrimination, and that Diaz did not appear to have this option, given his relationship with his brothers and the fact that this prevented his mother and sister from contact with him because of the threat of retaliation.

The Federal Court held that Diaz's submission that he would experience persecution and risk as an HIV-positive Mexican without meaningful family support, with the potential for systemic barriers to employment, and with the potential for discrimination in health care delivery, were not sufficiently addressed by the Board. Therefore, the Court set the Board's decision aside, and the matter was referred to a newly-constituted panel for redetermination.

¹ *Diaz v. Canada (Minister of Citizenship and Immigration)*, [2008] F.C.J. No. 1543 (QL).

Federal Court rules all evidence must be considered in determining risk of persecution of refugee claimant

On 24 November 2008, the Federal Court allowed an application for judicial review of a negative Pre-Removal Risk Assessment (PRRA) decision involving a gay HIV-positive man from El Salvador.¹

In August 2006, Joaquin Ramirez Aragon came to Canada from El Salvador to attend the international AIDS conference and claimed refu-

gee status on the basis of persecution in El Salvador. Aragon's claim for protection was based on both a specific risk of retaliation by a police

officer who he alleged had sexually assaulted him and consequently infected him with HIV, and the general risk he faced as a gay man in

El Salvador. To support his claim, Aragon provided documentary evidence that gay people in El Salvador were abused by the authorities.

In May 2007, his claim was denied by the Refugee Protection Division of the Immigration and Refugee Board on the basis that the claim of a specific risk of retaliation by the police officer was not credible, and that Aragon had failed to rebut the presumption of state protection because he had made no effort to report the incident in the months that had passed prior to his departure for Canada. In August 2007, Aragon's application for leave for judicial review of that decision was dismissed.

On 11 January 2008, a negative PRRA was issued, for which Aragon sought judicial review. In the Federal Court's view, the case turned on the

question of whether Aragon's claim of a risk of persecution by reason of his status as a gay male had ever been properly assessed.

According to the Federal Court, the PRRA officer proceeded on the assumption that the Refugee Protection Division had considered all of the risks raised by Aragon, and so he focused on whether Aragon had submitted any new evidence with regard to risks which may have developed in the interim. However, it was clear from a close reading of the decisions of the Refugee Protection Division and the PRRA officer that neither expressly considered how the documentary evidence set out in various reports might support Aragon's fear of persecution.

Aragon had complained of a long history of persecution because of his sexual orientation. The documen-

tary evidence contained information which could be construed as supporting his claim of risk if returned to El Salvador. In the Federal Court's view, it was unreasonable for the PRRA officer to have assumed that the Refugee Protection Division had conducted a complete risk assessment and not to have considered whether, on all of the evidence, Aragon faced a risk of persecution and to his safety if returned to El Salvador.

The Court thus granted Aragon's application and remitted the matter for reconsideration by a different PRRA officer.

¹ *Aragon v. Canada (Minister of Citizenship and Immigration)*, [2008] F.C.J. No. 1710 (QL).

Thai woman's deportation postponed until resolution of her criminal appeal

In January 2007, the Ontario Superior Court of Justice convicted Suwalee Iamkhong, originally from Thailand, of criminal negligence causing bodily harm and aggravated assault for failing to disclose her HIV status before having unprotected sex with her husband. On 16 August 2007, she was sentenced to two years on each count, to be served concurrently.¹

Persons in Canada who are not citizens may be removed from Canada if they have been convicted of serious criminality, which is defined as a

crime that was punished by at least two years' imprisonment. As a result of Iamkhong's conviction, an inadmissibility report was issued against her pur-

suant to section 44 of the *Immigration and Refugee Protection Act*.

In December 2008, Iamkhong's challenge of the inadmissibility report

was dismissed.² That same month, an admissibility hearing was held and a date was set for Iamkhong's deportation; and Iamkhong completed her sentence and was delivered to the immigration authorities pursuant to section 59 of the *Immigration and Refugee Protection Act*.

On 19 January 2009, at a detention review hearing to determine if Iamkhong should be held in custody until her deportation, the Immigration Division of the Immigration and Refugee Board ordered Iamkhong's release by accepting a bond of \$6,000 in cash and \$17,000 in performance from several individuals. Her release was predicated in part on the fact that Iamkhong actively participated in HIV/AIDS service organizations (including working as a volunteer); and on the fact that she "publicly presenting [herself] as an HIV carrier." Iamkhong was thus deemed not to be a danger to the public.³

The Minister of Public Safety and Emergency Preparedness challenged this order. On 21 January 2009, the Federal Court held that the Board member authorizing Iamkhong's release had not sufficiently examined "the character of the bondspersons, themselves, or the relationship of the bondspersons to the Respondent."⁴

The Federal Court also suggested that Iamkhong's lack of education would render her likely to re-offend, when it stated, "...if the Respondent reoffends, as recognizing from elements of the background of the case (*level of understanding due to less*

than completion of primary education, previous assault convicted offences, even with voluntary service), by having unprotected sex, this would result in irreparable harm for a victim."⁵ [emphasis added]

The Federal Court did not further elaborate on how Iamkhong would be a danger to the public, and did not address the fact that her specific medical and nutritional needs may not be adequately met in detention, before it stayed the order of the Immigration Division.

On 19 February 2009, another detention review hearing was held. The Board member refused to release Iamkhong from custody, concluding Iamkhong was a flight risk because the people willing to post her bonds to ensure she would appear for deportation did not know her well enough.⁶ The bondspersons were Noulmook Sutdhibhasilp, Executive Director of Asian Community AIDS Services, who had worked with Iamkhong from the beginning of her criminal proceedings, and friends of Iamkhong who had known her for 10–15 years.

Iamkhong's appeal of her criminal conviction was scheduled to be heard on 24 March 2009. If the Ontario Court of Appeal agrees to reduce her two-year sentence by one day, her conviction would no longer constitute serious criminality and Iamkhong would be able to appeal a removal order against her.

