

Canadian HIV/AIDS Legal Network

# HIV/AIDS POLICY & LAW REVIEW

VOLUME 14, NUMBER 2, DECEMBER 2009

## Criminalization of HIV transmission: poor public health policy

Criminalization of HIV transmission and exposure is an ineffective tool for combating AIDS and a costly distraction from programs that we know work — programs such as effective prevention, protection against discrimination, reducing stigma, empowering women and providing access to testing and treatment. In this article, which is based on a public lecture he gave at “From Evidence and Principle to Policy and Action,” the 1<sup>st</sup> Annual Symposium on HIV, Law and Human Rights, held on 12–13 June 2009 in Toronto, Canada, Justice Edwin Cameron analyzes the surge in criminal prosecutions, discusses the role that stigma plays in these prosecutions and makes the case against criminalization.

### Introduction

The AIDS-rights movement must pick its way carefully through the political and conceptual complexities of the criminalization debate. That involves three tasks: one, strategic and moral; a second, reflective; and a third, political and organizational.

The first is that of turf-definition. We must start by granting that the criminal law has a proper and useful role to play in public health emergencies. This involves accepting not only that people living with HIV who expose others to infection may in some circumstances legitimately face prosecution, but also that to prosecute them will on occasion be

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### Special Section: Symposium on HIV, Law and Human Rights

This issue of the Review includes a Special Section containing the proceedings of “From Evidence and Principle to Policy and Practice,” the 1<sup>st</sup> Annual Symposium on HIV, Law and Human Rights, held on 12–13 June 2009 in Toronto, Ontario, Canada.

The Special Section starts on this cover and continues on page 61.

  
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Defending Liberty Pursuing Justice

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

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

Managing Editor:  
David Garmaise dgarmaise@gmail.com

Editor, Canadian Developments:  
Cécile Kazatchkine ckazatchkine@aidslaw.ca

Editor, International Developments:  
Leah Utyasheva lutyasheva@aidslaw.ca

Editor, HIV/AIDS in the Courts — Canada:  
Sandra Ka Hon Chu schu@aidslaw.ca

Editor, HIV/AIDS in the Courts — International:  
Patricia Allard pallard@aidslaw.ca

Editor, Special Section:  
David Cozac dcozac@aidslaw.ca

Coordinator: Vajdon Sohaili

Translators: Roger Caron, Jean Dussault, Josée Dussault,  
Johanne Forget

Layout: Liane Keightley

For the list of members of the Editorial Board of the *HIV/AIDS Policy & Law Review*, please visit [www.aidslaw.ca/review](http://www.aidslaw.ca/review).

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### About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://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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The Ontario HIV Treatment Network ([www.ohtn.on.ca](http://www.ohtn.on.ca)) promotes excellence and innovation in HIV treatment, research, education and prevention in Ontario to improve the health and well being of people with HIV, to contribute to HIV prevention efforts, to promote knowledge exchange among all HIV stakeholders, and to ensure value for resources.

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Established in 1974, the Law Foundation of Ontario (LFO) ([www.lawfoundation.on.ca](http://www.lawfoundation.on.ca)) is a grant-making organization with a long tradition of funding programs and initiatives that promote and enhance justice for all Ontarians. Formed under an amendment to the Law Society Act (the governing legislation of lawyers in Ontario), the LFO receives interest on lawyers' mixed trust accounts to fund worthwhile programs for law-related activities. In 2008, the Act was further amended to include the interest on mixed trust accounts from paralegals.

## Comments?

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

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# Clean switch: the case for prison needle and syringe programs

In Canada and in many other countries, prisons have become incubators for the transmission of HIV and hepatitis C virus (HCV). Estimates of HIV and HCV prevalence in Canadian prisons are at least 10 and 20 times, respectively, the reported prevalence in the population as a whole<sup>1</sup> — and prevalence rates have been reported to be significantly higher for people who inject drugs.<sup>2</sup> Although people who inject drugs may inject less frequently while incarcerated, the risks of injection drug use are amplified because of the scarcity of sterile syringes and the sharing of injecting equipment in prison.<sup>3</sup> Making sterile injection equipment available to people in prison is an important response to evidence of the risk of HIV and HCV transmission through sharing syringes to inject drugs. In this article, Sandra Chu explains why the government is obligated under international human rights standards and Canadian correctional and constitutional law to provide prison-based needle and syringe programs (PNSPs).

PNSPs have been introduced in over 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia, Luxembourg, Romania, Portugal and Iran.<sup>4</sup>

In Canada, over 200 needle and syringe programs (NSPs) serve Canadian communities, and enjoy the support of all levels of government.<sup>5</sup> Despite numerous evaluations of NSPs demonstrating that they reduce the risk of HIV and HCV, are cost effective, and facilitate access to care, treatment and support services, no NSPs exist in Canadian prisons.<sup>6</sup>

Evaluations of PNSPs — including in 2006 by the Public Health Agency of Canada (PHAC) at the request of the Correctional Service of Canada (CSC) — have shown similar results. While these PNSPs have been implemented in diverse environments and under differing circumstances, the results of the programs have consistently demonstrated that PNSPs:

- decrease needle sharing among people in prison;

- increase referrals of users to drug treatment programs;
- decrease the need for health-care interventions related to injection-site abscesses;
- decrease the number of overdose-related health-care interventions and deaths;
- do not result in PNSP syringes being used as weapons;
- do not lead to increased institutional violence;
- do not lead to increased drug use or increased initiation by people in prison of injecting drug use;
- are effective in a wide range of institutions; and
- have effectively employed different methods of needle distribution, such as peer distribution by people in prison, distribution by prison health care staff or outside agencies, and automatic dispensing machines.<sup>7</sup>

In Canada, numerous bodies, including the Correctional Investigator of Canada,<sup>8</sup> the Canadian Medical Association,<sup>9</sup> the Ontario Medical Association<sup>10</sup> and the Canadian

Human Rights Commission,<sup>11</sup> have recommended that CSC develop, implement and evaluate pilot NSPs in prisons. Further reinforcing the public-health imperative for PNSPs are compelling human rights and legal arguments, under both international and Canadian law, for such programs.

## International health and human rights standards

In the context of PNSPs, two principles are particularly relevant to the rights of people in prison. First, the international community has generally accepted the “principle of retaining all rights,” which means that people in prison retain all human rights that are not taken away as a result of the loss of liberty flowing from imprisonment.<sup>12</sup>

This includes the right to the highest attainable standard of health, which is recognized in the *International Covenant on Economic, Social and Cultural Rights*.<sup>13</sup> According to the U.N. Committee on Economic, Social and Cultural Rights, “States are under the obligation to respect the right to health by, *inter alia*, refraining from

denying or limiting equal access for all persons, including prisoners or detainees ... to preventive, curative and palliative health services.”<sup>14</sup>

Since HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states’ obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons. The U.N. Human Rights Committee has clarified that under the *International Covenant on Civil and Political Rights*, states are obligated to take “positive measures” in order to “increase life expectancy” and “eliminate ... epidemics.”<sup>15</sup>

Second, the “principle of equivalence” entitles people in detention to have access to a standard of health care equivalent to that available outside prison, including preventive measures comparable to those available in the general community. The right of people in prison to access health care equivalent to that available in the community is reflected in declarations and guidelines from the U.N. General Assembly,<sup>16</sup> the World Health Organization (WHO),<sup>17</sup> the U.N. Office on Drugs and Crime (UNODC)<sup>18</sup> and the Joint U.N. Programme on HIV/AIDS (UNAIDS).<sup>19</sup>

Moreover, numerous international health and human rights bodies support the position that, as a corollary to the right of people in prison to preventive health services, the state has an obligation to prevent the spread of contagious diseases in places of detention. Prison health standards and declarations from the WHO<sup>20</sup> and the World Medical Association,<sup>21</sup> for example, are clear that incarcerated people must be provided with measures to prevent the transmission of disease.

The specific issue of providing sterile syringes to people in prison as a means of preventing the spread of blood-borne viruses has also been considered and supported by numerous international organizations, as a matter of both sound public-health policy and human rights. For example, UNAIDS and the Office of the U.N. High Commissioner on Human Rights have called on prison authorities to “provide prisoners ... with access to ... condoms, bleach and clean injection equipment.”<sup>22</sup>

**The state has an obligation to prevent the spread of contagious diseases in places of detention.**

The WHO affirms the principle of equivalence by recommending that in “countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request it.”<sup>23</sup>

Similarly, UNODC, the WHO and UNAIDS recommend that prison systems “ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are also available to prisoners,” and specifically recommend that sterile needles and syringes be accessible to incarcerated people

in a confidential and non-discriminatory manner.<sup>24</sup>

## Canadian correctional law

CSC — which is responsible for the administration of all federal prisons — is governed by the *Corrections and Conditional Release Act (CCRA)* and its accompanying regulations.<sup>25</sup> The CCRA obligates CSC to “take all reasonable steps to ensure that penitentiaries, the penitentiary environment, the living and working conditions of inmates and the working conditions of staff members are safe, healthful and free of practices that undermine a person’s sense of personal dignity.”<sup>26</sup> The CCRA also reflects the principle of retaining all rights by stipulating that “offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence.”<sup>27</sup>

The CCRA mandates that the CSC must provide every incarcerated person with “essential health care” that will contribute to his or her rehabilitation and reintegration into the community.<sup>28</sup> Further, the CCRA stipulates that medical care for people in prison “shall conform to professionally accepted standards,” thereby implying a right to comparable health care as offered in the community at large. This is confirmed by CSC *Commissioner’s Directive 800* on “Health Services,” which stipulates that people in prison “have reasonable access to other health services ... which may be provided in keeping with community practice.”<sup>29</sup>

While the principle of equivalence is not directly stated in the CCRA, the broad definition given to “health care” and the proviso to provide health services “in keeping with

community practice,” are correctly interpreted as meaning that people in prison are entitled to equivalence of essential health services, including HIV prevention services, particularly in light of the CCRA’s explicit statement that people in prison retain all rights except those necessarily limited by incarceration.

## Canadian Constitutional Law

### I. Charter, Section 7

Section 7 of the *Canadian Charter of Rights and Freedoms* (Charter) protects everyone’s right to “life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”<sup>30</sup> To establish an infringement of Section 7, one must demonstrate:

- an interest protected by the right to “life, liberty and security of the person”;
- a “deprivation” by the state with respect to that interest; and
- that the deprivation is contrary to the principles of fundamental justice.<sup>31</sup>

#### Life

The right to life is concerned with state activity which can cause death to a person. Because HIV and HCV are potentially fatal diseases, the right to life is relevant in considering CSC’s obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons by, *inter alia*, the provision of sterile syringes.

In *PHS Community Services Society v. Attorney General of Canada*, the B.C. Supreme Court held that allowing the criminal prohi-

bition on drug possession to extend to the premises of a supervised injection site would engage the right to life because it “forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death.”<sup>32</sup>

Similarly, CSC’s failure to provide PNSPs prevents safer injection by people in prison, which could lead to HIV and HCV infection and potentially death.

#### Liberty

In *Blencoe v. British Columbia*, Justice Bastarache, for the majority of the Supreme Court of Canada, affirmed that liberty in Section 7 applies whenever the law prevents a person from making “fundamental personal choices.”<sup>33</sup> Accordingly, Section 7 has been applied to invalidate conditions imposed by the criminal justice system that interfere with a person’s access to health care services.

For example, in *R. v. Parker*, a criminal prohibition against the use of marijuana to alleviate severe pain was considered a violation of the individual’s liberty to choose a medically suitable course of treatment.<sup>34</sup> In *R. v. Reid*, the B.C. Provincial Court found that the blanket imposition of a “red zone” as a condition of probation for all people convicted of drug offences violated the rights to liberty and life because it was arbitrary, did not take into account the accused’s need to access the NSP located within the “red zone” part of the city (which the order prohibited him from entering), and put the accused’s life at risk because he was “effectively forbidden from accessing necessary health and other social services.”<sup>35</sup>

Significantly, in *Reid*, Justice Gove weighed any perceived benefit of the red zone prohibition with the harms it causes. He observed that imposing “the ‘red zone’ condition as a means to stop the activity of street drug trafficking has not been demonstrated as being successful. To the limited extent that it may have some value, the effect on individual rights is greatly disproportionate to any perceived social gain.”<sup>36</sup>

Denying incarcerated people access to sterile injecting equipment potentially has grave impact on their health, but has little or no impact on the use of drugs inside prisons.

In the context of PNSPs, denying incarcerated people access to sterile injecting equipment which is available to people outside of prison has a potentially grave impact on their health, with little or no impact on the use of drugs inside prisons.<sup>37</sup> The disproportionate effect of this deprivation lends further support to the argument that the infringement of incarcerated persons’ liberty interest is unjustified.

#### Security of the person

The right to “security of the person” protects individuals’ physical and psychological integrity<sup>38</sup> and is infringed by state action that has the

likely effect of seriously impairing a person's health.<sup>39</sup> In the prison context, the B.C. Supreme Court in *McCann v. Fraser Regional Correctional Centre* held that the short notice provided for a smoking ban could put incarcerated people "in danger as a result of aggressive behaviour of other inmates because they are suffering from [nicotine] withdrawals" and was therefore a "risk to the security of the inmates" and a breach of Section 7.<sup>40</sup>

In *PHS Community Services Society v. Attorney General of Canada*, the B.C. Supreme Court held that denying an addict access to a health-care facility "where the risk of morbidity associated with infectious disease is diminished, if not eliminated" threatened the security of the person.<sup>41</sup> Given the severe health consequences of HIV and HCV infection, the risk of harm posed by banning PNSPs qualifies as sufficiently "serious" to ground a violation of security of the person under Section 7.

Not only are actual impairments of life, liberty or security of the person violations of Section 7, but so too are risks of impairment. In *Singh v. Minister of Employment*,<sup>42</sup> the majority of the Supreme Court of Canada cited with approval *Collin v. Lussier*, in which the Court held that the security of a person is infringed when state action increases an individual's "anxiety as to his state of health" and "is likely to make his illness worse ... by depriving him of access to adequate medical care."<sup>43</sup> Accordingly, an imminent deprivation of life, liberty or security of the person (i.e., one that has not yet occurred) is sufficient to establish a violation of Section 7.

Because HIV and HCV transmission among people in prison has

been amply documented in numerous studies,<sup>44</sup> an applicant need not prove actual HIV or HCV infection in order to prove a violation of Section 7. Demonstrating a risk of infection is sufficient, and this risk has been recognized by numerous organizations, both within Canada and worldwide, and supported by studies of confirmed outbreaks of HIV in prison.<sup>45</sup>

### Deprivation of these rights by the state

The violation of the right to life, liberty or security of the person must be the direct causal result of a state action.<sup>46</sup> In the context of PNSPs, the denial of clean needles by CSC, which exercises exclusive state control over people in prison, could not be more apparent.

As the Ontario Court of Appeal held in *R. v. Parker*, "[P]reventing access to a treatment by threat of criminal sanction" constitutes a deprivation of security of the person.<sup>47</sup> Similarly, the Federal Court (Trial Division) in *Covarrubias v. Canada (Minister of Citizenship and Immigration)* held that the state controlled "the quality of the medical services that would be available to [the incarcerated person] in the maximum security unit. The risk to the inmate's security interests, if established, would have been entirely caused by 'the state's conduct in the course of enforcing and securing compliance with the law.'"<sup>48</sup>

Although the government in *PHS Community Services Society* argued that the threat to life associated with drug injection resulted from an individual's choice to inject rather than state action, the B.C. Supreme Court rejected that argument and held that "the subject with which those actions are concerned has moved beyond

the question of choice to consume in the first instance.... However unfortunate, damaging, inexplicable and personal the original choice may have been, the result is an illness called addiction."<sup>49</sup> Therefore, the Court held that a law that prevented access to health-care services that could prevent death engaged the right to life.<sup>50</sup>

Because people in prison are under the jurisdiction of CSC and are entirely dependent upon it for their health care, the nexus between CSC's refusal to implement PNSPs and their risk of HIV and HCV infection is clear. The absence of sterile needles and syringes has been proven in numerous studies to increase prisoners' risk of HIV and HCV infection, and evidence of actual outbreaks also directly link CSC's failure to implement PNSPs with increased risk of harm to incarcerated persons' life and security of the person.

### Principles of fundamental justice

Depriving someone or a class of people of any of the rights to life, liberty or security of the person is a breach of Section 7 of the Charter only if the deprivation is "not in accordance with the principles of fundamental justice." In *Rodriguez v. British Columbia (Attorney General)*, the Supreme Court held that the principles of fundamental justice must be "capable of being identified with some precision and applied to situations in a manner which yields an understandable result"; and that a law or state action must not be so arbitrary "as to be no more than vague generalizations about what our society considers to be moral or ethical."<sup>51</sup>

Building upon the principles set out in *Rodriguez*, the court in *Chaoulli v. Quebec (Attorney General)* provided that a law is arbi-

trary where “it bears no relation to, or is inconsistent with, the objective that lies behind [it].”<sup>52</sup> Moreover, the Supreme Court has consistently ruled that where depriving a person or class of persons of any of the rights to life, liberty or security of the person does not enhance the state’s interest, then a breach of fundamental justice will be made out, since the individual’s interest has been deprived for no valid purpose.<sup>53</sup>

In the absence of any clear statement from the government as to why PNSPs have not been instituted, completing a Section 7 analysis must presume that CSC’s objections reflect objections commonly raised by governments. These include claims that PNSPs:

- would undermine abstinence-based messages and programs by condoning drug use;
- would lead to increased violence and the use of needles as weapons;
- would lead to an increased consumption of drugs or an increased use of injection drugs among those who were previously not injecting; and
- do not necessarily work in Canada because other jurisdictions with successful PNSPs reflect specific and unique institutional environments.<sup>54</sup>

The first claim, that PNSPs condone drug use, is inconsistent in light of the availability of NSPs in the community. Despite the criminalization of illicit drug use in Canada, NSPs operate legally in the community, are recognized as a valuable harm reduction measure that reduces the risk of HIV and HCV transmission among people who inject drugs, and have

the support of various orders of government. Community NSPs are not viewed by the federal government as undermining abstinence or condoning drug use.