In addition to her criminal appeal, Iamkhong is being sued civilly by her ex-husband Percy Whiteman, the

complainant in her criminal convictions. Citizenship and Immigration Canada is a co-defendant in that case.

On 28 February 2009, Iamkhong requested the deferral of her removal, which was originally scheduled for 1 March 2009, pending resolution of her various court cases. The deferral request was originally denied. However, after her counsel filed the materials for her stay application at the Federal Court, the Canadian Border Services Agency agreed to postpone Iamkhong's deportation date until after the Ontario Court of Appeal decision.⁷

¹ See S. Chu, "Two years' imprisonment for woman who 'ought to have known' that she was HIV-positive," *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 45.

² *Iamkhong v. Canada (Public Safety and Emergency Preparedness)*, 2008 FC 1349 (Federal Court).

³ Affidavit of Elizabeth Lim, *Minister of Citizenship and Immigration v. Suwalee Iamkhong*, 20 January 2009, at paras. 13 and 19.

⁴ *Canada (Minister of Public Safety and Emergency Preparedness) v. Iamkhong*, 2009 FC 52 (Federal Court) at para. 22.

⁵ *Ibid.* at para. 28.

⁶ T. Tyler, "Ex-stripper with AIDS denied release; Thai woman who infected spouse is fighting to stay in Canada; immigration judge rules her a flight risk," *The Toronto Star*, 20 February 2009, p. GT06.

⁷ Based on personal communication with Elizabeth Lim, immigration counsel for Suwalee Iamkhong, 6 March 2009.

Criminal law and cases of HIV transmission or exposure

Jail term substituted for conditional sentence in case of non-disclosure of HIV status

In December 2008, the Ontario Court of Appeal set aside a one-year conditional sentence imposed on Roger McGregor for aggravated sexual assault arising from two instances of engaging in unprotected sex with the complainant M.M. without disclosing his HIV-positive status. The Court substituted a one-year jail term.¹

The Crown had appealed McGregor's conditional sentence on the basis that the conditional sentence (a) failed to reflect the gravity of the offence and was "manifestly unfit"; (b) failed to adhere to the range of sentences established in similar cases; and (c) failed to give proper effect to the principles of general deterrence and denunciation.

At the trial level, the Ontario Superior Court of Justice found that McGregor and M.M., whose identity is subject to a publication ban, were involved in a sexual relationship from the fall of 2004 until the spring of 2006. In December 2004, McGregor was warned by a public health nurse of his obligation to inform all prospective sexual partners of his HIV-positive status, and was instructed to always use a condom during sex.

On two occasions, the couple had unprotected sex. At no time during their relationship did McGregor disclose to M.M. that he was HIV-positive.

M.M. discovered McGregor's HIV status by accident when she found a medication information sheet on his bedroom dresser. After learning the medication was for treating HIV, M.M. confronted McGregor and an altercation ensued. The couple broke up shortly afterwards. M.M. has not tested positive for HIV.

McGregor was subsequently charged with one count each of aggravated sexual assault, assault and unlawful confinement. The latter two charges related to the altercation that occurred when M.M. confronted McGregor about his HIV status. In February 2008, McGregor was found guilty of aggravated sexual assault and acquitted of the remaining two charges.

On 16 May 2008, the respondent was sentenced to a one-year conditional sentence, subject to terms of strict house arrest, plus three years' probation. The sentencing judge also granted a DNA database order against McGregor and ordered that he comply with the *Sex Offender Information Registration Act*.

The Court of Appeal held that McGregor's crime was "very serious" and that while McGregor did not occupy a traditional position of trust in relation to M.M., "any intimate relationship of the type entered into by the respondent with M.M. is based on a certain amount of trust and confidence, at least to the extent that each participant may reasonably expect that he or she will not knowingly be exposed by the other to a dangerous contagious disease."²

The Court said that the fact that McGregor withheld his HIV status from M.M., and on two occasions had unprotected sex with her, meant he breached that element of trust that formed the basis of his relationship with M.M.

Significantly, the Court of Appeal seemed to suggest that failure to disclose constitutes criminal conduct, even if a condom is used. In its decision, the Court stated,

[o]ne might also ask whether, if she had known that the respondent was HIV-positive, M.M. would have engaged in sexual intercourse with him at all: condoms sometimes fail. That choice, which was hers to make, was denied to M.M. by the respondent's deliberate decision to ignore his obligation to disclose his HIV-positive status to her.³

The Court of Appeal held that the sentencing judge was alert to the serious nature of the offence but erred in her approach to sentencing when she found "no appellate authority in Ontario that would mandate a necessary or automatic term of incarceration in any and every case of conviction for aggravated sexual assault."⁴

The Court found that although the sentencing judge properly directed herself that a custodial sentence is usually required in the circumstances of the offence, she held that denunciation and deterrence could be achieved in McGregor's case by a suitably restrictive conditional

sentence. In the Court of Appeal's view, "[w]hile it is true that the authorities reflect a wide range of sentences in cases involving sexual intercourse and the non-disclosure of HIV-positive status, absent a guilty plea by the involved offender or a joint submission on sentencing, the sentences imposed involve actual incarceration of some duration."⁵

The Court said that the dearth of authority in support of the sentencing judge's approach confirmed that aggravated sexual assault involving non-disclosure of HIV status would generally compel a custodial term of imprisonment.

Therefore, accepting the sentencing judge's findings that McGregor's actions were not wanton or calculated, that no specific planning, deliberation or willful intent to expose M.M. to the risk of HIV was involved on the two occasions of unprotected sex, and that McGregor did not engage in a pattern of violent or predatory behaviour and was of good character, the Court of Appeal set aside the conditional sentence and substituted a custodial sentence of 18 months imprisonment, reduced by six months for time served by McGregor both prior to sentencing and under his conditional sentence.

Man convicted of attempted aggravated sexual assault where evidence indicates condom not worn

On 23 February 2009, the Ontario Superior Court Justice found William Imona-Russel guilty of assault caus-

ing bodily harm, assault with a weapon, threatening death, assault, two counts of sexual assault and attempted aggravated sexual assault.⁶

Imona-Russel, who represented himself, came to Canada from Nigeria in April 2003 and made a refugee claim. Soon after, he met the complainant in the apartment building where they both lived. According to Imona-Russel, they began a sexual relationship, always using a condom, until an immigration doctor informed him in July 2003 that he was HIV-positive. Imona-Russel testified that he disclosed this fact to the complainant and that they never had sex again after that.⁷

The complainant alleged that they had consensual sex until August 2003 and twice in 2004, and at no time did Imona-Russel disclose to her that he was HIV-positive. She also indicated she was not certain if he wore a condom on those occasions.

During Imona-Russel's trial, a Toronto doctor testified that he had tested Imona-Russel for HIV as part of the immigration process and had informed Imona-Russel on or prior to 2 June 2003 that he was HIV-positive and cautioned him about having safe sex.⁸

The complainant testified she eventually broke off her relationship with Imona-Russel because she felt he was too controlling and violent. After they broke up, the complainant alleged that Imona-Russel physically and sexually assaulted her twice in March 2005.

On 3 March 2005, the complainant alleged Imona-Russel attended her apartment, physically assaulted her, put a drill to her head, threatened to kill her, and raped her. On 13 March 2005, the complainant alleged that

Imona-Russel returned to her apartment, physically assaulted her and raped her again. Imona-Russel's semen was detected on the complainant's underwear after the 13 March 2005 incident.

Subsequent to these incidents, and upon the police's advice, the complainant was tested for and diagnosed with HIV in late March 2005.⁹

The Court cited a number of internal inconsistencies in Imona-Russel's testimony and held that Imona-Russel knew his HIV status as of 2 June 2003, after which he continued to have sex with the complainant.

Since the complainant did not know whether Imona-Russel wore a condom during sex, the Court held it was possible that he did wear one during most of the sexual encounters. However, the Court found Imona-Russel had unprotected sex with the complainant at least once, on 13 March 2008, based on evidence of his semen on her underwear. Justice McMahon referred to the decision of the Supreme Court of Canada in *R. v. Williams*, and held that the requisite elements of attempted aggravated sexual assault had been met in that instance.¹⁰

The Court also found Imona-Russel guilty of charges related to the physical and sexual assaults that took place in March 2005. The Crown had charged Imona-Russel with aggravated sexual assault in relation to the sexual assault that took place on each of the two occasions. However, the Court held that there was no evidentiary foundation to determine whether the complainant was already HIV-positive at the time of those attacks, and convicted Imona-Russel of two counts of the lesser and included offence of sexual assault.

Man found guilty of four counts of aggravated sexual assault for non-disclosure of HIV status

Charles Kokanai Mzite was found guilty on 2 March 2009 of four counts of aggravated sexual assault for having unprotected sex with four Victoria women without telling them he was HIV-positive.¹¹

Mzite, a school teacher who later performed with a popular marimba band, moved to Canada in 2001 and applied for refugee status. At the time, Citizenship and Immigration Canada did not require an HIV test for prospective immigrants. During trial, there was evidence that Mzite's wife had died in 2000 from what he believes were complications related to AIDS, and that several of Mzite's siblings had also passed away from the disease.¹²

The four complainants, whose names are protected by a publication ban, had sexual relationships with Mzite between 2001 and 2007. In July 2001, Mzite took an anonymous HIV test at a Victoria clinic. He had tested positive, but did not return to the testing clinic to pick up his result.

The main issue during Mzite's trial was when he first learned he was HIV-positive. Mzite claimed that he did not know his HIV status until late 2004, when he was tested after prompting from one of the complainants. The Crown argued Mzite had known he was HIV-positive since 1995.

One of the complainants, who tested positive for HIV, heard of Mzite's HIV status from a friend. After testing positive for HIV, she took Mzite to be tested in 2004, and returned with him for his results.¹³ She further testified that Mzite subsequently told

her that he had known he was HIV-positive since 1995.¹⁴

In September 2007, Mzite was arrested. After his arrest, Mzite was videotaped telling Detective Scott McGregor he had known he was HIV-positive since 1995.¹⁵ The B.C. Supreme Court ruled the Crown had proved beyond a reasonable doubt that Mzite knew he was HIV-positive at the time he had unprotected sex with the four complainants, and that he either denied or failed to disclose his status to them, exposing them to the risk of serious bodily harm.

Ontario woman pleads guilty to sexual assault and criminal negligence for failing to disclose HIV status

On 27 February 2009, Lara Dick pleaded guilty in the Ontario Court of Justice to sexual assault and criminal negligence causing bodily harm for failing to disclose her HIV status to her partner before having unprotected sex with him.¹⁶ Dick was originally charged with aggravated sexual assault and criminal negligence causing bodily harm.

According to media reports, Dick learned she was HIV-positive in 2006. In January 2008, Dick, a former sex worker, met the complainant in Cambridge, Ontario. A relationship ensued and the couple had unprotected sex between 50 and 75 times from January to October 2008.¹⁷

Dick was living with the complainant in Kitchener, Ontario, when he discovered she was HIV-positive. After learning of Dick's condition, the complainant contacted police,

claiming Dick had not disclosed her medical condition to him.¹⁸ The complainant was subsequently tested and found to be HIV-positive.