As confirmed by the PNSP evaluations cited above, studies have refuted the assumptions that PNSPs lead to increased violence or the use of needles as weapons against other people in prison or staff, or lead to increased drug use or an increased use of injection drugs among those who were previously not injecting.

There is no support for the argument that prison-based needle and syringe programs would not work in Canada.

Finally, PNSP studies worldwide have demonstrated that they work in a variety of different institutions; thus, there is no support for the argument that PNSPs would not work in Canada. The positive public-health benefits of PNSPs observed from numerous evaluations, and the evidence disproving CSC’s presumed concerns, confirm that the prohibition of PNSPs is arbitrary and does not enhance the “state’s interest.” As the Supreme Court of Canada held in *Chaoulli*, “[R]ules that endanger health arbitrarily do not comply with the principles of fundamental justice.”<sup>55</sup> Where state action puts individuals’ lives at stake, there must be a clear connection between that measure and its underlying legislative goals. In

the case of PNSPs, there is no such connection.

## II. Charter, section 15

Section 15(1) of the Charter provides:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The Supreme Court of Canada recently set out the analytical framework to assess Section 15 claims in *R. v. Kapp*.<sup>56</sup> In that case, the Court affirmed the framework set out in *Andrews v. Law Society of British Columbia* and held that in order to find a violation of the Charter’s equality rights clause:

- there must be a distinction based on an enumerated or analogous ground; and
- the distinction must create a disadvantage by perpetuating prejudice or stereotyping.<sup>57</sup>

### A distinction based on an enumerated or analogous ground

As discussed above, NSPs have enjoyed the support of the Canadian government at all levels, and constitute a benefit available to people injecting drugs outside prison. Denying clean needles to incarcerated people exposes them to increased risk of HIV and HCV infection, and reflects a clear distinction in treatment between people who inject drugs in the community and people who inject drugs in prison.

Since the status of prisoner is not an enumerated ground, it must be

determined whether this distinction is based on an analogous ground, for which a number of indicators have been identified by courts. In *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, the Supreme Court of Canada described an analogous ground as involving personal characteristics that are “immutable or changeable only at unacceptable cost to personal identity.”<sup>58</sup>

Contextual factors that may be relevant to finding an analogous ground include whether the matter is important to the person’s “identity, personhood, or belonging,” whether people defined by the characteristic “are lacking in political power, disadvantaged, or vulnerable to becoming disadvantaged or having their interests overlooked,” and whether the ground is protected under federal or provincial human rights legislation.<sup>59</sup>

Previously, in *Sauvé v. Canada (Chief Electoral Officer)*, a minority of the Supreme Court of Canada took the position that “the status of being a prisoner does not constitute an analogous ground” under Section 15 of the Charter.<sup>60</sup> On a number of occasions, the Federal Court of Canada and Tax Court of Canada have both taken a similar view.<sup>61</sup> This position, however, has not been endorsed by a majority of the Supreme Court of Canada or by provincial appellate courts. These judgments are not binding on those courts, and the position they espouse should be reconsidered and rejected, for at least two reasons.

First, the overly simplistic reasoning underlying this conclusion leads logically to results at odds with the basic principles underlying the Charter and internationally accepted human rights principles. In the dissenting opinion in *Sauvé*, Justice

Gonthier held that, because the unifying characteristic of people in prison is “past criminal behaviour,”<sup>62</sup> different treatment under the law is justifiable.

Under this analysis, past criminal behaviour disentitles prisoners as a class to any protection of rights under the equality rights provision of the Charter, and the state could single out incarcerated people for any number of arbitrary measures and would be immune from scrutiny under Section 15. This runs directly counter to the well-established principles of retaining all rights and of equivalence already noted above.

Second, the categorical denial of protection under Section 15 to people in prison ignores the specific characteristics of those who are incarcerated, including multiple intersecting grounds of disadvantage that are clearly of concern under Section 15. In *Law v. Canada (Minister of Employment and Immigration)*, the Supreme Court was clear in its disapproval of a mechanistic and formalistic approach to Section 15 that fails to address “the true social, political and legal context underlying each and every equality claim.”<sup>63</sup>

The Court also recognized that grounds on which people have experienced discrimination can intersect.<sup>64</sup> To a great extent, prisons are home to people who have been socially marginalized. According to the Canadian Centre for Justice Statistics, the majority of people in prison come from disadvantaged backgrounds characterized by poverty, substance abuse, low levels of education and high levels of depression and attempted suicide.<sup>65</sup> While people who inject drugs in prison and those who inject outside share numerous characteristics, as a class

the “pre-existing disadvantages” of people who inject drugs in prison are arguably more severe, and their vulnerability is ostensibly compounded by incarceration.

People in prison also disproportionately embody multiple immutable characteristics recognized as traditional grounds on which discrimination is prohibited.<sup>66</sup> In particular, the denial of PNSPs to people in prison disproportionately affects Aboriginal people, who are disproportionately represented in federal prisons.<sup>67</sup> In *Sauvé*, Justice McLachlin, writing for the majority of the Supreme Court, noted that the negative effects of the impugned provision prohibiting people in prison from voting in federal elections had “a disproportionate impact on Canada’s already disadvantaged Aboriginal population.”<sup>68</sup> Similarly, denying incarcerated people access to sterile needles and syringes would have a disproportionate impact on Aboriginal Canadians, who are already disproportionately represented among people who inject drugs and people living with HIV in the population as a whole.<sup>69</sup>

People with mental illnesses are also overrepresented among people in prison. In 2001, a CSC study found that, in the Pacific region, 84 percent of people in prison had at least one lifetime diagnosis of a mental disorder at entry, including substance abuse.<sup>70</sup> More broadly, the CSC recently reported that 12 percent of men and 26 percent of women in federal prisons had been identified with “very serious mental health problems”;<sup>71</sup> 15 percent of men and 29 percent of women in federal prisons had previously been hospitalized for “psychiatric reasons”;<sup>72</sup> and the percentage of people in federal prisons prescribed medication for

“psychiatric concerns” at admission had more than doubled from 10 percent in 1997–1998 to 21 percent in 2006–2007.<sup>73</sup>

Most people in prison come from disadvantaged backgrounds characterized by poverty, substance abuse and low levels of education.

The widespread incarceration of people who use drugs is also well documented, with over 20 percent of people admitted to federal prisons having at least one drug-related conviction.<sup>74</sup> Substance abuse is identified as a contributing factor to the criminal behaviour of 70 percent of the people admitted to federal prisons.<sup>75</sup> A significant number of people in prison who inject drugs are also addicted to drugs. According to PHAC, approximately 67 percent of people in federal prisons have substance abuse problems, of which 20 percent require treatment.<sup>76</sup>

People with addictions have been recognized by Canadian tribunals and courts as worthy of protection against discrimination on the basis of the disability of drug dependence,<sup>77</sup> and there is significant jurisprudence from labour arbitrators, human rights commissions and courts recognizing drug dependence as a disability requiring, among other things, a duty to accommodate, and awarding damages for discrimination.<sup>78</sup>

While people who inject drugs both inside and outside prison may share the experience of disability, as a group people who inject drugs in prison arguably suffer from a more severe dependency, because conflict with the law and incarceration are often a result of offences related to the financing of drug use or offences related to behaviours brought about by drug use.<sup>79</sup>

Denying access to sterile injection equipment also has a disproportionate impact on women. Though women constitute a minority of those incarcerated in Canada, a significant percentage of women in Canadian prisons were incarcerated for offences related to drug use, often linked to underlying factors such as experiences of sexual or physical abuse or violence.<sup>80</sup> As the Canadian Human Rights Commission has observed, “[A]lcohol and drugs tend to figure more prominently in the lives and criminal offences of incarcerated women, for whom income-generating crimes such as fraud, shoplifting, prostitution and robbery are often perpetrated to support their addictions.”<sup>81</sup>

Moreover, a 2003 study of federally incarcerated women found that 19 percent reported injecting drugs while in prison;<sup>82</sup> and a previous history of injection drug use is consistently found more frequently among women than men in Canadian prisons.<sup>83</sup> In a number of studies, HIV and HCV prevalence has also been shown to be higher among incarcerated women than among incarcerated men in Canada.<sup>84</sup>

As the Commission concluded, “Although sharing dirty needles poses risks for any inmate, the impact on women is greater because of the higher rate of drug use and HIV infection in this population,”

an impact that “may be particularly acute for federally sentenced Aboriginal women.”<sup>85</sup>

Considered from the broader social and historical context, denying people in prison access to PNSPs disproportionately affects people who represent an intersection of the Charter’s enumerated grounds. As such, courts should recognize prisoner status as an analogous ground for which unjustifiable discrimination by the state is prohibited.

### **A distinction which creates a disadvantage by perpetuating prejudice or stereotyping**

As noted above, community-based NSPs have demonstrated for many years their efficacy in reducing risk behaviour related to HIV and HCV transmission, an obvious benefit for people who inject drugs in the community. Correlatively, the failure to provide PNSPs in federal prisons creates a disadvantage for people who inject drugs in prison because they are forced to use non-sterile injection equipment.

The Supreme Court of Canada has repeatedly held that “once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner.”<sup>86</sup> CSC’s exclusion of people in prison from the full range of health benefits available to people in the general community creates an environment in which it is acceptable to treat people who inject drugs in prison as second-class citizens and to subject them to risks of irreparable harm. Insofar as the government provides, or allows access to, a service such as NSPs, it must provide it equally.

Further, denying access in prison to proven health services such as NSPs must be understood as existing under the following conditions

of inequality in Canadian society: “higher rates of poverty and institutionalized alienation from mainstream society” among Canada’s Aboriginal population;<sup>87</sup> a significant proportion of people in prison suffering from, and receiving inadequate treatment for, mental illness;<sup>88</sup> a significant number of women in prison who struggle with addiction;<sup>89</sup> the routine experience of people who use drugs of negative stereotyping, social stigmatization and marginalization from members of society, social service agencies and health-care providers;<sup>90</sup> and the historical inadequacy of health services for persons who use drugs and for incarcerated people.<sup>91</sup>

“Once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner.”

People who inject drugs are already identified with numerous negative stereotypes, including the view that drug users are of lesser moral value and, therefore, are less worthy of health care, a perception that is exacerbated by incarceration.<sup>92</sup> These attitudes and misconceptions have resulted in a variety of harms, including public apathy, undiagnosed mental illness and inaccessible treatment and rehabilitation programs.<sup>93</sup> As a group, people in prison are further disadvantaged by heightened vulnerability to disease and infection,

and subject to pernicious prejudice and stigmatization.<sup>94</sup>

CSC’s prohibition of PNSPs fails to take into account conditions of systemic inequality, imposes a serious health burden on people in prison, and perpetuates the stereotype that they are less worthy of recognition and value as members of Canadian society. The distinction in treatment is thus an unjustifiable infringement of the right of incarcerated people to equal protection and equal benefit of the law.

### III. Charter, Section 12

Section 12 of the Charter provides that all individuals have a right “not to be subjected to any cruel and unusual treatment or punishment.” In order to come within the protection of Section 12, an applicant must first demonstrate that he or she has been subject to “treatment” or “punishment” at the hands of the state. Numerous courts have referred to conditions of incarceration as “treatment” contrary to section 12,<sup>95</sup> including in the context of the state’s failure to provide facilities which made adequate medical care available for detained people with HIV.<sup>96</sup> Clearly, CSC’s failure to provide PNSPs falls within the ambit of “treatment” covered under Section 12. Whether CSC’s inaction with respect to PNSPs constitutes “cruel and unusual” treatment depends on conditions which have been articulated over a number of section 12 cases — namely, whether such treatment is:

- “grossly disproportionate” for the incarcerated person;
- so excessive as to “outrage standards of decency”; and
- having regard to all contextual factors.

### Whether the treatment is excessively or grossly disproportionate

Denying access to health services is not a legitimate objective of incarceration. Neither the *Criminal Code* nor the CCRA reflect a view of incarceration that denies health care to people in prison, and the principle of equivalence is clearly opposed to jeopardizing individuals’ health by virtue of their incarceration. In *R. v. Smith*, Justice Wilson provided that she understood “grossly disproportionate” to mean that “no one, not the offender and not the public, could possibly have thought that that particular accused’s offence would attract such a penalty. It was unanticipated in its severity either by him or them.”<sup>97</sup>

The effect of CSC’s inaction is incarcerated people’s heightened risk of HIV and HCV infection, an outcome that is grossly disproportionate to any rationale for their incarceration. Not only people who inject drugs in prisons, but others in prison and the community as a whole face greater risk of grave illness when incarcerated people become increasingly infected with blood-borne viruses. Given the magnitude of this public health risk, CSC’s prohibition of PNSPs is grossly disproportionate to any of its purported aims.

### Whether the treatment is in accordance with public standards of decency

The impact of CSC’s failure to provide PNSPs — an increased risk of infection with HIV and HCV — could be said to outrage a collective standard of decency. This is especially true if, as affirmed by the Supreme Court of Canada in *R. v. Goltz* and *R. v. Morrissey*, the specific characteris-

tics of the population most affected are considered.<sup>98</sup> Undoubtedly, people who inject drugs in prison are among the most marginalized of society, for whom sterile needles and syringes are crucial if they are to remain free of HIV or HCV infection. Further reinforcing their marginalization by subjecting them to unnecessary health risks (that are not imposed on the population as a whole) cannot be in accordance with public standards of decency.

Denying people in prison the right to protect themselves against HIV and HCV infection constitutes treatment that is contrary to minimum standards of decency and human rights.

Furthermore, people in prison retain all their rights and are entitled to access an equivalent standard of health care. These principles should inform “public standards of decency” with respect to the health of people in prison. In an environment where NSPs enjoy widespread support in the community, and there is significant evidence of the efficacy of PNSPs in reducing the use of non-sterile injection equipment, denying people in prison, particularly those who are addicted to drugs, the right to protect themselves against HIV and HCV infection constitutes treatment that

is contrary to minimum standards of decency and human rights.

#### Contextual factors

A determination of whether treatment is “cruel and unusual” must not merely assess the government’s refusal or failure to implement PNSPs, but also the effects of such action, considering the particular needs of incarcerated people, the actual effect of the treatment on them and the availability of adequate alternatives.<sup>99</sup> As noted above, the majority of people in prison come from disadvantaged backgrounds characterized by poverty, substance abuse, low levels of education and high levels of depression and attempted suicide. Thus, the actual effect of failing to provide PNSPs poses severe health risks, especially in view of the escalating rates of HIV and HCV in prisons.

For many people in prison suffering from addiction, the effect of prohibiting PNSPs is an even greater risk of HIV and HCV infection, a potentially fatal health outcome that is neither “decent” nor “proportionate” to the reasons for their incarceration. The “treatment” is senseless especially in light of the alternative of providing PNSPs, a move that would fulfill CSC’s obligations under the CCRA and be in accordance with international health and human rights standards.

#### IV. Charter, Section 1

If violations under Sections 7, 15 or 12 have been established, it is theoretically still possible that the violation or violations could be justified under Section 1 of the Charter.<sup>100</sup> According to Section 1, the Charter “guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law

as can be demonstrably justified in a free and democratic society.” The test to determine what can be accepted as “demonstrably justified” under this section has been outlined by the Supreme Court in *R. v. Oakes* and subsequent cases.<sup>101</sup> To justify the infringement of a Charter right by a law or government policy or action, the government must demonstrate that:

- the objective of the government measure is of sufficient importance to warrant overriding a constitutional right, meaning that, at a minimum, it must relate to concerns which are pressing and substantial;
- the government measure is rationally connected to achieving this objective, meaning it is not arbitrary, unfair or based on irrational considerations;
- the government measure impairs as little as possible the constitutional right(s) in question; and
- the harm done by limiting the right does not outweigh either the importance of the measure’s objectives or the benefits of the measure.

#### Pressing and substantial purpose to justify limiting Charter rights

As noted earlier, principal objections raised by governments in response to PNSPs have included the notion that PNSPs condone drug use and lead to an increased consumption of drugs or an increased use of injection drugs among those who were previously not injecting; that PNSPs lead to increased violence and to the use of syringes as weapons against other people in prison and staff; and that PNSPs may not work in Canada

because other jurisdictions with successful PNSPs reflect specific and unique institutional environments.

Admittedly, concerns about drug use in prison and prison safety may be “pressing and substantial.” However, the notion that PNSPs may not work in Canadian prisons is no justification for delaying their implementation, especially in view of the evidence worldwide demonstrating their efficacy in a range of institutions and the possibility of piloting PNSPs in select institutions.

Even if any of CSC’s purported concerns are deemed “pressing and substantial,” there is no nexus between those concerns and the prohibition of PNSPs.

#### **Rational connection between measure and objective**

Significantly, the government’s objectives in refusing to implement PNSPs must be rationally connected to the means undertaken to achieve them. In this respect, the prohibition of PNSPs fails Section 1 scrutiny. The lack of access to sterile needles and syringes in prison undermines CSC’s interest in mitigating the harms caused by injection drug use, an interest reflected in CSC’s statutory obligation to protect the health and well-being of people in its custody.

In spite of the federal government’s “zero tolerance” drug policy and interdiction efforts, there is undeniable evidence that drugs are being smuggled into prisons and used by people in prison, a fact that the government’s own research demonstrates and that it acknowledges.<sup>102</sup> Numerous studies have indicated that, despite the absence of sterile injection equipment, people in prison inject drugs; non-sterile injection equipment is merely used more fre-

quently because of the shortage of injecting equipment.<sup>103</sup>

While CSC may not wish to be seen to condone drug use, it already acknowledges injection drug use within prisons by making bleach available, with “instructions on the proper cleaning of syringes and needles.”<sup>104</sup> Correspondingly, community NSPs operate within a legal environment where drug use is criminalized, yet NSPs are not accused of condoning drug use. As noted above, studies of PNSPs worldwide have indicated that drug consumption and the use of injection drugs among those who were previously injecting do not increase when PNSPs have been introduced, that PNSPs do not lead to increased violence, and that PNSP syringes have not been used as weapons against staff or other prisoners.

**A blanket prohibition on prison-based needle and syringe programs does little or nothing to advance the state’s interest in protecting people in prison or the public.**

Finally, PNSPs can be introduced in prisons of different sizes, regions and security levels. In Western European prisons, programs have proven effective in prisons where incarcerated people are housed in ranges of individual cells, similar to the Canadian situation.<sup>105</sup> PNSPs have also been successfully imple-

mented in jurisdictions that are relatively well-resourced and well-financed (i.e., Switzerland, Germany, Spain), as well as in countries in economic transition that operate with significantly less funding and infrastructural support (i.e., Moldova, Kyrgyzstan, Belarus).<sup>106</sup>

Given the reality of injection drug use in prisons and the evidence invalidating the purported harms of PNSPs worldwide, a blanket prohibition on PNSPs does little or nothing to advance the state’s interest in protecting people in prison or the public. There is, therefore, no rational connection between such objectives and the prohibition.

#### **Minimal impairment of Charter rights**

Under section 1 of the Charter, if rights are to be infringed, the level of infringement must not exceed the minimum required to fulfil the desired purpose. The requirement for minimal impairment is also reflected in the CCRA, which obligates CSC to “use the least restrictive measures consistent with the protection of the public, staff members and offenders.”<sup>107</sup> Denying people in prison access to a form of health care poses a significant risk of HIV and HCV infection and contravenes the principle of retaining all rights and the principle of equivalence. Such impairment is far from “minimal,” even if the prohibition of PNSPs could be said to be rationally connected to CSC objectives.

#### **Proportionality between harms and benefits of the measure**

Finally, under Section 1 of the Charter, the harm done by the government in limiting constitutional rights must not outweigh either the

importance of the legitimate government objective or the benefits achieved by the government's measure. Evidence confirms that denying people in prison access to sterile needles and syringes is not simply ineffective, but excessively harmful. In light of the extent of injection drug use in prisons, PNSPs are crucial to reducing the risks associated with non-sterile injection equipment.

Prohibiting sterile needles and syringes in prisons subjects people who inject drugs in prison to a significant risk of HIV and HCV infection, a harm that outweighs the purported "benefits" of the prohibition — benefits which are not supported by evidence from evaluations of PNSPs worldwide. In contrast, the health benefits of providing sterile needles and syringes actually advance the state's interest in reducing the harm to people in prison and to society of the use of harmful drugs.

## Conclusion

Viewed in light of (a) the reality of HIV, HCV and injection drug use in prisons, (b) the well-established legal principles of retaining all human rights and of equivalence in health care standards, (c) the availability and general acceptance of NSPs in the community as a vital harm reduction measure, and (d) CSC's obligations to take effective measures to prevent the spread of infectious diseases among people in prison, the government's failure to provide PNSPs in Canadian prisons does not meet Canada's commitments to international health and human rights standards, its mandate under Canadian correctional legislation, or its obligations under the Charter.

With increasing HIV and HCV prevalence in Canadian prisons,

the urgency for action is mounting: people's lives, both inside and outside prisons, are dramatically affected by the lack of clean needles every passing day. The dire need for safe access to clean needles within Canadian prisons must be met to ensure that the rights enshrined in Canadian and international law are not abstract values, but tangible rights to be enjoyed by all.

— Sandra Chu

Sandra Chu is a senior policy analyst with the Canadian HIV/AIDS Legal Network.

<sup>1</sup> See R. Lines et al, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, Second edition*, Canadian HIV/AIDS Legal Network, 2006, p. 6; S. Skoretz, G. Zaniewski and N.J. Goedhuis, "Hepatitis C virus transmission in the prison/inmate population," *Canada Communicable Disease Report* 30(16) (2004): 141–148 at 142; and R. Remis et al, *Estimating the Number of Blood Transfusion Recipients Infected by Hepatitis C Virus in Canada, 1960–85 and 1990–92*, report to Health Canada, 1998.

<sup>2</sup> Correctional Service of Canada (CSC), *Springhill Project Report*, 1999, p. 12.

<sup>3</sup> See, for example, the studies cited in footnote 22 of S. Chu and R. Elliott, *Clean Switch: The Case for Prison Needle and Syringe Programs in Canada*, Canadian HIV/AIDS Legal Network, 2009.

<sup>4</sup> R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, WHO, UNODC and UNAIDS, 2007, p. 25.

<sup>5</sup> See, for example, footnotes 49–52 of S. Chu and R. Elliott, *Clean Switch* (supra).

<sup>6</sup> See, for example, studies cited in footnotes 53–56 of S. Chu and R. Elliott, *Clean Switch* (supra).

<sup>7</sup> See, for example, studies cited in footnote 60 of S. Chu and R. Elliott, *Clean Switch* (supra); and Public Health Agency of Canada (PHAC), *Prison Needle Exchange: Review of the Evidence*, report prepared for CSC, 2006.

<sup>8</sup> See, for example, Correctional Investigator of Canada (CI), *Annual Report of the Correctional Investigator 2003–2004*, 2004; CI, *Annual Report of the Office of the Correctional Investigator of Canada 2005–2006*, 2006; CI, *Annual Report of the Office of the Correctional Investigator 2006–2007*, 2007.

<sup>9</sup> Canadian Medical Association, 2005 Annual Meeting, Resolution 26.

<sup>10</sup> Ontario Medical Association, *Improving Our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.

<sup>11</sup> Canadian Human Rights Commission (CHRC), *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*, 2004.

<sup>12</sup> U.N. General Assembly, *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc. A/45/49 (1990), Principle 5.

<sup>13</sup> See Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976) [ICESCR].

<sup>14</sup> U.N. Committee on Economic, Social and Cultural Rights, "General Comment 14: The Right to the Highest Attainable Standard of Health," 22<sup>nd</sup> Sess., (2000) UN Doc E/C.12/2000/4, para. 34 [emphasis in original].

<sup>15</sup> U.N. Human Rights Committee, *General Comment No. 6: "The Right to Life (Article 6),"* 16<sup>th</sup> Sess., (1982) UN Doc. HRI/GEN/1/Rev.1, para. 5.

<sup>16</sup> U.N. General Assembly, *Basic Principles* (supra), para. 9.

<sup>17</sup> WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993.

<sup>18</sup> UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, p. 10.

<sup>19</sup> UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-Second Session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997) p. 3.

<sup>20</sup> WHO, *WHO Guidelines* (supra).

<sup>21</sup> World Medical Association, *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases*, 2000.

<sup>22</sup> Office of the High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights, Consolidated Version*, UN Doc. HR/PUB/06/9, 2006, Guideline 4, para. 21(e).

<sup>23</sup> WHO, *WHO Guidelines* (supra), Guideline 24. More recently, the WHO reiterated that the range of services required for people in prison includes "clean needle and syringe provision": WHO, *Priority Interventions: HIV/AIDS Prevention, Treatment and Care in the Health Sector*, 2008, p. 25.

<sup>24</sup> UNODC, WHO and UNAIDS, *HIV/AIDS Prevention* (supra), Recommendation 60.

<sup>25</sup> *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c 20; SOR/92-620; and *Corrections and Conditional Release Regulations*, SOR/92-620.

<sup>26</sup> CCRA, s. 70.

<sup>27</sup> CCRA, s. 4(e).

<sup>28</sup> CCRA, ss. 85–88.

<sup>29</sup> CSC, *Commissioner's Directive 800: Health Services*, 2004.

<sup>30</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 (Charter).

- <sup>31</sup> *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429 (Supreme Court of Canada), para. 75.
- <sup>32</sup> *PHS Community Services Society v. Attorney General of Canada*, 2008 B.C.S.C. 661 (B.C. Supreme Court), para. 140. The Court therefore maintained, as a matter of constitutional entitlement, the exemption for Vancouver's Insite from Canada's criminal law prohibiting drug possession, ruling that access to this health service had to take priority over an inflexible application of the criminal law.
- <sup>33</sup> *Blencoe v. British Columbia*, [2002] 2 S.C.R. 307.
- <sup>34</sup> *R. v. Parker* (2000), 49 O.R. (3d) 481 (Ontario Court of Appeal).
- <sup>35</sup> *R. v. Reid*, [1999] B.C.J. No. 1603, paras. 78 and 80.
- <sup>36</sup> *Ibid.*, para. 61.
- <sup>37</sup> From 1998 to 2007, CSC spent significantly more time and money than it had in previous years on efforts to prevent drugs from entering prisons, yet drug use declined less than one percent during that period. See CI, *Annual Report of the Office of the Correctional Investigator 2006–2007* (supra), p. 12.
- <sup>38</sup> *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (Supreme Court of Canada).
- <sup>39</sup> See *R. v. Morgentaler*, [1988] 1 S.C.R. 30 (Supreme Court of Canada); and *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 (Supreme Court of Canada) para. 123.
- <sup>40</sup> *McCann v. Fraser Regional Correctional Centre*, [2000] B.C.J. No. 559, para. 15.
- <sup>41</sup> *PHS Community Services Society* (supra), paras. 144–145.
- <sup>42</sup> *Singh v. Minister of Employment*, [1985] 1 S.C.R. 177.
- <sup>43</sup> *Collin v. Lussier*, [1983] 1 F.C. 218 (Federal Court Trial Division), p. 239.
- <sup>44</sup> See, for example, studies cited in footnote 132 of S. Chu and R. Elliott, *Clean Switch* (supra).
- <sup>45</sup> See, for example, outbreaks described on pp. 3–4 of S. Chu and R. Elliott, *Clean Switch* (supra).
- <sup>46</sup> *Operation Dismantle v. R.*, [1985] 1 S.C.R. 441 (Supreme Court of Canada), para. 102.
- <sup>47</sup> *R. v. Parker* (2000), 49 O.R. (3d) 481, para. 97.
- <sup>48</sup> *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, [2005] F.C.J. No. 1470, para. 86.
- <sup>49</sup> *PHS Community Services Society* (supra), para. 142.
- <sup>50</sup> *Ibid.*
- <sup>51</sup> *Rodriguez* (supra), para. 141.
- <sup>52</sup> *Chaoulli* (supra), para. 130.
- <sup>53</sup> See, for example, *Rodriguez* (supra) and *R. v. Ruzic*, [2001] 1 S.C.R. 687 (Supreme Court of Canada).
- <sup>54</sup> R. Lines, *Prison Needle Exchange* (supra), pp. 44–52.
- <sup>55</sup> *Chaoulli* (supra), para. 133.
- <sup>56</sup> *R. v. Kapp*, 2008 S.C.C. 4.
- <sup>57</sup> *Ibid.*, para. 17. See also, *Ermineskin Indian Band and Nation v. Canada*, 2009 S.C.C. 9 (Supreme Court of Canada), para. 188.
- <sup>58</sup> *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203, para. 13.
- <sup>59</sup> *Ibid.*, para. 60.
- <sup>60</sup> *Sauvé v. Canada (Chief Electoral Officer)*, [2002] 3 S.C.R. 519, paras. 189–206. The specific Section 15 issue was not addressed by the majority, which decided the case on other grounds; the minority was in dissent on those grounds.
- <sup>61</sup> See cases cited in the dissenting opinion written by Justice Gonthier in *Sauvé*, *ibid.*, para. 193.
- <sup>62</sup> *Ibid.*, para. 195.
- <sup>63</sup> *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, para. 110.
- <sup>64</sup> *Ibid.*, paras. 93–94.
- <sup>65</sup> D. Robinson et al, *A One-Day Snapshot of Inmates in Canada's Adult Correctional Facilities*, Canadian Centre for Justice Statistics, 1998, p. 5. See also, Anonymous, "A Health Care Needs Assessment of Federal Inmates in Canada," *Canadian Journal of Public Health* 95 (2004): S12–S18.
- <sup>66</sup> S. Galea and D. Vlahov, "Social determinants and the health of drug users: socioeconomic status, homelessness and incarceration," *Public Health Reports* 117 (Supp.1) (2002): 135–145; A. Palepu et al, "The social determinants of emergency department and hospital use by injection drug users in Canada," *Journal of Urban Health* 76(4) (1999): 409–18; R. Room, "Stigma, social inequality and alcohol and drug use," *Drug and Alcohol Review* 2 (2005): 143–155; and Canadian Association of Social Workers, *The Declining Health and Well-Being of Low Income Women in Canada*, 2006.
- <sup>67</sup> In 2006–2007, Aboriginal people represented approximately 17 percent of people incarcerated in federal prisons but less than three percent of the adult population in Canada: Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, 2007, p. 57. This ratio is even more disproportionate for Aboriginal women in federal prisons, who comprise 28 percent of female prisoners: CSC, *Basic Facts about the Correctional Service of Canada*, 2005.
- <sup>68</sup> *Sauvé* (supra), para. 60.
- <sup>69</sup> National HIV estimates indicate that 53 percent of all new HIV infections among Aboriginal people in 2005 were attributable to injection drug use, a proportion considerably higher than the 14 percent of overall new HIV infections in this category: PHAC, *HIV/AIDS Epi Updates*, November 2007, p. 74.
- <sup>70</sup> M. Daigle, "Mental health and suicide prevention services for Canadian prisoners," *International Journal of Prisoner Health* 3(2) (2007): 163–171 at 164.
- <sup>71</sup> CSC, *Changing Offender Population: Quick Facts*, 2007.
- <sup>72</sup> Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, 2007, p. 55.
- <sup>73</sup> *Ibid.*
- <sup>74</sup> PHAC, *Atlantic Region: Environmental Scan of Injection Related Drug Use, Related Infectious Diseases, High Risk Behaviours, and Relevant Programming in Atlantic Canada*, 2006, p. 39.
- <sup>75</sup> *Ibid.*, pp. 38–39.
- <sup>76</sup> PHAC, *HIV/AIDS: Populations at Risk*, 2006. A subsequent report by the CSC Review Panel states, "About 4 out of 5 offenders arrive with a serious substance abuse problem, with 1 out of 2 having committed their crime while under the influence": *A Roadmap to Strengthening Public Safety*, Report of the CSC Review Panel, 2007, p. v.
- <sup>77</sup> Under the *Canadian Human Rights Act*, for example, disability is defined as including previous or existing dependence on alcohol or a drug: *Canadian Human Rights Act*, R.S.C. 1985, c. H-6, s. 25. See also, *Employment Equity Act*, S.C. 1995, c. 44, in conjunction with Human Resources Development Canada, *Defining Disability: A Complex Issue*, 2003, p. 16; *Human Rights Act* (Nova Scotia), R.S.N.S. 1989, c. 214, s. 3(1)(vii); and *Human Rights Act* (Nunavut), S.Nu. 2003, c. 12, s. 1.
- <sup>78</sup> See, for example, cases cited in footnote 227 of S. Chu and R. Elliott, *Clean Switch* (supra).
- <sup>79</sup> R. Lines, *Prison Needle Exchange* (supra), p. 9.
- <sup>80</sup> J. Csete, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs*, Canadian HIV/AIDS Legal Network, 2007, pp. 36–37; and S. Boyd and K. Faith, "Women, illegal drugs and prison: views from Canada," *International Journal of Drug Policy* 10 (1999): 195–207 at 199.
- <sup>81</sup> CHRC, *Protecting Their Rights* (supra), p. 7, citing Auditor General of Canada, *Correctional Services Canada — Reintegration of Women Offenders*, Public Works and Government Services Canada, 2003, para. 4.23.
- <sup>82</sup> A. DiCenso et al, *Unlocking Our Futures: A National Study on Women, Prisons, HIV and Hepatitis C*, Prisoners' HIV/AIDS Support Action Network (PASAN), 2003.
- <sup>83</sup> PHAC, *Final Report: Estimating the Number of Persons Co-Infected with Hepatitis C Virus and Human Immunodeficiency Virus in Canada*, 2001.
- <sup>84</sup> See, for example, studies cited in footnote 233 of S. Chu and R. Elliott, *Clean Switch* (supra).
- <sup>85</sup> CHRC, *Protecting Their Rights* (supra), p. 37.
- <sup>86</sup> See, for example, *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 (Supreme Court of Canada), para. 73; and *Halpern v. Canada (Attorney General)* (2003), 65 O.R. (3d) 161 (Ontario Court of Appeal).
- <sup>87</sup> See *Sauvé* (supra), para. 60; and Minister of Supply and Services Canada, *Report of the Royal Commission on Aboriginal Peoples*, 1996.
- <sup>88</sup> See, for example, CI, *Annual Report of the Office of the Correctional Investigator 2006–2007* (supra) (regarding the need to build mental health-care capacity in federal prisons).
- <sup>89</sup> See J. Csete, "Vectors, Vessels and Victims": *HIV/AIDS and Women's Human Rights in Canada*, Canadian HIV/AIDS Legal Network, 2005, p. 36; and PHAC, *Final Report* (supra).
- <sup>90</sup> K. Blankenship and S. Koester, "Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users," *Journal of Law, Medicine and Ethics* 30(4) (2002): 548–559 at 553; PHAC, *Resource Library: Hepatitis C Information for Health Professionals*, undated; R. Room, "Stigma..." (supra).
- <sup>91</sup> E. Ritson, "Alcohol, drugs and stigma," *International Journal of Clinical Practice* 53(7) (1999): 549–551; P. Ford and W. Wobeser, "Health care problems in prisons," *Canadian Medical Association Journal* 162(5) (2000): 664–665; P. Ford et al, "HIV, hepatitis C and risk behaviour in a Canadian medium-security penitentiary," *QJM: An International Journal of Medicine* 93 (2000): 113–119.
- <sup>92</sup> S. Hartwell, "Triple stigma: persons with mental illness and substance abuse problems in the criminal justice system," *Criminal Justice Policy Review* 15(1) (2004): 84–99.
- <sup>93</sup> F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues,

F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *Reducing the Harm Associated with Injection Drug Use in Canada*, 2001, p. 2.

<sup>94</sup> See, for example, N. La Vigne et al, *Voices of Experience: Focus Group Findings on Prisoner Reentry in the State of Rhode Island*, Urban Institute Justice Policy Center, 2004, pp. 13, 18, 33, 39, 48 and 51; D. Pager, "The mark of a criminal record," *American Journal of Sociology* 108(5) (2003): 937-975; and R. Small, *The Importance of Employment to Offender Re-Integration*, FORUM on Corrections Research, CSC, undated.

<sup>95</sup> See, for example, cases cited on pp. 32–33 of S. Chu and R. Elliott, *Clean Switch* (supra).