Dick was sentenced to 41 months' incarceration for each count, to be served concurrently. She was also ordered to be placed on the national sex offenders' registry for 20 years. Finally, she received a 10-year weapons prohibition.¹⁹

Further developments in Johnson Aziga case

Evidence of Juliet Aziga

In October 2008, the Crown in the Johnson Aziga case applied for a ruling on the competency and compellability of Aziga's estranged wife, Juliet Aziga, to testify against her husband.²⁰ Johnson Aziga is charged with first degree murder and aggravated sexual assault for having unprotected sex with 13 women without disclosing his HIV-positive status.

Johnson and Juliet Aziga were married in 1988. In 1996, Aziga tested positive for HIV, after which medical professionals counselled the couple on safe sex practices. The Crown sought to adduce at trial Juliet Aziga's evidence with respect to what was said by the medical professionals to Aziga during these counseling sessions.

Justice Lofchik of the Ontario Superior Court of Justice referred to a common law exception to the rule of spousal incompetency rendering spouses competent to testify for the prosecution when they have become irreconcilably separated, which he found to apply to Johnson and Juliet Aziga. Moreover, as the evidence

to be given by Juliet Aziga did not relate to any communication Aziga made to her during marriage, the judge said that section 4(3) of the *Canada Evidence Act* did not come into play.²¹

Therefore, Justice Lofchik found that Juliet Aziga was both competent and compellable to testify, and that her evidence was applicable to both the aggravated sexual assault counts and the murder counts in the indictment.

Prior sexual conduct of complainants

In November 2008, Aziga brought an application pursuant to Section 276(2) of the *Criminal Code* to adduce evidence relating to prior sexual conduct of the complainants who tested positive for HIV, in order to determine other possible sources of their HIV infection.²²

Justice Lofchik of the Ontario Superior Court of Justice allowed the application. In his view, the evidence would be introduced as evidence of other possible sources of HIV infection, “rather than evidence of the propensity or otherwise of these women to engage in the physical acts of sex, regarding whether in this case the sex acts alleged occurred and if they did whether they were consensual, matters which are the essential issue in most sexual assault cases and to which the ‘rape shield’ protection of Section 276 is directed.”²³

According to Justice Lofchik, section 276 of the *Criminal Code* did not prevent Aziga from exploring possible sources of infection of the women who died or tested HIV-positive since “[t]he gravamen of the offence here is not the sexual act itself but rather the failure to advise the sexual partner of the HIV status and infecting the sexual partner with the virus.”²⁴

Moreover, the judge found, the evidence sought to be adduced had significant probative value that was not substantially outweighed by the danger of prejudice to the administration of justice, having considered the factors set out in subsection 276(3) of the *Criminal Code*. Therefore, Aziga was permitted to ask questions about any sexual activity of the complainants that took place with persons other than Aziga prior to their testing HIV-positive.

Challenge to admissibility of evidence

In December 2008, Aziga sought an application to exclude the Crown’s expert evidence about a scientific technique performed on blood samples taken from Aziga and his alleged victims.²⁵ Aziga argued the testing was flawed and questioned the chain of custody of the samples, suggesting the samples may have been tainted or tampered with.

Health Canada had assisted with the police investigation of Aziga by employing phylogenetic analysis to identify the strains of HIV present in specimens from Aziga and the infected complainants. The analysis yielded the conclusion that the same strain of HIV was present in all the specimens, that this strain was rare in Canada, and that it would be highly unusual for the complainants to have come by the strain through means other than by having contact with the same infected person (in all likelihood, Aziga).

Aziga argued the testing was flawed because the samples against which the complainants’ specimens were compared (the Canadian HIV Strain and Drug Resistant Surveillance Program and the Los Alamos HIV Sequence Database in

California) did not come from HIV-positive males in Hamilton, Ontario – the community to which Aziga belonged. The failure to test samples taken from HIV-positive males in Hamilton ruled out the possibility of detection of other infected individuals who may have infected the complainants, Aziga said.

The Ontario Superior Court of Justice dismissed Aziga’s application. In its view, there was no merit to the argument the samples were tampered with. With regard to phylogenetic testing, the Court found the technique had been used in the U.S. and elsewhere for some time and was generally accepted in the scientific community. The Court held that the objections raised by Aziga about the methodology of the analysis went to the weight and not the admissibility of the Crown’s evidence.

The Court considered the evidence and held that it met the criteria for admissibility because it was relevant, necessary and not excluded by any rule of evidence; and because the Crown’s witness was an acknowledged qualified expert in the field of phylogenetic analysis.

B.C. man guilty of aggravated sexual assault for failing to disclose his HIV status

In February 2008, the B.C. Supreme Court found Michael Wright guilty of two counts of aggravated sexual assault for not disclosing his HIV-positive status to two women he had unprotected sex with.²⁶

The incidents occurred between 2004 and 2006 in Bella Coola, B.C., where Wright had moved to work as

a floorer. Both complainants claimed to have had unprotected sex with Wright. Neither woman was infected with HIV. According to Wright's defence lawyer, Wright maintains he either told the women he was HIV-positive or that he had protected sex with them.

Wright was subsequently sentenced to four and a half years in prison, less credit for time served in pre-trial detention.²⁷

Trevis Smith released on parole and to be deported to United States

Former Saskatchewan Roughrider Trevis Smith was released from Saskatchewan Penitentiary on 25 February 2009 after serving two years of his six-year sentence for two charges of aggravated sexual assault involving unprotected sex with two women without first disclosing to them that he was HIV-positive.²⁸

On 14 January 2009, Smith was granted full parole after serving one-third of his sentence. A spokeswoman for the National Parole Board indicated, however, that a condition of Smith's parole was that he would not be released into the community and that he faced a standing depor-

tation order to the U.S. upon his release.²⁹ Smith is to serve the rest of his sentence on parole in his native state of Alabama.

¹ *R. v. McGregor*, 2008 ONCA 831 (Ontario Court of Appeal).

² *Ibid.* at para. 30.

³ *Ibid.* at para. 34.

⁴ *Ibid.* at para. 36.