<sup>96</sup> See *R. v. Downey*, (1989) 42 C.R.R. 286 (Ontario District Court).

<sup>97</sup> *R. v. Smith*, [1987] 1 S.C.R. 1045 (Supreme Court of Canada), para. 112.

<sup>98</sup> *R. v. Goltz* [1991] 3 S.C.R. 485; *R. v. Morrissey*, [2000] 2 S.C.R. 90.

<sup>99</sup> See, for example, *Goltz*, *ibid.*; and *Morrissey*, *ibid.*, paras. 27–28; and *R. v. Wiles*, [2005] 3 S.C.R. 895 (Supreme Court of Canada), para. 5.

<sup>100</sup> While it may be slightly artificial to group the Section 1 arguments and analyses for violations of Sections 7, 15 and 12 together, many of the arguments under each rights violation overlap. Section 1 justifications of Section 7 violations may have a higher threshold, in part because much of the Section 1 analysis occurs during a consideration of Section 7.

<sup>101</sup> *R. v. Oakes*, [1986] 1 S.C.R. 103. See also, *R. v. Edward Books and Art*, [1986] 2 S.C.R. 713 (Supreme Court of

Canada); *Dagenais v. CBC*, [1994] 3 S.C.R. 835 (Supreme Court of Canada); and *Thompson Newspaper Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877 (Supreme Court of Canada).

<sup>102</sup> See, for example, Public Safety and Emergency Preparedness Canada, *Corrections Fast Facts 2: Drugs in Prisons*, undated.

<sup>103</sup> See, for example, studies cited in footnotes 284–285 of S. Chu and R. Elliott, *Clean Switch* (supra).

<sup>104</sup> CSC, *Commissioner's Directive 821-2: Bleach Distribution*, 2004, s. 7.

<sup>105</sup> R. Lines, *Prison Needle Exchange* (supra), p. 50.

<sup>106</sup> *Ibid.*, p. 51.

<sup>107</sup> CCRA, s. 4(d).

# 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 Cécile Kazatchkine (ckazatchkine@aidslaw.ca), policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, the articles for this issue were written by Ms Kazatchkine.

## Quebec's funding cut endangers study on alternative treatment for people addicted to heroin

In August 2009, the Quebec government decided to cut \$600,000 in funding from a study on alternative treatment for drug users suffering from chronic opiate addiction despite the publication, at the same time, of promising results of the first phase of the trial.<sup>1</sup> The decision could endanger the research project.

The Study to Assess Longer-Term Opioid Medication Effectiveness (SALOME), a three-year project, involves testing whether hydromorphone (trade name "Dilaudid"), an opiate licensed for the relief of pain, would be as effective as heroin-assisted therapy in benefiting people

who suffer from chronic opiate addiction and who are not benefiting sufficiently from other treatment. The study is also designed to test if people who have been effectively treated with injectable medications can be successfully switched to orally administered formulations of

the same medications in order to cut needle risks.<sup>2</sup>

The research project, which is unique in the world, is the logical follow-up to a previous study called NAOMI (North American Opiate Medication Initiative), the results of which suggested that heroin-assisted

therapy is a safe and effective alternative treatment because it keeps patients in treatment, improves their health and reduces illegal activity.<sup>3</sup>

Ten percent of the NAOMI participants received hydromorphone instead of heroin on a double-blind basis (neither they nor the researchers were told which drug they were getting). It was observed (a) that the participants did not distinguish hydromorphone from heroin; and (b) that hydromorphone appeared to provide similar results and benefits as heroin.<sup>4</sup> However, the study was not designed to test this conclusively, and this is why the SALOME project was a necessary next step.

If the study, which was supposed to take place in Vancouver as well as in Montreal, were to prove that hydromorphone is as effective as heroin, it would demonstrate the value of a legal and less politically contentious alternative treatment for the most chronically drug-dependant peo-

ple who are not benefiting from other treatment (such as methadone therapy or abstinence-based programs).

However, the decision of the Quebec government seriously jeopardizes the implementation of the research project because the \$600,000 grant was dedicated to the functioning of the clinic in Montreal that would help to carry out the study. The decision is all the more worrying because it could lead to the loss of funding for the trial from the Canadian Institutes for Health and Research, amounting to \$1 million for three years, which would have been shared between the Montreal and Vancouver researchers.<sup>5</sup>

Harold Fortin, press secretary for Quebec Health and Social Services Minister Lise Thériault, said that the funds were withdrawn as part of a cost-cutting exercise because it was felt that the money would be better spent funding treatment for a wider range of people.<sup>6</sup>

According to Martin Schechter, NAOMI lead investigator, it costs \$7,500 a year to treat an addict under the NAOMI and SALOME models, whereas health and legal-system costs for addicts in general are about \$50,000 a year.<sup>7</sup>

<sup>1</sup> A. M. Paperny, "Quebec's landmark heroin study in jeopardy," *The Globe and Mail* (online), 25 August 2009.

<sup>2</sup> *Salome Clinical Trial Questions and Answers*, p. 2, online: [www.naomistudy.ca/documents.html](http://www.naomistudy.ca/documents.html).

<sup>3</sup> A. Symington, "Results of the first North American prescription heroin study are promising," *HIV/AIDS Policy and Law Review* 13(2/3) (2008): 11–12; NAOMI, "Results show that North America's first heroin therapy study keeps patients in treatment, improves their health and reduces illegal activity," news release, Vancouver, B.C., 17 October 2008.

<sup>4</sup> *Salome* (supra), pp. 2–3; M. Bélair-Cirino, "Recherche — SALOME se fait couper les vivres," *Le Devoir* (online), 20 August 2009.

<sup>5</sup> *Ibid.*

<sup>6</sup> A. M. Paperny (supra).

<sup>7</sup> E. O'Connor and E. Baron, "When all else fails, there's free heroin; bold experiment seeks ways to stabilize addicts' lives," *The (Vancouver) Province* (online), 8 July 2009.

## Constitutionality of gay blood donor ban challenged in court

**Kyle Freeman, a gay Canadian man, is challenging in the Ontario Superior Court of Justice the constitutionality of the Canadian Blood Services' (CBS') lifetime ban on men who have sex with men (MSM). He claims that the questionnaire used by the agency to screen out unsuitable donors violates his equality rights<sup>1</sup> under the Canadian Charter of Rights and Freedoms (Charter).<sup>2</sup>**

His legal action is a countersuit launched after the CBS sued him for negligent misrepresentation for

lying on the screen form. Freeman, who knew he was HIV-negative, had repeatedly donated blood between

1990 and June 2002, hiding the fact that he had sex with men. Freeman claims that he was entitled to hide

the information because the question asked by the agency was unlawful.<sup>3</sup>

The controversial question reads as follow: "Have you had sex with a man, even one time, since 1977?"<sup>4</sup> Currently, if prospective donors respond "Yes" to this question, they are banned for life from donating blood.<sup>5</sup>

According to the Canadian AIDS Society (CAS), which will appear as a "friend of the court" in the Freeman case, the wording of the questionnaire endorsed by the Canadian government is based on sexual orientation and is discriminatory towards MSM. CAS notes that a ban of only one year is imposed on any woman who said that she had sex with a bisexual man in the previous 12 months. Moreover, CAS said, such discrimination is no longer justified for reasons of safety and, therefore, constitutes a violation of the equality rights in the Charter.<sup>6</sup>

CAS said that the suit provides an opportunity to "propose an amendment to update the CBS' screening questionnaire, with a desire to improve safety and gain community support for the Canadian Blood System" by focusing on risk behaviour rather than risk groups.<sup>7</sup>

According to Douglas Elliott, the CAS lawyer:

The current discriminatory wording of the screening questionnaire needs to be updated. With new, highly accurate HIV testing, it is no longer scientific, as American blood banks have acknowledged with respect to their own similar policy. It's eroding confidence in the blood system, and turns away many youth and gay men who are not at risk of HIV at a time when Canada's blood supply is in need of donors....

The questionnaire is not scientifically valid, which compromises the safety

of the system by encouraging self-screening and inciting boycotts on blood donation based on human rights principles.<sup>8</sup>

CAS suggests narrowing the blood donor ban by developing questions that are equally effective in protecting safety and respecting equality rights. CAS suggests that the CBS ask the following question of prospective male donors: "Have you had sex with another man in the past five years?" If the donor says "No," he would be treated like any other donor. If he says "Yes," he would respond to a further question, as follows: "Have you had unprotected anal sex (i.e., without a condom) with more than one male partner in the last 12 months. If the donor response "Yes," he would receive a 12-months deferral (i.e., ban). If he says "No," he would receive a six-month deferral.<sup>9</sup>

To justify its position, the CBS argues that "it is critical to patient and donor safety that potential donors are truthful in their responses on the questionnaire."<sup>10</sup> They have a duty to tell the truth whether or not they sincerely believe that questions are necessary or justified or even discriminatory.<sup>11</sup>

Furthermore, the CBS says that it has reviewed its deferral policy for MSM, and that it concluded that since tests to detect HIV in the blood are not 100 percent accurate, and because there is a much higher prevalence of HIV among MSM than in the general population, the current policy is justified to ensure the security of blood donations.<sup>12</sup>

The CBS also says that many individuals and groups are not eligible to give blood, "all based on behaviours and circumstances known

to increase risk."<sup>13</sup> However, as Mr. Freeman pointed out, the CBS does not ask all donors whether they had had unprotected sex in the last three to six months, which corresponds to the "window period" where an HIV test might not detect the presence of the virus.<sup>14</sup>

Currently, blood services in Australia, Japan, Argentina and Hungary have one-year deferral policies for MSM. There are no restrictions on MSM giving blood in Italy, Spain and Russia. Regulations in the U.S, as well as in the U.K. and France require the indefinite deferral of men who have had sex with men even once since 1977.<sup>15</sup>

The hearings in the Freeman Case began in September 2009 and the judgment is expected in early 2010.

*[Editor's note: A similar case occurred recently in Australia. See the Courts — International section of this issue.]*

<sup>1</sup> A. Seymour, "Gay man battles blood agency; donor who lied about sexual past says screening violates his Charter rights," *The Ottawa Citizen* (online), 29 September 2009.

<sup>2</sup> Section 15(1) of the *Canadian Charter of Rights and Freedom*, 1982 reads as follows: "Every individual is equal before and under the law and has the right to the equal protection of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

<sup>3</sup> R. D. Elliott, "Let's change the question; in 1985 it was necessary to exclude all gay men from giving blood — that is no longer the case," *The Ottawa Citizen* (online), 3 October 2009.

<sup>4</sup> CBS, *Donor Questionnaire*, online: www.bloodservices.ca.

<sup>5</sup> CAS, "Canadian AIDS Society proposes solution to update and enhance the safety of Canada's blood screening survey," news release, Ottawa, Ontario, 27 September 2009.

<sup>6</sup> *Ibid.*; R. D. Elliott (*supra*).

<sup>7</sup> CAS (*supra*).

<sup>8</sup> *Ibid.*

<sup>9</sup> *Ibid.*

<sup>10</sup> CBS, "Canadian Blood Services defends charter rights claim on MSM policy," online: [www.bloodservices.ca](http://www.bloodservices.ca) (look under "Hot Topics").

<sup>11</sup> A. Seymour (*supra*).

<sup>12</sup> CBS, *Questions and Answers MSM Policy Decision*, online: [www.bloodservices.ca](http://www.bloodservices.ca) (follow the links in Note 10).

<sup>13</sup> CBS, "Canadian Blood Services defends..." (*supra*).

<sup>14</sup> A. Seymour (*supra*).

<sup>15</sup> CAS (*supra*); CBS, *Questions and Answers...* (*supra*).

## In brief

### Report: Cancelled prison tattoo initiative had potential to reduce disease transmission

Despite the possible positive outcomes reported in a draft evaluation,<sup>1</sup> the Federal Government decided in September 2006<sup>2</sup> to cancel the Pilot Safer Tattooing Practices Initiative (STPI) that had been launched in August 2005 in six federal prisons.

This sudden decision was strongly condemned by human rights advocates, including the Canadian HIV/AIDS Legal Network, which claimed that shutting down the STPI was "fiscally irresponsible and a threat to public health and human rights."<sup>3</sup>

In April 2009, the final report of the STPI's evaluation conducted by the Correctional Service of Canada (CSC) was finally released<sup>4</sup> — more than two years after the government's decision to terminate the program. The report confirmed that the initiative (a) was cost-effective; (b) was successful in raising awareness regarding blood-borne infectious disease prevention and control practices; and (c) had the potential to reduce the risk of disease transmission.<sup>5</sup>

According to the report, the STPI was also consistent with the goals and objectives of the Federal Initiative to Address HIV/AIDS in Canada.<sup>6</sup> Moreover, although the correctional officers union had raised objections to the program,<sup>7</sup> the report stated that about two-thirds of the surveyed staff members indicated that they felt the initiative made the institution safer for both staff members and inmates.<sup>8</sup>

The report said that a large majority of inmates indicated that they would prefer to receive a tattoo through the safe and controlled environment created via the STPI.<sup>9</sup>

Christopher McCluskey, a spokesman of the Public Safety Minister Peter Van Loan, declared that the government had no plan to reverse its decision and resurrect the initiative.<sup>10</sup>

### Municipal support on Vancouver Island for access to crack pipe kits

In July 2009, Victoria City Council agreed to support the distribution of crack pipes kits in the city, but only on a pilot basis.<sup>11</sup> Crack pipes kits including mouthpieces and push

sticks will be distributed in order to decrease harms associated with crack use, including chronic cuts, burns, open sores on lips and the subsequent risk of acquiring diseases like hepatitis C, tuberculosis and HIV.<sup>12</sup>

The project will be overseen by the Vancouver Island Health Authority (VIHA) and implemented through the city's needle exchanges.<sup>13</sup>

The VIHA is also approaching other municipalities. A similar initiative was unanimously approved by the City Council of Courtenay in September 2009, but was rejected by the City of Nanaimo,<sup>14</sup> where a similar program was suspended in 2007 after a community backlash.<sup>15</sup>

To date, crack pipes kits have been distributed in several cities in Canada including Vancouver, Edmonton, Calgary, Winnipeg, Montreal, Guelph, Yellowknife, Ottawa, Toronto and Halifax.<sup>16</sup>

### Rapid, free and anonymous HIV testing for gay and bisexual men in Montreal

SPOT, a project offering rapid, free and anonymous HIV testing to gay

and bisexual men began in a community venue in Montreal's Gay village in July 2009, and was recently launched in three clinics.<sup>17</sup>

The three-year pilot project is a joint initiative by researchers and community organizations designed to increase HIV testing and reduce the spread of HIV. The project focuses essentially on gay and bisexual men because it is the most at-risk population for HIV in Montreal.<sup>18</sup>

Rapid HIV testing, considered to be more than 99 percent accurate, only requires drops of blood using a finger prick and can produce results within five minutes, while standard HIV testing usually require waiting three weeks to obtain results. However, the rapid test costs about ten times more than the standard test (\$10 vs. \$1), and is therefore rarely available.<sup>19</sup>

SPOT is funded by the Canadian Institutes of Health Research and the *Fonds de la recherche en santé du Québec*.<sup>20</sup> It also benefits from the collaboration of the HIV test manufacturer which agreed to provide screening kits at a fraction of the original cost.<sup>21</sup>

Pre and post-test counselling will be done by volunteers from the community as well as nurses and clinicians.<sup>22</sup> Researchers expect to complete 4000 tests by 31 December 2010.<sup>23</sup>

<sup>1</sup> G. Betteridge, "Draft evaluation suggests pilot safer tattooing program had potential to reduce disease transmission," *HIV/AIDS Policy & Law Review* 12(1) (2007): 19–20.

<sup>2</sup> G. Betteridge, "CSC closes safer tattoo pilot sites," *HIV/AIDS Policy & Law Review* 11(2/3) (2006): 28.

<sup>3</sup> Canadian HIV/AIDS Legal Network, "Prison tattoo closure irresponsible, says Legal Network," news release, Toronto, Ontario, 4 December 2006; R. Elliott, "Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons," *Canadian Medical Association Journal* 177(3) (2007): 262–264.

<sup>4</sup> CSC, *Evaluation Report: Correction Service Canada's Safer Tattooing Practices Pilot Initiative*, Evaluation Branch, Performance Assurance Sector, January 2009.

<sup>5</sup> *Ibid.*, pp. viii and 26.

<sup>6</sup> *Ibid.*, pp. viii and 43–46.

<sup>7</sup> K. Harris, "Prisons tattoo program cuts risk of HIV: report," (*Grande Prairie, Alberta*) *Daily Herald-Tribune* (online), April 2009.

<sup>8</sup> CSC (supra), p. 31.

<sup>9</sup> *Ibid.*, p.32.

<sup>10</sup> K. Harris (supra).

<sup>11</sup> "Victoria addicts to get free crack-pipe parts; drug kit includes mouthpiece intended to reduce spread of HIV, hepatitis C," *CBC News* (online), 10 July 2009; J. Lavoie, "City to give away crack-pipe kits; harm reduction approach aims to cut incidence of hepatitis and other diseases," (*Victoria*) *Times Colonist* (online), 25 September 2009.

<sup>12</sup> *Ibid.*

<sup>13</sup> "Victoria addicts..." (supra).

<sup>14</sup> *Ibid.*; P. Round, "Unanimous support for free crack pipes plan," *Canada.com* (online), 22 September 2009.

<sup>15</sup> "Victoria addicts..." (supra); J. Lavoie (supra).

<sup>16</sup> "Victoria addicts..." (supra); Canadian HIV/AIDS Legal Network, *Distributing Safer Crack Use Kits in Canada: Questions and Answers*, 2008.

<sup>17</sup> E. Hale and E. Doryan, "Free HIV testing in the Village; projects target population hit hardest by HIV: men who sleep with men," *The McGill Daily* (online), 24 September 2009; P. Gravel, "Dépistage du VIH — Gratuit, anonyme et rapide," *Le Devoir* (online), 17 September 2009. See also, information available at [www.spottestmontreal.com/En/depistage.aspx](http://www.spottestmontreal.com/En/depistage.aspx).

<sup>18</sup> E. Hale and E. Doryan (supra). Men who have sex with men made up 61.2 percent of new HIV cases in 2007 in Quebec; recent studies in Montreal have shown that 50 percent of new HIV transmissions occur from newly infected persons who are largely unaware of their HIV-positive status: [www.spottestmontreal.com/En/depistage.aspx](http://www.spottestmontreal.com/En/depistage.aspx).

<sup>19</sup> C. Fildelman, "HIV test provides results in 5 minutes; researchers team up with storefront clinics in the city's Gay Village as part of health project," *The (Montreal) Gazette*, 17 September 2009.

<sup>20</sup> P. Gravel (supra).

<sup>21</sup> C. Fildelman (supra).

<sup>22</sup> *Ibid.*; P. Gravel (supra).

<sup>23</sup> C. Fildelman (supra).

# 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 Leah Utyasheva ([lutyasheva@aidslaw.ca](mailto:lutyasheva@aidslaw.ca)), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, Ms Utyasheva wrote the articles in this section.

## Mexico decriminalizes small-scale drug possession

On 20 August 2009, the Mexican government adopted legislation decriminalizing possession of small amounts of drugs. According to the new law, possession amounts for “personal and immediate use” — defined as up to half a gram of cocaine, five grams of marijuana, 50 milligrams of heroin, 40 milligrams of methamphetamine and 0.015 milligrams of LSD — will not lead to criminal prosecution.<sup>1</sup>

According to the law, people found with drugs up to the amounts for personal and immediate use will be encouraged to seek treatment instead.

Those caught with drugs for a third time will be referred to mandatory treatment programs. However, the law does not specify penalties for

noncompliance with treatment programs.<sup>2</sup>

Under the previous law, possession of any amount of drugs was

punishable by prison sentence, but there was leeway for dependent people caught with small amounts. According to Bernardo Espino del Castillo, Coordinator of state offices for the Attorney General's office, in practice nobody was prosecuted and sentenced to imprisonment for small time possession.<sup>3</sup>

Thus, the new legislation simply recognizes the existing practice of not prosecuting people found with small amounts of drugs while, at the same time, setting rules and limits.<sup>4</sup> Additionally, the decision to decriminalize removed the discretion of whether to expose drug users to a potential jail sentence away from police.<sup>5</sup>

The new law was adopted to reduce drug demand by treating dependent people as potential treatment patients rather than criminals, to fight corruption among the police, and to concentrate resources on organized crime.<sup>6</sup> One of the reasons for this change is allegedly the current upsurge in drug-related violence in Mexico: There have been more than 11 000 deaths since December 2006.<sup>7</sup>

According to observers, in 2006 a similar Mexican initiative provoked controversy, passed in the Parliament, but was rejected by the President at the time, Vicente Fox, allegedly after the U.S. publicly criticized the initiative.<sup>8</sup>

The Mexican reform is based on the Portuguese model. In 2001, Portugal decriminalized all drugs for personal use. Drug possession is still prohibited in Portugal, but is deemed to be violation of administrative law. According to a recent report, this new policy has proved to be successful, particularly in reducing the spread of HIV and exposure to drugs among teenagers.<sup>9</sup>

### Commentary

Mexico's move towards adoption of a sensible and evidence-based drug policy is a welcome development. Increasingly, more and more countries are realizing the futility of the "war on drugs" and are making changes to their prohibitionist approaches to public health-oriented policy.

Brazil decriminalized possession for personal use in 2004. In recent months, courts in two Latin American countries moved their countries towards decriminalization of possession of small amounts of drugs: (1) Argentina's Supreme Court ruled it unconstitutional to prosecute cases involving the possession of drugs for personal consumption; and (2) a Colombian court ruled that possession of illegal drugs for personal use is not a criminal offence.<sup>10</sup> According to reports, Argentina is preparing to discuss a legislative proposal to

decriminalize possession of small quantities of drugs for personal use.<sup>11</sup>

See more on the court judgments in Argentina and Colombia in the "Courts — International" section of this issue.

<sup>1</sup> M. Stevenson, "Mexico decriminalizes small-scale drug possession," *The Washington Post*, 20 August 2009.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> M. Lacey, "In the streets of Mexico: ambivalence on a drug law," *The New York Times*, 4 August 2009.

<sup>6</sup> C. Cosh, "Going their own way: while the US turns a blind eye, its 'partner' states are quietly decriminalizing illicit drugs," *National Post*, 28 August 2009.

<sup>7</sup> M. Lacey (supra).

<sup>8</sup> J. Ferry, "Legalization the only way to win the drug war: attitudes shift with Mexico's choice to decriminalize pot," *The (Vancouver) Province*, 26 August 2009.

<sup>9</sup> G. Greenwald, *Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies*, White Paper, Cato Institute, 2009.

<sup>10</sup> "Colombian court rules against criminalization of personal consumption," *Latin American Herald Tribune*, 10 September 2009.

<sup>11</sup> M. Jelsma, "Stepping away from the darkness," *Newsweek Argentina*, 27 August 2009.

# Burundi: New Penal Code criminalizes homosexuality

**Burundi has become the latest African nation to outlaw homosexuality.<sup>1</sup>  
A law amending the *Penal Code* became effective in April 2009.**

The law first passed the National Assembly in November 2008, but was rejected by the Senate in February 2009, amid international pressure. The National Assembly, however, refused to accept the Senate's rejection of the bill.

With this law, consensual same-sex sexual conduct becomes illegal for the first time in Burundi's history. According to the law, "Whoever has sexual relations with a person of the same sex is punished by a prison sentence of 3 months to 2 years and a fine of 50,000 to 100,000 francs (US \$40–80), or one of these penalties."<sup>2</sup>

Burundi President Pierre Nkurunziza personally led the charge to get the law passed, including organizing an anti-gay march in Bujumbura following the Senate's rejection of the law by busing in protesters from rural areas, and by lobbying individual legislators for the April 2009 passage.<sup>3</sup>

The international reaction to this development has been critical. "We consider the law to violate the rights to privacy and freedom from discrimination protected by Burundi's Constitution and enshrined in its international treaty commitments," Human Rights Watch (HRW) and 62 Burundian, African, and international human rights organizations said in a joint statement issued on 24 April 2009.<sup>4</sup>

"We deeply regret that the Burundian government has made a decision that writes human rights

violations into law," the statement added. "We regret that the law will hamper Burundi's attempts to fight AIDS, by further marginalizing an at-risk population." The signatories to the joint statement have pledged to monitor carefully any arrests made on the basis of the new law.

Amnesty International voiced concern that the provision could result in the imprisonment of people solely for their actual or imputed sexual orientation, including private sexual relations between consenting adults.<sup>5</sup> Health organizations said that the new law may also limit the effectiveness of their work to curb HIV/AIDS in Burundi. They stated that the amendment undermines attempts to ensure that people have access to voluntary counselling and testing, access to information about prevention of infection, and access to treatment where needed.<sup>6</sup>

Boris Dittrich, advocacy director of the Lesbian, Gay, Bisexual, and Transgender Rights Program at HRW, which actively opposed the law's passage, said that his group has not given up its efforts to rescind the criminalization of homosexuals in Burundi. HRW is hopeful that the international backlash Burundi received for its actions will pressure the government to modify the law after the 2010 elections.<sup>7</sup>

Interviews conducted by HRW since the passing of the new law have documented the increasing difficulties

of being a gay or lesbian in Burundi, including instances of sexual violence, family rejection, police intimidation, and now the daily danger of imprisonment.<sup>8</sup>

The group says that like similar trends that are happening globally, there is a growing tolerance among Burundi's youth for gays and lesbians (though mostly limited to its capital city of Bujumbura), while older generations are much more likely to consider it taboo.<sup>9</sup>

According to the International Lesbian and Gay Association, as of May 2009, 80 countries have laws prohibiting same sex activity between consenting adults, many of them in Africa.<sup>10</sup>

– Grace Wang

Grace Wang (graceyqw@gmail.com) is an articling student at Carranza Barristers & Solicitors in Toronto.

<sup>1</sup> "Rights groups slam Burundi law criminalizing gays," *Associated Free Press*, 25 April 2009.

<sup>2</sup> "Petition from Burundian and international human rights NGOs on the criminalization of homosexuality in Burundi," *HRW*, 24 April 2009.

<sup>3</sup> A. Boswell, "Burundian homosexuals suffer under new anti-gay law," *VOAnews.com*, 3 August 2009.

<sup>4</sup> "Petition..." (supra).

<sup>5</sup> "Burundi criminalizes homosexuality," *365 Gay*, 27 April 2009.

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

<sup>7</sup> *Ibid.*

<sup>8</sup> A. Boswell (supra).

<sup>9</sup> *Ibid.*

<sup>10</sup> D. Ottosson, *State-Sponsored Homophobia: A World Survey of Law Prohibiting Same Sex Activity Between Consenting Adults*, International Lesbian and Gay Association, 2009.

## Uzbekistan: Government discontinues pilot opiate substitution therapy program

**In this decade, with support from the international community, most countries of the former Soviet Union introduced opiate substitution therapy (OST) programs, using methadone or buprenorphine, in order to curb the spread of HIV and to introduce more efficient drug dependence treatment options. However, the development is uneven: While some countries have expanded their pilot projects, others have not gone beyond the pilot stage. One Central Asian country — Uzbekistan — has recently closed its pilot OST project.**

Aiming to prevent HIV infection among injecting drug users, the Uzbek Ministry of Health has studied international OST experience in the framework of joint projects with U.N. agencies and countries such as India, Switzerland and Lithuania.<sup>1</sup> OST was considered as part of the response, facilitated by the fact that the country's *Law on Narcotic Drugs and Psychotropic Substances* (Narcotics Law) does not prohibit the use of methadone or buprenorphine.<sup>2</sup>

The legislative framework was established in 2003, with the decision of the State Commission for Drug Control approving a pilot OST program, and the issuance of guidance on OST by the Ministry of Health.<sup>3</sup> The pilot treatment program started in 2006 in the country's capital, Tashkent, with buprenorphine, and was later extended to include methadone. The initial financial support was provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2007, the Ministry of Health was ordered to allocate funding to procure medical opioids from the state budget.<sup>4</sup>

In 2008, there were 140 participants in the program, with many others on a waiting list.<sup>5</sup> Since 2006,

almost 350 drug users took part in the program.<sup>6</sup>

Although OST is legal in Uzbekistan, the program's organizers faced difficulties when disseminating information about it, because the Narcotics Law prohibits "propaganda" of drug use.<sup>7</sup> Nevertheless, the results of the pilot project were encouraging: Almost 160 clients obtained employment; 60 improved their family situation; and many improved their psychosocial condition.<sup>8</sup>

However, in spite of earlier plans to mainstream OST into healthcare and to replicate the program in other parts of the country, in June of 2009 the Ministry of Health unexpectedly ended the pilot project — without consultation with international agencies, civil society or patients.

According to patients' testimonials, they were not provided with medical follow up or alternative treatment options. This has since contributed to increased criminal behaviour among the former patients, some of whom have been arrested.<sup>9</sup>

According to observers, the decision to close the program may have been caused by problems identified through evaluations. Allegedly, there

was evidence of unauthorised diversion of controlled substances to the black market. In addition, a lack of qualified personnel and overall support for OST in society were observed.<sup>10</sup> Rather than improve the quality of health care by educating health care personnel, and tighten the control over incidents of diversion, the Government decided to end the program altogether.

As well, according to anecdotal evidence, the use of OST may have been seen by the police and some policymakers as "incompatible with national traditions."<sup>11</sup>

As of 2008, there were an estimated 15 831 people infected with HIV in Uzbekistan, among whom 7373 (47 percent) were injecting drug users.<sup>12</sup> In recent years, the number of people living with HIV in the country has increased dramatically: Between 2000 and 2003, the annual number of new HIV infections grew 16-fold.<sup>13</sup> Until 1999, HIV was transmitted mostly sexually (98 percent of all cases) but, starting in 1999, HIV infections attributed to injection drug use became the predominant mode of transmission (80 percent of new infections in 1999, and 66 percent in 2006).<sup>14</sup> It is estimated that

Uzbekistan has approximately 80 000 injecting drug users.<sup>15</sup>

## Commentary

OST is a proven and evidence-based method of drug dependence treatment and HIV prevention<sup>16</sup> but, unfortunately, it remains controversial in some countries of the former Soviet Union. The Uzbekistan program closure sends negative signals to neighbouring countries who have also just started their pilot OST programs (e.g., Kazakhstan), and to countries that are contemplating the introduction of OST (e.g., Tajikistan). OST remains unavailable in Russia and Turkmenistan.

– Avet Khachatryan

Avet Khachatryan (khachatryan.a@gmail.com) is a consultant with the Eurasian Harm Reduction Network and a volunteer with the Canadian HIV/AIDS Legal Network.

<sup>1</sup> S. Kargin, "Pilot Substitution Therapy Project: initial results" [Пилотный проект по заместительной терапии: первые результаты], presentation at the regional Global Fund projects meeting in Tbilisi, 18 September 2007; J. Huber and S. Wirth, *Harm Reduction Drug Project: Uzbekistan*, Interim Report, Swiss Federal Office of Public Health, 2004.

<sup>2</sup> Law No. 813-1, 19 August 1999, art. 37.

<sup>3</sup> State Commission for Drug Control, Regulation "On the Implementation of the Pilot Project for Administering Substitution Treatment using Methadone," 5 October 2003.

<sup>4</sup> Order of the Ministry of Health of the Republic of Uzbekistan "On the Strengthening of Prevention Activities and the Organization of Medical and Social Aid Related to HIV Infection in the Republic of Uzbekistan," No. 480, 30 October 2007.

<sup>5</sup> International AIDS Society, "Expanding Access to Opioid Substitution Therapy for Injecting Drug Users in Eastern Europe and Central Asia," Report from the IAS Yalta Scientific Leadership Summit, 17-18 October 2008, p. 6.

<sup>6</sup> IA Ferghana.Ru, "Drug Use in Uzbekistan. View of the Situation" [Наркопотребление в Узбекистане: Взгляд на ситуацию], 8 July 2009, online: [www.ferghana.ru/article.php?id=6226](http://www.ferghana.ru/article.php?id=6226).

<sup>7</sup> Narcotics Law, art. 36.

<sup>8</sup> S. Kargin (supra).

<sup>9</sup> "IA Ferghana.Ru (supra).

<sup>10</sup> S. Kargin (supra).

<sup>11</sup> Personal communication with Raminta Stulките, Executive Director of Eurasian Harm Reduction Network, after visit to Uzbekistan, July 2009.

<sup>12</sup> Information reported by the National AIDS Center as of 2006.

<sup>13</sup> UNDP, "Bringing down barriers: regional cooperation for human development and human security," in *Central Asia Human Development Report*, 2005, p. 146.

<sup>14</sup> Ibid.

<sup>15</sup> United Nations Office on Drugs and Crime (UNODC), *Compendium: Drug Related Statistics*, July 2007, online: [www.dbregional.info/filebox/5/stat\\_compendium\\_en.pdf](http://www.dbregional.info/filebox/5/stat_compendium_en.pdf).

<sup>16</sup> World Health Organisation (WHO), UNODC, UNAIDS, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper*, 2004, p. 13.

## Indonesian parliament adopts strict anti-drug law

**On 14 September 2009, after four years of deliberations, the Indonesian House of Representatives passed the anti-narcotics bill into law. The House says that the law is designed to curb drug trafficking and to save youth from drug use. Critics say the law criminalizes drug users and will have a negative impact on their health.**

The law criminalizes drug use, and establishes criminal liability up to four years in prison for using what are termed "Category I" drugs. Use of "Category II" drugs is punishable by up to two years in prison; and use of "Category III" drugs is punishable by up to one year in prison.<sup>1</sup> The

maximum penalty for some offences, such as buying or receiving Category I drugs, is the death penalty.

According to the new law which, if endorsed by the President and the government, will replace the old 1997 law, the parents or guardians of a minor who is dependent on drugs

are required to report the minor to authorities for treatment and rehabilitation.<sup>2</sup> Adult dependent people are also required to be reported, or to report themselves to a community centre or hospital.

Failure of parents and guardians to report their children's drug use to

authorities is an offence, punishable by a fine of one million rupiahs (US\$100) or a maximum of six months in prison.<sup>3</sup> The law also provides for up to six months in prison and a fine of up to two million rupiahs (US\$200) for “deliberately” not reporting oneself to authorities as a drug user.

The law contains a chapter on public participation in prevention and eradication of drug abuse and illicit trafficking. People are required to report to authorities if they know about drug abuse or trafficking. Exceptional services in prevention

and eradication of drug abuse and illicit trafficking, and disclosure of drug offences, is rewarded by the government.

According to commentators, these provisions “transfer the job of fighting drug trafficking from the government to society.” According to the Indonesian Coalition for Drug Policy Reform (ICDPR), “the law might encourage exploitation by civil society groups, including acts of vigilantism.”<sup>4</sup>

ICDPR coordinator Asmin Fransisca said that by subjecting people who use drugs to criminal charg-

es, the law “classifies drug addicts as criminals. The law should recognise that a proper solution to drug addiction is to empower drug addicts, not to punish them as criminals.”<sup>5</sup>

<sup>1</sup> *Draft Law of the Republic of Indonesia on Narcotics* [unofficial translation], art. 92.

<sup>2</sup> International Harm Reduction Association, “New Indonesian anti-drug law prescribes prison for parents who fail to report children’s drug use,” 16 September 2009, online: [www.ihrablog.net](http://www.ihrablog.net).

<sup>3</sup> *Draft Law* (supra), art. 93.

<sup>4</sup> “Drug addicts branded as criminals under new law,” *The Jakarta Post*, 15 September 2009.

<sup>5</sup> *Ibid.*

## India refuses patent protection for two key HIV drugs

**In September 2009, the Indian Patent Office (IPO) rejected applications for patents from two U.S. pharmaceutical companies for tenofovir and darunavir.**

Tenofovir, produced by Gilead Science, is a drug recommended by the World Health Organisation for first-line treatment. Darunavir, produced by Tibotec Pharmaceuticals, is an expensive, second generation drug.<sup>1</sup> Access to both medicines is limited by their high prices.