⁵ *Ibid.* at para. 39.

⁶ Transcript of oral reasons in *R. v. William Imona-Russel*, 23 February 2009, Ontario Superior Court of Justice.

⁷ *Ibid.* at p. 6.

⁸ "Man told of his HIV positive status, doctor tells sex assault trial," Canadian Press, 21 January 2009.

⁹ Transcript of oral reasons... at pp. 4-5.

¹⁰ *Ibid.* at p. 18.

¹¹ "HIV-positive musician guilty; man convicted for having unprotected sex with four Victoria women," *The Vancouver Sun*, 3 March 2009, p. A3.

¹² L. Dickson, "Mzite's path from Africa to jail," *Times Colonist (Victoria)*, 3 March 2009, p. A3.

¹³ L. Dickson, "Victoria man knew he has HIV positive before having sex, court hears," *The Vancouver Sun*, 18 November 2008.

¹⁴ *Ibid.*

¹⁵ L. Dickson, "Tape shows remorseful sex suspect; in police interview, a tearful Mzite says he knew he was HIV-positive," *Times Colonist (Victoria)*, 22 January 2009, p. A4.

¹⁶ "Woman gets 4 years for not telling sex partner she was HIV positive," Canadian Press, 27 February 2009.

¹⁷ *Ibid.*

¹⁸ "Former prostitute charged with exposing her boyfriend to HIV," Canadian Press, 14 November 2008.

¹⁹ Based on communication with Kitchener office of the Ontario Court of Justice, Criminal Division.

²⁰ *R. v. Aziga*, [2008] O.J. No. 4085 (QL).

²¹ Section 4(3) of the *Canada Evidence Act*, R.S.C. 1985, provides that "No husband is compellable to disclose any communication made to him by his wife during their marriage, and no wife is compellable to disclose any communication made to her by her husband during their marriage."

²² *R. v. Aziga*, [2008] O.J. No. 4669 (QL).

²³ *Ibid.* at para. 9. Subsection 276 of the *Criminal Code*, R.S.C. 1985, provides:

(1) In proceedings in respect of an offence under section 151, 152, 153, 153.1, 155 or 159, subsection 160(2) or (3) or section 170, 171, 172, 173, 271, 272 or 273, evidence that the complainant has engaged in sexual activity, whether with the accused or with any other person, is not admissible to support an inference that, by reason of the sexual nature of that activity, the complainant

(a) is more likely to have consented to the sexual activity that forms the subject-matter of the charge; or
(b) is less worthy of belief.

(2) In proceedings in respect of an offence referred to in subsection (1), no evidence shall be adduced by or on behalf of the accused that the complainant has engaged in sexual activity other than the sexual activity that forms the subject matter of the charge, whether with the accused or with any other person, unless the judge ... determines, in accordance with the procedures set out in sections 276.1 and 276.2, that the evidence

(a) is of specific instances of sexual activity;
(b) is relevant to an issue at trial; and
(c) significant probative value that is not substantially outweighed by the danger of prejudice to the proper administration of justice.

²⁴ *Ibid.* at para. 15.

²⁵ *R. v. Aziga*, [2008] O.J. No. 5131 (QL).

²⁶ K. Fraser, "Crown wants jail in HIV case; conditional term more appropriate for attacks on women," *The Vancouver Province*, 16 May 2008, p. A12.

²⁷ Based on personal communication with Crown Counsel in the case, Brian MacFarlane.

²⁸ "Trevis Smith expected to be deported back to U.S.," Canadian Press (online), 25 February 2009. For a summary of the case, see G. Betteridge, "Ex-professional football player guilty of two counts of aggravated sexual assault," *HIV/AIDS Policy & Law Review* 12(1) (2007): 43.

²⁹ D. Healy, "Ex-CFL player Trevis Smith free on parole," Canwest News Service (online), 25 February 2009.

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 Alison Symington (asymington@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network. Ms Symington is the author of all of the articles in this section.

South Africa: High Court orders Minister to release report on inmate's death

An inmate known as “MM” died in Westville Correctional Centre, Durban, South Africa, in August 2006. He was HIV-positive and had begun treatment less than four weeks before his death. After a two year battle, the Treatment Action Campaign (TAC) has won access to the report into his death.¹

In the decision, Southwood J decisively rejects all of the procedural arguments against releasing the report that

were put forth by the defendants, the Minister of Correctional Services and the Judicial Inspectorate of Prisons.

The arguments included that TAC did not have standing to bring the case, had failed to exhaust the inter-

nal appeal procedure, and had failed to bring the application within 30 days; and that the Minister does not have the report.²

The judge further rejected arguments that disclosure of the report would involve disclosure of personal information about the deceased inmate.³ In the reasons for judgment, Southwood J stated:

The papers in this case demonstrate a complete disregard by the Minister and his department of the provisions of the Constitution and PAIA [the Promotion of Access to Information Act] which require that records be made available....

It is disturbing that the first respondent has relied on technical points which have no merit and instead of complying with its obligations have waged a war of attrition in the court. This is not what is expected of a government Minister and a state department. In my view their conduct is not only inconsistent with the Constitution and PAIA but it is reprehensible. It forces

the applicant to litigate at considerable expense and is a waste of public funds.⁴

The judge ordered the Minister to provide TAC with unedited hard and electronic copies of the MM report. He also ordered the Minister to pay the costs of the application.⁵

The Minister of Correctional Services applied for leave to appeal, but his application was denied.⁶

Jonathan Berger of the AIDS Law Project (attorneys for TAC) described the ruling as just a small part of TAC's campaign to secure access to treatment for inmates. It was hoped that the report would allow the organization to find out whether delays in treatment led to MM's death and how such deaths can be prevented.⁷

The AIDS Law Project was given a copy of the report from the Judicial Inspectorate of Prisons on 10 February 2009.⁸ TAC expressed its frustration that the report relies almost exclusively on an in-house investigation conducted by the

Minister of Correctional Services and offers no independent expert evidence into the cause of MM's death.