The patent applications were rejected on the grounds that they constituted “evergreening,” which is the practice of introducing minor modifications to existing drugs to make them appear as new ones, without producing significant improve-

ments in therapeutic effect. The IPO said that clinical trials did not prove that the new compounds were more efficacious than the existing ones.<sup>2</sup> Evergreening is prohibited by India’s patent law.<sup>3</sup>

The IPO’s decision was applauded by Indian and international civil society groups. “The rejection of the patents on tenofovir opens up the market for new generic competitors to drive down the price of this key HIV/AIDS drug” said Michelle Childs, Director of Policy for the Access to Essential Medicines campaign at Medicines

Sans Frontiers (MSF). “The decision regarding darunavir is significant because the drug is one of the newest and most expensive of HIV/AIDS drugs.”<sup>4</sup>

The decision raises hopes of lowering prices of these two drugs globally. It also facilitates continuing access for patients in developing countries to life-saving HIV/AIDS drugs. The Brazilian Interdisciplinary AIDS Association had said that if India granted a patent for Tenofovir, this would have a direct impact on the ability of Brazil

to produce and access affordable generic versions of the drug.<sup>5</sup>

### Related developments

On 14 July 2009, GlaxoSmithKline (GSK) announced that it was waiving patent restrictions to allow generic manufacturers to make cheaper versions of its HIV drugs, including abacavir, a second-line treatment used when the initial treatment fails.<sup>6</sup>

In order to make HIV drugs more affordable, there have been increasing calls to establish a patent pool.<sup>7</sup> Under this system, a number of patents held by different parties are bought together

and made available to others for production and further development.<sup>8</sup>

The patent holders receive royalties from patent users. Systems of this kind are in place in other industries.

According to UNITAID, the international drug purchasing agency, a pool will facilitate the development of combination pills and children's formulations of HIV drugs for which patents from two or three different companies are required.<sup>9</sup> A pool would also enable robust competition among drug companies to ensure that international AIDS resources are spent efficiently.<sup>10</sup>

<sup>1</sup> R. Prasad, "India rejects patent claims on two HIV/AIDS drugs," *The Hindu*, 4 September 2004.

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

<sup>3</sup> *Indian Patent Act, 1970*, amended by the *Patents (Amendment) Act, 2005*, No. 15, s. 3(d).

<sup>4</sup> MSF, "Response to India's rejection of patents on key HIV/AIDS drugs," 2 September 2009, online: [www.msf.org](http://www.msf.org).

<sup>5</sup> J.C. Mathew, India refuses patent protection for AIDS drug of US company," *Business Standard*, 2 September 2009..

<sup>6</sup> "All together now," *The Economist*, 16 July 2009.

<sup>7</sup> For example, see MSF, "MSF calls on drug companies to pool HIV patents," online: [www.msffaccess.org](http://www.msffaccess.org).

<sup>8</sup> E. Hoen, "The need for HIV patent pools is urgent," *The Guardian*, 15 September 2009.

<sup>9</sup> For more on UNITAID, see: [www.unitaid.eu](http://www.unitaid.eu).

<sup>10</sup> E. Hoen (*supra*).

## Cambodian Government creates *de facto* AIDS colony

**On 18 June 2009, the Cambodian government forcibly relocated 20 HIV-affected families living in a housing development in Phnom Penh to substandard housing at a remote site 25 kilometers from the city. Another 20 such families were moved there on 23 July 2009.<sup>1</sup>**

According to reports, the families were resettled into crude metal sheds that are baking hot in the daytime and lack running water and adequate sanitation. The housing conditions at the site were said to be inadequate in terms of size, fire safety and sanitation. According to observers, the living conditions at the new substandard housing pose serious health risk, particularly to people with compromised immune systems.<sup>2</sup>

The evictions were carried out to make way for a commercial develop-

ment, which received government approval with the understanding that the developer would build new housing on site for residents displaced by the project.<sup>3</sup> However, with few exceptions, the HIV-affected families displaced by the development have not been screened for eligibility for the on-site housing — unlike other families who are not affected by HIV.

In an open letter to Cambodia's prime minister and health minister, more than 100 non-governmental organizations expressed concern

about the "discriminatory and potentially life-threatening treatment of HIV-affected families," and called on the government to stop evictions and protect rights of the affected families.<sup>4</sup>

Shiba Phyrailatpam, of the Asia-Pacific Network of People Living with HIV/AIDS, said that "by bundling people living with HIV together into second-rate housing, far from medical facilities, support services, and jobs, the government has created a *de facto* AIDS colony."<sup>5</sup>

The open letter opposed the segregation and isolation of people living with HIV, claiming that such policies promote stigmatization and discrimination, and that they may seriously jeopardize access to necessary prevention, care, treatment and support services.

The Ministry of Health has reportedly assured the evicted HIV-affected families that antiretroviral medica-

tion and treatment will be available to them. However, at the time that the open letter was sent, the government had not directly provided such services, but relied instead on NGOs to ensure continued access to medicines, for example by paying transportation costs for the evictees to come to hospitals in the city.<sup>6</sup>

<sup>1</sup> "Open letter to the Government of Cambodia

regarding the treatment of HIV-affected families from the community of Borei Keila", 27 July 2009, online: [www.hrw.org/node/84641](http://www.hrw.org/node/84641).

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Human Rights Watch, "Cambodia: 'AIDS Colony' Violates Rights: HIV/AIDS and Social Justice Groups Call on Government to Halt Evictions of HIV-Affected Families," 28 July 2009, online: [www.hrw.org/en/news/2009/07/28/cambodia-aids-colony-violates-rights](http://www.hrw.org/en/news/2009/07/28/cambodia-aids-colony-violates-rights).

<sup>6</sup> Ibid.

## U.K.: Success of heroin prescription trials

**In September, the U.K. released positive results of evaluations of a heroin prescription trial, resulting in a call from the National Treatment Agency for Substance Misuse to expand the projects nationwide.<sup>1</sup>**

The National Treatment Agency began the heroin prescription trial four years ago in three areas of London, Brighton and Darlington.<sup>2</sup> The purpose of the initiative was to minimize the social harm to individuals and society. At the time, critics argued that it would result in an explosion of drug dealing and crime. According to news reports, the effect was quite the opposite – i.e., there was a fall in both crime and drug dealing.<sup>3</sup>

The results showed that prescribing heroin to long-time dependent people has major benefits in cutting crime and reducing the street sales of drugs.

The first clinic opened in South London in 2005. Later, clinics opened in Darlington (2006) and in Brighton (2007). During the trial, 127 participants who were dependent on heroin, who had failed other treatments, and who had served repeated prison sentences received drugs at the clinics. The participants were divided into three groups — one received heroin, while the others received either oral or intravenous methadone.<sup>4</sup> Although all three groups showed improved physical and mental health, the heroin group fared much better than the others.

In the "heroin group," participants attended clinic twice a day and

received a dose of diamorphine (pharmaceutical grade heroin), which they injected themselves, under supervision.<sup>5</sup> The rules allowed no "take-away" doses, and all injections at the clinics were witnessed.

After six months, three-quarters of the participants in the heroin group had largely stopped taking street heroin, and the number of crimes committed by people in the group dropped from 1700 in the 30 days before the program began to an average of 91 for each of the first six months of the trial.<sup>6</sup> Three-quarters of participants "substantially reduced" their use of street drugs,

and their spending on drugs fell from £300 to £50 a week.<sup>7</sup>

On 20 September 2009, the U.K.'s Justice Secretary supported the expansion of the trial and said that there could be "huge benefits" to prescribing drugs to chronically dependent people, including potentially reducing the £15 billion a year cost of the abuse of hard drugs. According to Jack Straw, "For the most problematic heroin users it may be the best means of reducing the harm they do themselves, and of stamping out the crime and disorder they inflict on the community."<sup>8</sup>

According to Professor John Strang, of the National Addiction Centre, who led the trial, "It is 'intensive care' for drug addicts, more expensive than standard treatment,

but a third of the cost of sending them to prison at £44,000 a year. And [when they are sent to prison] they become re-addicted on release."<sup>9</sup> The cost of the program is £15,000 a year per patient.<sup>10</sup>

According to observers, national expansion of the program should not be hard, because of the strong political backing for the trial. Additionally, in the U.K., heroin is already considered a medicine and is legal for use by doctors.<sup>11</sup>

U.K. doctors have been allowed to prescribe heroin for a small number of hard-to-treat patients since the 1920s, but in the 1970s and 1980s doctors became reluctant to prescribe doses high enough to be effective, fearing patients would sell them on the black market.<sup>12</sup>

Similar positive results have been reported at heroin prescription clinics in Switzerland, the Netherlands and Germany.<sup>13</sup>

<sup>1</sup> "An injection of common sense," *The Independent*, 14 September 2009.

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

<sup>3</sup> *Ibid.*

<sup>4</sup> *Ibid.*

<sup>5</sup> J. Laurance, "Clamour grows for heroin on the NHS," *The Independent*, 14 September 2009.

<sup>6</sup> G. Faure, "Why doctors are giving heroin to heroin addicts," *The Times*, 28 September 2009.

<sup>7</sup> D. Gardham, "Jack Straw calls for heroin on prescription," *The Sunday Telegraph*, 20 September 2009.

<sup>8</sup> *Ibid.*

<sup>9</sup> J. Laurance (supra).

<sup>10</sup> *Ibid.*

<sup>11</sup> G. Faure (supra).

<sup>12</sup> *Ibid.*

<sup>13</sup> "An Injection..." (supra).

## The U.N. system issues calls to strengthen harm reduction interventions

**In 2009, harm reduction interventions, critical for prevention of HIV transmission among people who inject drugs, received attention and endorsement from several U.N. bodies.**

The sharing and use of contaminated injection equipment among people who inject drugs remains one of the most devastating modes of HIV transmission. Outside of sub-Saharan Africa, it accounts for approximately one-third of all HIV infections.<sup>1</sup> In some regions of the

world, such as South East Asia, Eastern Europe, and Latin America, the prevalence of HIV among people who inject drugs has been reported to be over 40 percent.<sup>2</sup>

In 2009, the World Health Organization (WHO), the United Nations Office on Drugs and Crime

(UNODC) and UNAIDS issued a Technical Guide spelling out what the UNAIDS family understands by comprehensive prevention programmes for injecting drug users—namely nine essential interventions: (1) needle and syringe programmes; (2) opioid substitution therapy and

other drug dependence treatment; (3) HIV testing and counselling; (4) antiretroviral therapy; (5) prevention and treatment of sexually transmitted infections; (6) condom programmes for injecting drug users and their sexual partners; (7) targeted information, education and communication for injecting drug users and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of tuberculosis.<sup>3</sup>

On 12 March 2009, the Commission on Narcotic Drugs, at its highest level, adopted a “Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy To Counter the World Drug Problem,” which made reference to harm reduction and underlined the commitment of the Commission to “work towards the goal of universal access to comprehensive prevention programmes and treatment, care and related support services.”<sup>4</sup>

In June 2009, UNAIDS Executive Director Michel Sidibé reported that “we have evidence that effective programmes for harm reduction and substitution therapy can save billions of dollars.” Sidibé also said that during the current economic crisis, “UNAIDS will champion these and other evidence informed prevention programmes as smart investments for saving money, saving lives and restoring health and dignity of people.”<sup>5</sup>

On 24 June 2009, the UNAIDS Programme Coordinating Board requested the UNAIDS Secretariat and Cosponsors to “support increased capacity and resources for provision of a comprehensive package of services for injecting drug users including harm reduction programmes in relation to HIV as enumerated in the Technical Guide.”<sup>6</sup>

On 27 July 2009, the U.N. Economic and Social Council (ECOSOC) approved a resolution on UNAIDS, in which it said that ECOSOC

[r]ecognizes the need for UNAIDS to significantly expand and strengthen its work with national governments and to work with all groups of civil society to address the gap in access to services for injecting drug users in all settings, including prisons; to develop comprehensive models of appropriate service delivery for injecting drug users; to tackle the issues of stigmatization and discrimination; and to support increased capacity and resources for the provision of a comprehensive package of services for injecting drug users including harm reduction programmes in relation to HIV as elaborated in the ... Technical Guide, in accordance with relevant national circumstances.<sup>7</sup>

On 21 August 2009, the UNODC and UNAIDS circulated a letter clarifying their understanding of harm reduction.<sup>8</sup> Commenting on the above developments, representatives of the two organizations said that

the decision of these three UN entities indicate that there is a common understanding in the UN system on what is a comprehensive package of HIV services for injecting drug users, namely ‘harm reduction.’ For the first time in history, the UN system has clearly defined what harm reduction in relation to HIV is — the nine interventions as enumerated in the WHO, UNODC, UNAIDS Target setting guide.”<sup>9</sup>

<sup>1</sup> C. Kroll and P. de Lay, “Letter from UNODC and UNAIDS Secretariat on Recent Decision on Harm Reduction,” UNODC and UNAIDS, online: [www.idpc.net/alerts/unaids-unodc-joint-letter-harm-reduction](http://www.idpc.net/alerts/unaids-unodc-joint-letter-harm-reduction).

<sup>2</sup> B. Mathers et al., “Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,” *The Lancet* 372 (online), 24 September 2008.

<sup>3</sup> WHO, UNODC, UNAIDS, *Technical Guide for Countries To Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2009.

<sup>4</sup> Commission on Narcotic Drugs, *Report on the Fifty-Second Session (14 March 2008 and 11–20 March 2009)*, Economic and Social Council Official Records, 2009, Supplement No. 8.

<sup>5</sup> C. Kroll and P. de Lay (supra).

<sup>6</sup> UNAIDS, *24th Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland, 22–24 June 2009: Decisions, Recommendations and Conclusions*.

<sup>7</sup> ECOSOC, *Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS)*, Resolution E/2009/L.23, 24 July 2009, para. 19.

<sup>8</sup> C. Kroll and P. de Lay (supra).

<sup>9</sup> Ibid.

## Russia: Future of harm reduction uncertain

**Civil society and international organisations have expressed grave concern over the future of HIV prevention interventions for most-at-risk groups in Russia.**

In 2009, the GLOBUS project — Global Efforts Against AIDS in Russia — funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), comes to an end.

HIV prevention among most-at-risk groups in Russia is carried out primarily by NGOs, but they need funding to continue these programs. However, as a country with high income, Russia is no longer eligible for Global Fund funding (Russia is a Global Fund contributor itself).<sup>1</sup>

Despite earlier promises by the government that funding will be continued after the end of the GLOBUS project, a recent letter from the Deputy Minister of Health and Social Development stated that governmental strategic priorities in the area of HIV/AIDS are now promotion of health among general population, thus raising doubts that government funding for most-at-risk groups will be available.<sup>2</sup>

The GLOBUS project operated in 10 regions of the Russian Federation in 2004–2009, enabling over 200 NGOs to provide HIV prevention services to 54 000 people who inject drugs. These services have averted an estimated 37 000 HIV infections in this group.<sup>3</sup> (The NGOs also provide similar services to sex workers, men who have sex with men, prisoners and street children.)

GLOBUS was positively evaluated by the Global Fund, and internationally recognized as one of the most successful projects funded by the

organization.<sup>4</sup> The Russian government, however, disagrees.

During a recent Round Table organised by the State Duma Committee on Protection of Health, O. Krivonos, the Director of the Department of Health Care and Advancement of Public Health of the Ministry of Health and Social Development, provided a negative evaluation of GLOBUS harm reduction programs, in particular its needle and syringe initiatives. She said that HIV incidence among injection drug users grew three-fold or more in the regions involved in GLOBUS, compared to other regions.<sup>5</sup>

Earlier in a letter to GLOBUS partners, V. Skvortsova, Russia's Deputy Minister of Health and Social Development, referred to the "success of state in increasing access to antiretroviral treatment (ARV) and in providing chemoprevention for HIV-positive pregnant women." The letter also stated that the governments' strategic priority in HIV response is "propaganda of healthy life style among general population and forming responsible attitude towards health."<sup>6</sup>

In an open letter, a Consortium of (200) NGOs appealed to the Russian government to continue HIV prevention interventions for the most-at-risk social groups. In an editorial, the medical journal *Lancet* said that

the country's recent focus on health promotion is a most welcome step,

but this should not be to the detriment of the 1.8 million people who inject drugs.... Perhaps deciding which programmes to fund need not be mutually exclusive. Of course, general population health is important, but so are the harm reduction programmes to prevent HIV.<sup>7</sup>

The *Lancet* also suggested that the Global Fund review its criteria for countries eligible to receive grants:

Although wealth is an important criterion, NGOs and civil society groups working in countries that persistently neglect the needs of their vulnerable populations should be considered eligible for funding so they can provide crucial services to people who would otherwise not receive them.<sup>8</sup>

The International AIDS Society said that Russia's discontinuation of HIV prevention programs for most-at-risk populations could have disastrous consequences not only for Russia, but also for its neighbours.<sup>9</sup>

The government's negative attitude to harm reduction and HIV prevention among most-at-risk groups is especially troubling in light of the fact that about half of all HIV infections in Russia come from members of the most-at-risk groups, including injection drug users.<sup>10</sup>

The Russian government has consistently refused to introduce needle exchange programs. Opioid substitution therapy remains prohibited by legislation and inaccessible in Russia.

*[Editor's Note: On 11 November 2009, the Global Fund Board extended the GLOBUS grant to 31 December 2011.]*

<sup>1</sup>The remaining two Global Fund projects in Russia (after GLOBUS) will end in 2010.

<sup>2</sup>I. Vlasova, A. Sargin, "Russia is left face to face with AIDS," *Gazeta*, 21 September 2009.

<sup>3</sup>"The future of harm reduction programmes in Russia," editorial, *The Lancet* 374 (online), 10 October 2009.

<sup>4</sup>Ibid.

<sup>5</sup>I. Vlasova, "It was decided to fight AIDS with legislation," *Gazeta*, 9 October 2009.

<sup>6</sup>"The Neglected Epidemic?," open letter of the

Consortium of Non-Governmental Organizations, 18 September 2009.

<sup>7</sup>The future of harm reduction..." (supra).

<sup>8</sup>Ibid.

<sup>9</sup>International AIDS Society, "IAS Expresses Concern Over Future of HIV Prevention Efforts in Russia," statement, 8 October 2009.

<sup>10</sup>"The Neglected Epidemic?" (supra).