The report assigns no responsibility to the Minister of Correctional Services, but apportions some blame to a not-for-profit private institution that assists the state by putting public sector patients on to antiretroviral therapy.⁹

¹ "South Africa: Court victory for HIV prison inmates," *PlusNews*, 2 February 2009.

² *Treatment Action Campaign v. Minister of Correctional Services and Another*, (30 January 2009), Case Number 18379/2008, High Court of South Africa, Transvaal Provincial Division, paras. 9–31.

³ *Ibid.* at paras. 32–34.

⁴ *Ibid.* at para. 36.

⁵ *Ibid.* at para. 40.

⁶ TAC, "Justice prevails: Minister Balfour's appeal application in 'MM' case dismissed," 13 March 2009, online via www.tac.org.za/.

⁷ "South Africa: Court victory for HIV prison inmates," *PlusNews*, 2 February 2009.

⁸ TAC, "Minister of Correctional Services appeals court order to release report on death of HIV positive prisoner 'MM,'" 13 March 2009, online via www.tac.org.za/.

⁹ *Ibid.*

Criminal law and cases of HIV transmission or exposure

Australia: 18-year jail term for HIV offences

Micheal John Neal, who was found guilty in July 2008 of fifteen charges — including attempting to infect a person with HIV, rape, reckless con-

duct endangering a person and procuring sex by fraud — was sentenced in January 2009 to 18 years and nine months in jail. The sentence includes a non-parole period of 13 years and nine months.¹

This case drew attention to the

functioning of public health services and their approach to monitoring and preventing HIV. A file was opened on Neal in 2001, and several letters and warnings had been issued to Neal over a five-year period. Allegedly, he continued having unprotected sex.²

France: Woman receives five-year suspended sentence

In the first HIV transmission case to be tried in the Assize Court (“Cour d’assises,” which is the court which presides over the most serious crimes), a woman received a five-year suspended sentence for having transmitted HIV to her ex-husband. Other HIV transmission cases have been tried by the criminal courts, presumably because they did not involve spouses or partners.³

According to media reports, the woman contracted HIV in 1991 and met her ex-husband in 1995. He allegedly found out that he was infected with HIV in 1997 while in hospital suffering from malaria.⁴ By his account, the woman had not disclosed her status to him. As a result, she was charged with “the administration of harmful substance by a spouse or partner, followed by mutilation or permanent infirmity.”⁵

Having been found guilty of the offence, the woman faced up to 15 years in prison. Due to her poor health, she was given a suspended sentence.⁶

Switzerland: Geneva court finds no risk of HIV transmission, overturns conviction

In February 2009, the Court of Justice (Criminal Division) of the Republic and Canton of Geneva acquitted a man previously convicted of attempted spread of a human disease and attempted serious bodily harm (sections 231 and 122 of the Swiss Penal Code).⁷ He had been convicted by a lower court in 2008

in relation to sexual relationships with two women and sentenced to 18 months imprisonment.

Geneva’s Public Prosecutor called for the appeal. The Public Prosecutor summoned Professor Bernard Hirschel to appear at the hearing to provide expert evidence that according to current scientific research, the risk of HIV transmission by a patient undergoing AIDS treatment, whose viremia is undetectable, and who does not have any other infections, is too low to be scientifically quantified.⁸ Furthermore, the patient had been informed that if he was diligent with his treatment and does not have any other diseases, there is no risk of transmission.⁹

Making explicit reference to the Swiss Federal Commission for HIV/AIDS consensus statement on the effect of HIV treatment on transmission¹⁰ released in 2008, the court concluded:

In this case, it is established that the appellant has been regularly monitored since early 2008, i.e., prior to the facts for which he is being reproached, has been receiving proper antiretroviral treatment, has an undetectable viremia and does not have any other infections. During his Appeal Division hearing, Professor Hirschel confirmed that, in this case, there is no risk of contamination. Accordingly, sections 122 and 231 of the Penal Code cannot apply.¹¹ [translation]

The man was therefore acquitted of the charges.

Commentary

This decision is significant in that it demonstrates a prosecutor and a court changing the state of the law in accordance with evolving scientific evidence regarding risk level. It is

the first ruling of its kind in the world and suggests that, in Switzerland, effectively treated HIV-positive individuals should no longer be prosecuted for having unprotected sex.

U.K.: First HIV transmission conviction since issuing of Crown Prosecution Service guidance

An HIV-positive man has pleaded guilty and has been sentenced to one year in prison for recklessly transmitting HIV to his ex-girlfriend. Reports indicate that he is a haemophiliac who contracted HIV as a teenager from an infected blood transfusion. She was allegedly infected between 1994 and 1996.¹²

Allegedly, she passed the virus onto a subsequent male partner. Media reports about the trial indicate that he kept quiet about his infection because of the stigma associated with HIV.¹³

One commentator stated:

The first conviction for HIV transmission in the UK for over a year, the case will be of concern to campaigners. Worryingly, the case appears to have strong similarities with early convictions for reckless HIV transmission, relying on a guilty plea and vague “scientific evidence.” There will be concerns about the nature and quality of the legal advice the accused received.¹⁴

U.K.: Man jailed for two years in case of hepatitis B transmission non-disclosure

In what is believed to be the first criminal case involving sexual hepatitis B virus transmission, a man was

sentenced to two years in prison under Section 20 of the *Offences Against the Person Act 1861* (the same act used to prosecute “reckless” HIV transmission), for inflicting grievous bodily harm on a woman with whom he had sex. The man had pled guilty.¹⁵

Media reports indicate that he did not inform the woman that he was infected with hepatitis B before a single unprotected sexual encounter. The woman contacted police after she became ill.¹⁶