## In brief

### U.S. repeals HIV immigration and travel ban

On 2 November 2009, the Centers for Disease Control and Prevention (CDC), within the U.S. Department of Health and Human Services (HHS), published an amendment to its regulations to remove HIV from the definition of "communicable disease of public health significance" and to remove references to HIV from the scope of examinations of non-U.S. citizens.<sup>1</sup>

As a result of this final rule, non-U.S. citizens will no longer be inadmissible into the country based solely on the ground that they are HIV-positive, and they will not be required to undergo HIV testing as part of the required medical examination for U.S. immigration. The rule will go into full and final effect on 4 January 2010 after a routine waiting period.<sup>2</sup>

Under the previous regulations, non-U.S. citizens who were HIV-positive could not travel to the U.S. unless they were granted a waiver by the Department of Homeland Security, and immigrants were denied

entry to the country if they were HIV-positive.<sup>3</sup>

— Sandra Ka Hon Chu

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

### Mozambique: Parliament adopts law on domestic violence amid protests that the law discriminates against men

In July 2009, the Mozambican parliament adopted a law on domestic violence against women. The law defines domestic violence as a "public offence" which means that prosecution is not dependent on the complaint of the victim, who might be too scared to launch a complaint.

According to the law, intimate partners who beat women so severely as to endanger their lives could be sentenced to 8–12 years imprisonment. If the violence causes death, the penalty is up to 24 years impris-

onment, which is the penalty for first degree murder. Serious, but not life-threatening, physical injury is punishable by imprisonment from eight months to two years.

Under the law, minor assaults are punishable by community service or imprisonment from 1–6 months. Marital rape is punishable by imprisonment from six months to two years; threats and "verbal violence" carry a maximum sentence of one year.<sup>4</sup> Refusal to pay alimony and seizure of a woman's property by male relatives after the death of her husband are offences punishable by up to six month imprisonment.

When the bill passed its first reading earlier in July 2009, there were protests claiming that the new bill "is demonizing men." One paper carried an editorial accusing the Parliament of "mulherismo," an entirely new word in Portuguese language, which could be translated as "female chauvinism."<sup>5</sup> There were other instances of the press campaigning against the bill. Some media insisted that the bill violates the constitutional clause on equality between the sexes and should be "more inclusive."<sup>6</sup>

In order to save the initiative, the Assembly's Social Affairs Commission agreed to amend the bill to include an article which stated that "the provisions of the present law apply to men, under equality circumstances, and with the necessary adaptations."<sup>7</sup> After this amendment, the bill passed unanimously.

However, the amended law included one negative change in comparison to the earlier draft: The courts will not be able to order a violent man to leave the house he shares with his victim. All courts will be able to do in this situation is seize any weapons found in the possession of the man, forbid him from selling or removing any family property, and suspend his authority over children.

### **Mali: Law on women's equality in marriage blocked**

In the beginning of August 2009, the Malian Parliament passed a family law designed to give women equal rights in marriage and strengthen inheritance rights for women and children born out of wedlock.<sup>8</sup> The bill triggered mass protests in Mali's capital, Bamako, and other regions of the country.

At the end of August, President Amadou Toumani Toure, a strong supporter of the law, was obliged to announce that he is not going to sign the new law, and that he was returning it to Parliament for review and second reading.<sup>9</sup> The President said he was sending the law back for the sake of national unity, "to ensure calm and a peaceful society, and to obtain the support and understanding of our fellow citizens."<sup>10</sup>

One of the most contentious issues, according to reports, is the provision that women are no longer required to obey their husbands and that, instead, husband and wife owe each other "loyalty, protection, help and assistance." The bill also contained provisions to ensure that women received greater inheritance rights, and to raise the minimum age for girls to marry in most circumstances to 18. Marriage was defined as a secular institution.<sup>11</sup>

According to the head of a Muslim women's association, only a tiny minority of Malian women — "the intellectuals" — support the law. Hadja Sapiato Dembele, of the National Union of Muslim Women's Association, said that the law goes against Islamic principles.<sup>12</sup> "We have to stick to the Koran," Ms Dembele told the BBC's Focus on Africa program. "A man must protect his wife, a wife must obey her husband." Other Muslim leaders called the law "the work of the devil and against Islam."<sup>13</sup>

### **Zambia: Debate regarding compulsory HIV testing continues**

The case of two HIV-positive former military officers, currently underway in the High Court in Livingstone, has reignited an HIV testing debate in Zambia.

Two former air force officers allege that they were tested and treated for HIV without their knowledge, and were discharged for being medically unfit a year later.<sup>14</sup> Arguing that the dismissal was based on their HIV status, the former officers are suing the Zambian military for damages to

their mental and emotional health and are seeking reinstatement.

The air force has denied that the two men were tested for HIV, and that they were discharged based on their HIV status. The government claims that one of the men was discharged because he had cancer, and that the other had developed tuberculosis.

The case has reignited a debate about the different forms of HIV testing. According to the Ministry of Health, low awareness of the population of their HIV status is a problem — it is estimated that 14 percent of the population of 11.7 million are HIV-positive, but only 15 percent have ever been tested for HIV.<sup>15</sup>

Mandatory HIV screening is not permitted in Zambia. However, in 2005, in an attempt to increase the numbers of people who have been tested, the government introduced a policy of provider-initiated testing, whereby patients are routinely tested unless they expressly refuse.

In December 2008, the Health Minister Kapembwa Simbao called for the introduction of compulsory testing, saying: "VCT [voluntary testing and counselling] has reached its peak, and we have to move to ensure that we compel everyone to have an HIV test."

The Zambian National AIDS Network, an umbrella group for non-governmental organisations working in the area of HIV/AIDS, disagreed. Spokesperson Sam Kapembwa said that "military staff should be tested for fitness, and not for HIV... To test military personnel for HIV, let alone fire those who are [found to be] positive is unacceptable; it is promoting stigma and discrimination."<sup>16</sup>

A representative of the government's Human Rights Commission, Sam Kasankha, said the Commission

was considering the debate on mandatory testing but had yet to come up with a final position.

### **Kazakhstan: Violations of fire safety rules lead to tragedy in drug treatment facility**

On 13 September 2009, fire erupted in a drug clinic in Taldykorgan, Southern Kazakhstan, killing 37 drug and alcohol dependent patients. According to reports, the fire broke early in the morning and quickly spread throughout one-storey wooden building.<sup>17</sup> The cause of fire is not yet known.

There were a number of fire safety violations at the clinic that had been identified during an inspection in May 2009, including the lack of a fire alarm. After the inspection, some violations were fixed but no fire alarm was installed.<sup>18</sup>

According to the Emergency Situations Minister Vladimir Bozhko, patients could not escape because of barred windows and locked doors in the clinic's wards. Kazakhstan's Prime Minister Karim Masimov ordered that a commission be created to investigate the incident.<sup>19</sup>

Violations of safety regulations are common in health care facilities in the region. Barred windows and locked doors are common practice for drug and alcohol treatment centres, in order to prevent patients escaping and having contact with the outside world. In December 2006, fire in a drug treatment facility in Moscow, Russia, killed 44 HIV-positive women undergoing treatment for drug dependence.<sup>20</sup>

Previously, AIDS and human rights groups had expressed concern

regarding what they called an inhumane and ineffective system of drug dependence treatment in the former Soviet Union region.<sup>21</sup> U.N. agencies and human rights groups have repeatedly called on governments and the health care community to pay more attention to the observance of human rights principles in the management of drug dependence treatment programs, and to recognize the human rights of people who use drugs.<sup>22</sup>

### **Armenia amends HIV law, repeals travel ban for foreigners with HIV**

On 6 April 2009, the President of the Republic of Armenia signed the bill passed earlier by the National Assembly of Armenia, amending the *Law on Preventing the Disease Caused by the Human Immunodeficiency Virus*.<sup>23</sup>

According to the parliamentary committee, the old law did not meet the present-day requirements in the fight against HIV/AIDS.

The amended provisions repeal rules according to which HIV-positive foreigners entering the country for more than three months are refused visas or, if already in the country, are deported. According to Lena Nanushyan from the Standing Committee on Health, Maternity and Childhood in the National Assembly, the purpose of the amendments was not only to eliminate travel restrictions, but also to establish provision of pre- and post-test counselling.<sup>24</sup>

The new law also significantly narrows the scope of mandatory HIV-testing: According to the new law, only blood donors and children born by HIV-positive mothers are subject to such testing.<sup>25</sup> The amended law

also strengthens protection against stigma and discrimination, and provides for measures aimed at health education and HIV awareness.

However, provisions banning the admission of HIV-positive foreigners still exist in Armenia's *Law on Foreigners*.<sup>26</sup> It remains to be seen if this law will also be modified or, instead, if travel restrictions on HIV-positive foreigners will continue.

### **Uruguay: New law allows same sex adoptions**

On 9 September 2009, Uruguay legislators passed amendments to the existing adoption law to allow gay and lesbian couples to adopt children.<sup>27</sup>

This is the latest in several progressive changes supported by President Tabare Vazquez. In 2008, the President authorised "civil unions" for same sex couples.<sup>28</sup> In May 2009, access to military schools was opened for the lesbian, gay, bisexual and transgender (LGBT) community.<sup>29</sup>

The new law does not mention LGBT couples, but states that persons in civil unions have the same rights regarding adoption as married couples. Under the amended law, the power to make decision on adoption shifts from judges to the National Institute of Children and Adolescents.<sup>30</sup>

According to reports, the new law was backed by President Vazquez and his ruling coalition but faced strong opposition from the Roman Catholic Church. According to Mauricio Coitiño, of Colectivo Ovejas Negras, conservative opponents of the move claimed that the new law is not applicable to civil unions, but to 'de facto' heterosexual unions."

However, the “Technical Team” for adoptions, which decides whether a family is suitable for a certain child, has declared that sexual orientation of the prospective parents will not be relevant to the decision.<sup>31</sup>

This is unprecedented move, and it makes Uruguay the first Latin American country to allow gay couples to adopt children.<sup>32</sup>

<sup>1</sup> HHS, CDC, *Medical Examination of Aliens — Removal of HIV Infection from Definition of Communicable Disease of Public Health Significance*, Docket No. CDC-2009-0003.

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

<sup>3</sup> K. Eleveld, “Change coming to HIV immigration ban,” *Advocate.com*, 23 September 2009.

<sup>4</sup> “Mozambique: Assembly passes amended domestic violence bill,” *Pambazuka News* (Pan-African Voices for Freedom and Justice), Issue 444, 30 July 2009, online: <http://pambazuka.org/en/category/wgender/58077>.

<sup>5</sup> *Ibid.*

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

<sup>7</sup> *Ibid.*

<sup>8</sup> “Mali — Protests against new law on women’s equality in marriage,” *BBC News* (online), 23 August 2009.

<sup>9</sup> M. Vogl, “Mali women’s rights bill blocked,” *BBC News* (online), 27 August 2009.

<sup>10</sup> *Ibid.*

<sup>11</sup> *Ibid.*

<sup>12</sup> “Mali — Protests...” (supra).

<sup>13</sup> M. Vogl (supra).

<sup>14</sup> “Zambia: Court case reignites testing debate,” *PlusNews Global* (online), 14 October 2009.

<sup>15</sup> *Ibid.*

<sup>16</sup> *Ibid.*

<sup>17</sup> “Fire kills 37 at Kazakh drug rehab clinic,” *CBC News* (online), 13 September 2009.

<sup>18</sup> P. Leonard, “37 killed in fire at Kazakh drug rehab clinic,” *Associated Press News* (online), 13 September 2009.

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

<sup>20</sup> L. Utyasheva, “Russian Federation: Inhumane conditions in drug treatment facilities lead to tragedy,” *HIV/AIDS Policy and Law Review* 12(1) (2007): 32–33.

<sup>21</sup> Open Society Institute, *Human Rights Abuses in the Name of Drug Treatment: Reports from the Field*, Public

Health Fact Sheet, International Harm Reduction Development Program, 2009; and Human Rights Watch, *Rehabilitation Required: Russia’s Human Rights Obligation to Provide Evidence-Based Drug Dependence Treatment*, 2007.

<sup>22</sup> U.N. Office on Drugs and Crime and World Health Organization, *Principles of Drug Dependence Treatment*, Discussion Paper, 2008.

<sup>23</sup> *Law on Preventing the Disease caused by the Human Immunodeficiency Virus*, No. 3P-103, 15 February 1997.

<sup>24</sup> Personal communication with Lena Nanushyan.

<sup>25</sup> According to the old law, health care workers who deal with blood, prisoners, STI patients, pregnant women, children born to HIV-positive mothers, drug users and people returning from trips abroad of more than three months were all subject to mandatory HIV testing.

<sup>26</sup> “Armenian legislators amended law on AIDS,” *Agency of International Information*, 19 March 2009.

<sup>27</sup> Y. Olivera, “Uruguay approves Latin America’s first gay adoption law,” *Agence France-Press (AFP)*, 9 September 2009.

<sup>28</sup> *Ley de Unión Concubinaria*, No. 18.246, 1 January 2008.

<sup>29</sup> Y. Olivera (supra).

<sup>30</sup> “Uruguay allows same-sex adoption,” *BBC News* (online), 9 September 2009.

<sup>31</sup> E-mail communication with Mauricio Coitiño, *Colectivo Ovejas Negras*, Uruguay, 19 October 2009.

<sup>32</sup> “Uruguay allows...” (supra).

# 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 (schu@aidslaw.ca), senior policy analyst with the Canadian HIV/AIDS Legal Network and editor of this section. Unless otherwise noted, the articles in this section were written by Ms Chu.

## Court decision extends long-term income support to those dependent on alcohol or drugs

**On 20 April 2009, the Ontario Superior Court of Justice upheld a decision of the Social Benefits Tribunal which found the exclusion from long-term income support of people suffering from alcohol or drug dependency to be discriminatory.<sup>1</sup>**

In 1999, Robert Tranchemontagne and Norman Werbeski, who suffered from alcohol and drug dependency, applied for long-term income support under the *Ontario Disability Support Program Act* (ODSPA). At the time, they were both recipients of financial assistance under the Ontario Works

program (OW), which provides a substantially lower amount of temporary financial assistance and which requires recipients to pursue employment.

The applications of Tranchemontagne and Werbeski were rejected by the Director of the Ontario Disability Support Program

(ODSP) on the basis that they were not people with a disability within the meaning of the ODSPA. Section 5(2) of the Act excluded individuals from income support if they were “dependent on or addicted to alcohol, a drug or some other chemically active substance ... [which] has not been autho-

rised by prescription ... and the only substantial restriction in activities of daily living is attributable to the use of or cessation of use of the alcohol, drug or other substance at the time of determining or reviewing eligibility.”

Both men appealed the decision to the Social Benefits Tribunal, which found that the only disabling condition affecting Tranchemontagne and Werbeski was their addiction. They were therefore considered members of a “sole impairment group” and were thus ineligible to receive income support through the ODSP.

Tranchemontagne and Werbeski alleged that Section 5(2) of the ODSPA discriminated against them on the basis of their disability, and was therefore contrary to Section 1 of Ontario’s *Human Rights Code* (the Code) which prohibits discrimination on the basis of disability.<sup>2</sup> The Tribunal, however, dismissed their appeal and concluded that it had no jurisdiction to apply the Code to other legislation.

The men appealed the Tribunal’s decision to the Supreme Court of Canada, which held that the Social Benefits Tribunal — as a statutory tribunal empowered to decide questions of law — could apply all law, including the Code, to determine whether Tranchemontagne and Werbeski were eligible for income support. Accordingly, the case was remitted to the Tribunal for it to determine whether Section 5(2) of the ODSPA violated the Code.

In November 2006, the Social Benefits Tribunal concluded that Section 5(2) of the ODSPA was discriminatory and inconsistent with the Code. Tranchemontagne and Werbeski were, therefore, entitled to income support under the ODSP. The Director of the ODSP appealed

the Tribunal’s decision to the Ontario Superior Court of Justice.

The Court reviewed the findings of the Social Benefits Tribunal. In particular, it considered the evidence of an expert witness introduced by the Director of the ODSP, who had contended that all members of the sole impairment group were capable of working. Further, he believed that OW was the appropriate social assistance program for them because the work-related activities required by OW promoted responsibility and self-esteem, and the lower rate of financial assistance provided under OW assisted recovery by limiting the amount of money available to be spent on drug or alcohol use.

As such, the ODSP Director argued before the Tribunal that Section 5(2) of the ODSPA was not discriminatory because it provided those in the sole impairment group with an income support program that was better suited to their characteristics and circumstances.

Witnesses for Tranchemontagne and Werbeski had contended that some people with substance dependency would never recover or regain functionality or employability, despite treatment, so the need for support was likely to be long-term. With respect to the level of income support, they believed that individuals are in a better position to recover if they have stability and reduced stress, such as that which comes from having sufficient income.

The Social Benefits Tribunal found that the ODSPA created a distinction between persons with disabilities based on a personal characteristic — namely, disability caused by alcohol or drug dependence. This distinction imposed burdens and disadvantages on Tranchemontagne and Werbeski

which were not imposed on other disabled persons, by withholding and limiting their access to income support and advantages available to other disabled persons. As a consequence, Section 5(2) of the ODSPA infringed their right to equal treatment set out in the Code.

The Ontario Superior Court or Justice held that the Tribunal had reached its conclusion after appropriately considering all the evidence before it. Given the conflicting expert evidence, the Tribunal was entitled to prefer the evidence of Tranchemontagne and Werbeski, and the Court held that, given the evidence before the Tribunal, it would have reached the same conclusion.

As Justice Bellamy provided, the ODSP’s position “promotes a stereotypical attitude towards addicted persons. It suggests that those who do not suffer from an additional medically-recognized disorder are not genuinely disabled, or in any case are not as disabled as persons with concurrent disorders.”<sup>3</sup> As such, the Tribunal correctly determined that Tranchemontagne and Werbeski had established a *prima facie* case demonstrating that the service under Section 5(2) of the ODSPA created a distinction based on disability, a prohibited ground under the Code. The Court dismissed the appeal.

<sup>1</sup> *Ontario Disability Support Program v. Tranchemontagne*, 2009 CanLII 18295 (ON S.C.D.C.)

<sup>2</sup> Section 1 of Ontario’s *Human Rights Code* provides, “Every person has the right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.”