According to one commentator, the case sets a worrying precedent. Hepatitis B is significantly more infectious than HIV and can be transmitted in ways that do not involve sex. As well, public health messaging tends to promote vaccination for hepatitis B, not partner disclosure and condom use (as in the case of HIV).¹⁷

The case seems out of line with guidance from the Crown Prosecution Service on cases involving sexual transmission of serious infection.¹⁸ According to this guidance, prosecutions are unlikely to take place unless there is a longer-term relationship or series of encounters.¹⁹

The guidance also says that the evidence must show that the accused infected the complainant, including not only medical and scientific evidence about the infection, but also evidence about the relevant sexual behaviour and relevant sexual history of the complainant.²⁰

HIV advocates have expressed concern that this prosecution represented a miscarriage of justice.²¹

Estonia: HIV-positive sex worker jailed

According to media reports, an Estonian court sentenced an HIV-

positive sex worker to three years and seven months in jail for failing to disclose her HIV status and engaging in unprotected sex.²²

Allegedly, an investigation into the woman’s activities was launched when she accused a client of rape. The investigation did not confirm a rape took place, but resulted instead in charges against her.

This appears to be the first case in Estonia of an HIV-positive person being sentenced to prison for engaging in unprotected sex.²³

Uganda: Man jailed for infecting mentally ill woman with HIV

In December 2008, an HIV-positive man was sentenced to 14 years in jail for having sex with a mentally ill young woman and allegedly infecting her with HIV. While there is no criminal offence of HIV transmission in Uganda, under the Penal Code it is an offence to have sex with a mentally ill woman.²⁴

The prosecutor introduced a medical report indicating that the accused was HIV-positive and had infected the woman. The magistrate stated that the accused had intentionally infected the woman and, therefore, he was imposing the maximum sentence of 14 years imprisonment.²⁵

The *HIV/AIDS Prevention and Control Bill, 2008* was being debated while the trial was taking place. The bill would criminalize intentional or wilful transmission of the virus, with a punishment of the death penalty.²⁶ The bill has been the subject of intense public debate.

See the article on the *HIV/AIDS Prevention and Control Bill, 2008* in the International Developments section of this issue.

¹ K. Hagan, “Grandfather jailed for spreading HIV,” *The Age* (online), 16 January 2009. See “Australia: Man found not guilty of deliberate HIV transmission,” *HIV/AIDS Policy & Law Review* 13 (2/3) (2008): 45–46 on the verdict in the case.

² *Ibid.*

³ P. Jolly, “Condamnée pour avoir transmis le sida à son mari,” *Le Monde*, 4 December 2008.

⁴ *Ibid.*; “Une femme devant les assises du Loiret pour avoir transmis le sida à son mari,” Agence France-Presse, 2 December 2008.

⁵ “Administration de substance nuisible par conjoint ou concubine, suivie de mutilation ou d’infirmité permanente.”

⁶ E. Bernard, “France: Woman receives five year suspended sentence for HIV transmission to ex-husband,” Criminal HIV Transmission blog, 5 December 2008, online at <http://criminalhivtransmission.blogspot.com>.

⁷ Order of the Court of Justice, Criminal Division, Hearing of Monday, February 23, 2009, Between “Mr. S.” and “Mrs. S2” and “Ms. R.” At the time of writing, the judgment had not yet been officially reported.

⁸ *Ibid.* at para. D.

⁹ *Ibid.*

¹⁰ See 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* 1-2008, p. 165. Professor Hirschel, who provided the expert evidence at the hearing, was one of the authors of the Swiss consensus statement. See also, R. Pearhouse, “Switzerland: Statement on sexual transmission of HIV by people on ART,” *HIV/AIDS Policy & Law Review* 13(1): 37–38.

¹¹ Order of the Court..., p. 5/6 [in the original French-language version].

¹² M. Carter, “Conviction for reckless HIV transmission relies on confession and results in one year in jail,” *Aidsmap News*, 24 November 2008.

¹³ “Accrington man ‘knowingly infected girlfriend with HIV,’” *Lancashire Telegraph*, 22 November 2008; “‘Selfish’ man jailed after infecting lover with HIV,” *The Sentinel*, 22 November 2008.

¹⁴ M. Carter.

¹⁵ “Man jailed for infecting woman with deadly hepatitis during sex,” *Cotswold Journal*, 19 November 2008; “Two years for hepatitis sex liar,” *The Sun*, 19 November 2008.

¹⁶ Ibid.; “Man jailed for passing on hepatitis B,” *The Times*, 19 November 2008.

¹⁷ E. Bernard, “UK: Man jailed for two years for sexual hepatitis B transmission — world first?” *Criminal HIV Transmission* blog, 21 November 2008, online at <http://criminalhivtransmission.blogspot.com>.

¹⁸ *Policy for Prosecuting Case Involving Intentional or Reckless Sexual Transmission of Infection*, a policy statement designed for a general readership, is available at www.cps.gov.uk/publications/prosecution/sti.html. A more detailed legal guidance for prosecutors and casework-

ers, entitled *Intentional or Reckless Sexual Transmission of Infection*, is available at www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/.

¹⁹ See *Policy for Prosecuting...*, section entitled “Reckless transmission: Section 20 Offences Against the Person Act 1861.”

²⁰ See *Policy for Prosecuting...*, section entitled “The first stage of the Code test — the evidence.”

²¹ M. Carter, “Concerns over miscarriage of justice after the first UK conviction for transmission of hepatitis B,”

Aidsmap News (online), 21 November 2008.

²² “HIV-positive prostitute who accused client of rape jailed in Estonia,” *Agence France-Presse*, 11 February 2009.

²³ Ibid.

²⁴ D. Amazia, “Man Jailed for infecting girl with HIV,” *New Vision Online*, 3 December 2008.

²⁵ Ibid.

²⁶ “UGANDA: Draft HIV bill’s good intentions could backfire,” *PlusNews* (online), 24 November 2008.

In brief

Latin America: Case raises issue of reproductive rights of HIV-positive women

In February 2009, a woman living with HIV (known as “F.S.”) filed a complaint against Chile before the Inter-American Commission on Human Rights, alleging that the government had failed to protect her from being forcibly sterilized.

The 27-year old woman alleges that she was sterilized at a state hospital immediately after she gave birth. She claims that she was sterilized because of her HIV status and had never discussed the possibility of a surgical sterilization with hospital staff, nor given her consent for the procedure.¹

The Centre for Reproductive Rights and VIVO POSITIVO submitted the petition on her behalf. The woman previously submitted a private prosecution against the hospital and a lawsuit before the Chilean courts, but neither the Ministry of

Health nor the courts found any human rights violations.²

Chilean regulations mandate written consent for all sterilizations. However, VIVO POSITIVO and others conducted a study regarding the reproductive rights of Chilean women living with HIV, and found that many HIV-positive women are pressured to be sterilized, while others had also been sterilized without consent.³

In the complaint, the plaintiffs argue that the Chilean government violated F.S.’s rights to be free from discrimination, to decide on the number and spacing of her children, to be free from violence, and to have access to justice.

The plaintiffs are asking that the Commission recommend that Chile acknowledge the human rights violations, undo the harm to F.S., provide her with monetary compensation, and adopt policies that guarantee women living with HIV the freedom to make reproductive health decisions without coercion.⁴

Senegal: Nine gay men arrested, convicted and given harsh sentences

Homosexuality remains illegal in Senegal. Homosexual acts are punishable by up to five years in prison under the offense of “indecent and unnatural acts.” This offense has recently been used to imprison men involved in HIV prevention work in Senegal.

In late December 2008, the home of the head of AIDES Senegal, a non-profit HIV education and counselling organization, was raided by police. Nine men were arrested; condoms and lubricants were seized as evidence.⁵

The men were all found guilty under article 319.3 of the country’s penal code for “indecent and unnatural acts” and received the maximum sentence. Furthermore, they were also charged and found guilty of “criminal association” and sentenced to a further three years.⁶

UNAIDS criticised Senegal for jailing the men. Executive director

Michel Sidibé stated, “There is no place for homophobia. Universal access to HIV prevention, treatment, care and support must be accessible to all people in Senegal who are in need — including men who have sex with men.”⁷

The Society for AIDS in Africa, the International AIDS Society, the International Gay and Lesbian Human Rights Commission, and Human Rights Watch also spoke out against the decision.⁸ Critics were quick to point out that the arrests happened mere weeks after Senegal hosted the International Conference on AIDS and STIs in Africa, where the needs of men who have sex with men in Africa were highlighted.

The sentences are under appeal.⁹

See additional coverage of this story in the section on International Developments in this issue.

Update: Appeal in Dr Rath case lapses

As reported in Volume 13(2/3) of the *HIV/AIDS Policy & Law Review*, in June 2008 the High Court of South Africa ruled against a vitamin producer, Matthias Rath and the Rath Foundation, and the Government of South Africa in a case regarding alternative remedies being marketed as treatments for HIV/AIDS.¹⁰

Following the verdict, Matthias Rath was granted leave to appeal. However, Rath failed to file further court papers and has run out of time. The court process is therefore complete and the court order stands unchallenged.¹¹

In related news, the Treatment Action Campaign (TAC) reports that it has received a letter from Dr J. Gouws of the Department of Health’s Law Inspectorate indicating that the department has commenced investigations against Matthias Rath and the Rath Foundation to ensure compliance with the court order. The letter indicates that criminal cases have been opened and are being investigated by the South African Police Services in Durban.¹²

TAC welcomed this development and stated:

Bringing charlatanism under control following the era of state-supported AIDS denialism is an immense challenge, but by taking action against Rath the Department of Health is sending the right message to other charlatans. This is an important first step.

We hope that a warrant of arrest will soon be issued for Rath. While it is unlikely it will ever be executed because Rath has left South Africa, it will be important symbolically to close this tragic affair, which has directly cost the lives of several of Rath’s

patients and indirectly cost the lives of countless others who were confused by the false messages of Rath, supported by former Minister of Health Tshabalala-Msimang.¹³

¹ VIVO POSITIVO and Centre for Reproductive Rights, “Forcibly sterilized woman files international case against Chile,” news release, New York, 3 February 2009; A. Castellanos, “Chilean woman living with HIV sterilized without consent,” RHRealityCheck.org (online), 19 February 2009.

² A. Castellanos.

³ Ibid.

⁴ VIVO POSITIVO.

⁵ M. Carter, “Leading human rights organisation calls for release of HIV workers in Senegal,” *Aidsmap News* (online), 12 January 2009; L. Polgreen, “9 in Senegal to be jailed for 8 years,” *The New York Times*, 9 January 2009, p. 5.

⁶ Ibid.

⁷ “UNAIDS deplors Senegal’s jailing of gay men,” *YAHOO! News*, 15 January 2009.

⁸ “Shock at Senegal gay jail terms,” *BBC News* (online), 8 January 2009; M. Carter; and Society for AIDS in Africa and International AIDS Society, “Public health leaders call on Government of Senegal to release 9 men imprisoned for eight years based on their sexual orientation,” (joint statement), news release, Abuja/Geneva, 12 January 2009.

⁹ F. Thompson, “Activists express concern over sentencing of gay men in Senegal,” *VOA News*, 15 January 2009.

¹⁰ A. Symington, “South African court bans promotion of vitamin treatments as cures for AIDS,” *HIV/AIDS Policy & Law Review*, 13 (2/3) (2008): 43–44.

¹¹ Treatment Action Campaign, “End of the Matthias Rath affair?” 16 March 2009, online via www.tac.org.za/.

¹² Ibid.

¹³ Ibid.