<sup>3</sup> *Ontario Disability Support Program* (supra), para. 74.

## Federal Court orders judicial review of Hungarian Roma man's pre-removal risk assessment

**On 6 May 2009, the Federal Court allowed an application for judicial review of a Pre-Removal Risk Assessment (PRRA) officer's decision to reject the PRRA application of Imre Gorzsas, a gay, HIV-positive, Hungarian Roma man.<sup>1</sup>**

Gorzsas arrived in Canada from Hungary in 2000. In November 2003, his claim for refugee protection, based on a risk of persecution related to his ethnicity and his sexual orientation, was dismissed by the Immigration and Refugee Board.

The Board found that Gorzsas was not gay and that he had not proven that his Roma ethnicity put him at risk in accordance with the *Immigration and Refugee Protection Act* (IRPA). The Board also said that state protection would be available to Gorzsas. Leave to appeal the decision was denied.

In July 2007, Gorzsas submitted an application for a PRRA. It was rejected in October 2007. The rejection was based on the finding that there was no breakdown of state apparatus in Hungary and that certain organizations could be approached for assistance.

In February 2008, Gorzsas learned he was HIV-positive. He submitted another PRRA application in June 2008. In his review of Gorzsas' application, the PRRA officer accepted as fact Gorzsas' affidavit evidence stating that he was gay and HIV-positive.

However, in October 2008, the PRRA officer rejected the application on the basis that there was no

indication of sustained or systemic denial of core human rights and that there was insufficient evidence before him that Gorzsas — being a gay, HIV-positive Roma — would be denied the required medical treatment in Hungary. Gorzsas' removal was stayed, pending judicial review of the PRRA decision.

In its judicial review, the Federal Court considered: (1) whether the PRRA officer erred in his finding of fact regarding discrimination against HIV-positive persons in Hungary; and (2) whether the PRRA officer erred in failing to address the cumulative factors of being gay, HIV-positive and Roma.

Justice Teitelbaum held that the PRRA officer's finding of fact was unreasonable as he did not adequately focus on the issue of personal risk for Gorzsas in returning to Hungary with HIV. In Justice Teitelbaum's view, Gorzsas' evidence pointed to a personal risk based on discrimination documented in various sources. He found that a sustained or systemic denial of core human rights was not essential in proving personal risk under the IRPA.

Moreover, Justice Teitelbaum said, considering the cumulative effects of discrimination requires an analysis beyond a bare acknowledge-

ment that an individual has certain risk factors. In Gorzsas' case, he said, it required canvassing specifically what risks a gay, HIV-positive Roma returning to Hungary would face, distinct from discretely analyzing the risks faced by a gay man, an HIV-positive person, and a Roma person, which was what the PRRA officer did.

Justice Teitelbaum found that because the PRRA officer's reasons failed to address the intersectionalities of the evidence and failed to treat Gorzsas as a sum of his parts, his decision was in error. As such, the Federal Court allowed the application for judicial review and referred the matter to a different officer for further assessment.

<sup>1</sup> *Gorzsas v. Canada (Minister of Citizenship and Immigration)*, [2009] F.C.J. No. 561 (QL).

# Guatemalan man's application for judicial review of negative assessment dismissed

**On 20 May 2009, the Federal Court dismissed an application for judicial review of a Pre-Removal Risk Assessment (PRRA) submitted by an HIV-positive Guatemalan man.<sup>1</sup>**

In July 2005, Manuel Ramos Contreras entered Canada and claimed refugee status based on his fear of the Guatemalan police, military, friends, neighbours and family, as a result of his being gay and HIV-positive. Prior to entering Canada, Contreras had been living in the United States without status, and cohabiting with an American citizen since August 2003.

The Immigration and Refugee Board rejected Contreras' claim for refugee status on the grounds that he did not have a well-founded fear of persecution in Guatemala. Relying on the history of Contreras' life in Guatemala, where the Board observed that he lived without suffering any incidents, and Contreras' prior international travels (including to Canada), the Board found that Contreras lacked a subjective fear of persecution in Guatemala.

The Board further considered the issue of Contreras' ability to avoid persecution in Guatemala by relocating to another area in the country, and found that it would not have been unreasonable for Contreras to pursue an "Internal Flight Alternative" (IFA) in Guatemala City.

In his PRRA application, Contreras relied upon the same grounds of persecution and submitted new evidence, including a document — the "Aráujo Declaration" — showing identifiable reasons

why gay people often delay seeking protection, and as a response to the finding of the Board about his lack of subjective fear.

Contreras also submitted a letter from a Guatemalan physician addressing the impact of homophobia on the ability of gay, HIV-positive people to obtain proper treatment there. He further submitted a report from a physician in Toronto who diagnosed Contreras as suffering from a major depressive disorder arising from the possibility of separation from his American partner, with whom he resided in Canada.

In August 2008, a PRRA officer concluded that Contreras had failed to overcome the Board's finding that an IFA was available in Guatemala City and found that the new documentary evidence could not establish that Contreras would be at risk in Guatemala. As such, the officer rejected Contreras' PRRA application.

In its judicial review of the PRRA officer's decision, the Federal Court considered whether the PRRA officer committed a reviewable error by failing to find, on the basis of the factors identified in the Aráujo Declaration, that Contreras had a subjective basis for his fear of persecution. Justice Heneghan was not persuaded that the PRRA officer ignored the Aráujo Declaration, which, he said, could not, in any event, independently

establish the subjective element of persecution.

Justice Heneghan was also not persuaded that the PRRA officer ignored relevant evidence with respect to how gay men are treated in Guatemala, and held that Contreras failed to prove that medical treatment for gay, HIV-positive men in Guatemala is unavailable or denied on grounds of persecution.

Finally, Justice Heneghan held there was no breach of procedural fairness arising from the PRRA officer's failure to address the issue of Contreras' separation from his partner as a basis of persecution. Rather, he said, the separation of family members is not an independent ground of persecution for the purposes of the *Immigration and Refugee Protection Act*, but "an inevitable consequence of the application of the Act."<sup>2</sup>

Justice Heneghan concluded that the PRRA officer committed no reviewable error and dismissed the application for judicial review.

<sup>1</sup> *Contreras v. Canada (Minister of Public Safety and Emergency Preparedness)*, [2009] F.C.J. No. 648 (Q.L).

<sup>2</sup> *Ibid.*, para. 22.

# Criminal law and cases of HIV transmission or exposure

## Man convicted of first-degree murder sets disturbing precedent

On 4 April 2009, in the Ontario Superior Court of Justice, a jury convicted Johnson Aziga of two counts of first-degree murder, 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault in relation to sexual encounters he had with 11 women without disclosing his HIV-positive status.<sup>1</sup>

Of the seven complainants who tested HIV-positive at some point following their encounters with Aziga, two subsequently died of cancer argued to be related to their HIV infection.

### Aggravated sexual assault charges

Under Canada's Criminal Code, an aggravated assault or aggravated sexual assault is one that "endangers the life" of the complainant. Previously, the Supreme Court of Canada has established, in *R. v. Cuerrier* in 1998, that a person with HIV may be convicted of these offences if he or she, without disclosing his or her HIV-positive status, exposes another person to a "significant risk" of infection.<sup>2</sup>

Subsequent prosecutions for not disclosing HIV-positive status have largely involved charges for these offences, and hence the application of this "significant risk" test.

Therefore, of particular note in Aziga is that one of the counts of aggravated sexual assault advanced by the prosecution was based solely

on one instance of oral sex without a condom with one of the complainants (JC). Another of the counts of aggravated sexual assault, in relation to a different complainant (MD), was based on 3–4 instances of oral sex without a condom and approximately 12 instances of vaginal sex with a condom; there was no allegation by the Crown that Aziga had unprotected vaginal sex with this complainant.

All other counts, in relation to the nine other complainants, rested upon an allegation of unprotected vaginal sex on one or more occasions.

In his charge to the jury regarding the counts of aggravated sexual assault, trial judge Lofchik J. referred repeatedly to the Crown's duty to prove "unprotected penetrative sexual activity."<sup>3</sup> (It seems likely that by this he meant to refer to vaginal sex, but this is not stated clearly anywhere.)

Nonetheless, as Aziga was convicted on 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault in relation to one complainant (BH), this means that he was convicted of at least one count for not disclosing his HIV status prior to unprotected oral sex alone, and of at least one count in relation to unprotected oral sex and vaginal sex while wearing a condom.<sup>4</sup>

Drawing upon an earlier Supreme Court of Canada decision, *R. v. Williams*,<sup>5</sup> Justice Lofchik also outlined that, in order to obtain a conviction for aggravated sexual assault with respect to any complainant, the Crown had to prove beyond a reason-

able doubt that the complainant was HIV-negative at the time of having sex with Aziga. If there was some doubt as to this, and if it is possible that she might have already been HIV-positive by the time of having sex with Aziga, then only a conviction for *attempted* aggravated sexual assault would obtain. While the defence argued this was the case with respect to three of the women with whom Aziga had sex, the jury found that this was the case only in respect to one complainant (BH).

### Murder charges

With respect to the two murder convictions relating to the complainants who died, the trial judge charged the jury that, just as with the charges of aggravated sexual assault, the Crown was required to prove beyond a reasonable doubt that:

- Aziga had "unprotected penetrative sexual activity" with each complainant;
- he was aware that he was HIV-positive at the time of having sex with each complainant;
- he was aware that he was required to inform all prospective sexual partners that he was HIV-positive;
- he failed to advise the complainants of his HIV status prior to having penetrative sexual activity with them; and
- the complainant would not have consented to unprotected sex had Aziga told her he was HIV-positive.<sup>6</sup>

However, to obtain a conviction for murder, the Crown also had to prove that:

- the complainant became infected with HIV as a result of sex with Aziga;
- Aziga caused the complainant's death by infecting her with HIV through sex;
- he meant to cause the complainant's death or meant to cause bodily harm that he knew was likely to cause her death, and was reckless as to whether death ensued; and
- the aggravated sexual assault, the HIV infection and the death of the complainant was part of "one continuous sequence of events forming a single transaction," thus elevating the conviction to one of first-degree murder.<sup>7</sup>

### Sentencing

At this writing, sentencing was still pending, following a psychiatric assessment.<sup>8</sup> The Crown had notified the court of its intention to seek an order designating Aziga as a "dangerous offender" under the Criminal Code (Section 753), which would mean the possibility of indefinite imprisonment.

### Commentary

This precedent-setting case raises some significant questions and concerns.

In particular, because Aziga was convicted on at least one count of aggravated sexual assault based solely on oral sex without a condom, there is an implication that oral sex alone constitutes a "significant risk of serious bodily harm" which would suffice legally for a conviction. Yet, performing oral sex on a man not wearing a condom has generally been

considered to present only a "low risk" of HIV transmission at most;<sup>9</sup> some assessments have estimated the per-act risk of transmission as being in the range of 0.01percent (1:10 000).<sup>10</sup>

Similarly, the conviction for aggravated sexual assault where there was but unprotected oral sex and protected vaginal sex is also of concern, given that the risk of transmission to a receptive partner in vaginal sex when a condom is used is in the range of 0.1percent (10:10 000).<sup>11</sup> Broadening the scope of criminalization in a way that does not reflect the scientific evidence undermines the objective of the law by subjecting people living with HIV to criminal culpability where there is, at best, a marginal risk of harm.

The case also resulted in the first murder convictions in Canada for non-disclosure of HIV prior to unprotected sex, with respect to two of Aziga's sexual partners who subsequently died. Justice Lofchik instructed the jury that it had to find, beyond a reasonable doubt, that Aziga intended either to kill the two complainants or to cause bodily harm he knew would likely cause their death and was reckless as to whether death ensued.

In his charge, Justice Lofchik instructed the jurors to decide "whether [Aziga] did in fact form this intent or whether his intent was merely to have sex with the complainants without regard to the consequences," which would be the basis for a finding of manslaughter (as opposed to murder).<sup>12</sup>

The prosecution argued that Aziga's failure to tell them "about his HIV status before, during and after he had unprotected sexual activity with them so that they could obtain medical treatment, is evidence of the intent to kill [SB] and [HC]."<sup>13</sup> This

appears to have been the extent of the evidence regarding Aziga's intent.

In the end, because the jury convicted Aziga of murder in relation to each of the two women who died, this could be interpreted by police and prosecutors as a basis for more regularly pursuing charges for murder or attempted murder in the context of HIV non-disclosure in the future.

In the absence of an informed public debate, charges for non-disclosure of HIV prior to otherwise consensual sex have escalated in Canada from common nuisance and criminal negligence causing bodily harm to assault to aggravated sexual assault and, now, to murder. With little, if any, evidence that criminalizing HIV exposure has significant benefits for HIV prevention, the verdict in *Aziga* may further result in increasing — and increasingly serious — charges for HIV non-disclosure, including in cases where there is no "significant risk" of transmission.

— Sandra Ka Hon Chu  
and Richard Elliott

Richard Elliott (relliott@aidslaw.ca) is Executive Director of the Canadian HIV/AIDS Legal Network.

### HIV-positive man convicted of aggravated sexual assault for offences involving child

On 23 April 2009, Donald Mumford was convicted of two counts of aggravated sexual assault, two counts of touching a person under 14 for a sexual purpose, two counts of inviting a person under 14 to touch him for a sexual purpose, one count of uttering threats to cause bodily harm, and one

count of uttering death threats. The aggravated nature of the sexual assault convictions flowed from the fact that Mumford was knowingly HIV-positive during the commission of the acts and from the fact that some of the sexual activity was unprotected.<sup>14</sup>

The Ontario Superior Court of Justice found that Mumford committed the offences between January and May 2007, against “AD” who was seven years old at the time. Mumford had met AD through his mother TD in 2005 and they saw each other at their respective apartments.

In January 2007, TD experienced a respiratory attack and was hospitalized. After she returned home and while she was recovering from her illness, AD began to spend nights at Mumford’s apartment. In May 2007, AD told his mother that Mumford had touched him. The following day, TD called the Children’s Aid Society and took AD to the hospital, where AD gave a videotaped statement to police who then arrested Mumford.

The Court accepted AD’s testimony, in which he described engaging in oral and anal sex with Mumford. According to AD, Mumford always used a condom during anal sex with AD, but on one occasion, the condom broke and Mumford ejaculated on him. Condoms were not always used when AD performed oral sex on Mumford; on one occasion, while Mumford performed oral sex on AD, Mumford injured AD’s penis causing a lesion and bleeding.

Mumford was diagnosed with HIV in 1995. Because Mumford was knowingly HIV-positive at the time the sexual activities with AD occurred, the Court held that he knew the risks of infection associated with him having unprotected sex.

### **Thai woman’s appeal of criminal conviction dismissed, but sentence reduced**

On 12 June 2009, the Ontario Court of Appeal dismissed an appeal by Suwalee Iamkhong of her conviction for criminal negligence causing bodily harm and aggravated assault for failing to disclose her HIV status before having unprotected sex with her husband.<sup>15</sup>

Iamkhong, who is originally from Thailand, had tested positive for HIV in Hong Kong prior to working in Canada. At her trial, she testified that she believed she did not have HIV after a subsequent medical exam in Canada which, she mistakenly assumed, also included an HIV test.

The trial judge did not believe that Iamkhong did not know that she had HIV when she repeatedly had unprotected sex with her husband. Iamkhong was convicted in January 2007, and sentenced in August 2007 to two years on each count, to be served concurrently.<sup>16</sup>

In her appeal, Iamkhong submitted that the trial judge erred in rejecting her testimony insofar as he failed to consider her background and lack of sophistication in evaluating the credibility of her evidence. Iamkhong also submitted that the trial judge failed to consider the exculpatory effect of the fact that she had conscientiously refrained from sex after testing HIV-positive in Hong Kong, in order to avoid transmitting the disease, and resumed sex only after the Canadian medical examination.

The Ontario Court of Appeal held that the trial judge did not err in his assessment of Iamkhong’s credibility, since his reasons indicated that he

was aware that Iamkhong’s position was that she did not believe she was HIV-positive at the relevant time.

Iamkhong also submitted that the trial judge erred in finding that her right to a trial within a reasonable time under Section 11(b) of the *Canadian Charter of Rights and Freedoms* was not violated, and that the charges should have been stayed. The Ontario Court of Appeal dismissed this point of appeal, stating that the prejudice was not sufficient to warrant revisiting the trial judge’s finding and the overall delay was not unreasonable.

Finally, Iamkhong sought leave to appeal her sentence, asking that it be reduced by one day so as to retain her entitlement to appeal a potential deportation order. Iamkhong’s sentence denied her the right to appeal if she was ordered deported from Canada, since persons in Canada who are not citizens may be removed from the country if they have been convicted of a crime that was punished by at least two years’ imprisonment.

The Ontario Court of Appeal held that the trial judge would have been entitled to look at the deportation consequences for Iamkhong. In its view, a sentence of two years less a day after credit for strict bail conditions would be equally fit. As such, the Court set aside the sentence of two years imprisonment imposed at trial and substituted a sentence of two years less a day.

### **Man pleads guilty to assault with a weapon for wielding syringe**

Brendan Cudmore pleaded guilty on 12 May 2009 to threatening an

Edmonton police officer and two mall security guards with a syringe he claimed contained HIV.<sup>17</sup>

Cudmore was convicted in an Alberta provincial court of three counts of assault with a weapon, mischief and two counts of possession of stolen property. He was sentenced to eight months' imprisonment, which Justice Matchett ruled he had already served in pre-trial custody.

Justice Matchett was reported to have cited Cudmore's attempts to obtain substance abuse treatment and his guilty plea as reasons for awarding him a relatively light sentence.<sup>18</sup>

### **Non-disclosure of HIV status an aggravating factor in Quebec man's sentence<sup>19</sup>**

In March 2009, Sylvain Delangis, a 41-year-old HIV-positive man was sentenced to nine years in prison for having sexually assaulted a young girl. Arrested in March 2008 in Ste-Marthe-sur-le-Lac, he pleaded guilty to multiple sexual assault charges and admitted he had sex with the complainant several times between 2006 and 2008, when she was between the ages of 12 and 14.

At no time did Delangis disclose his health condition. The girl tested negative for HIV at the time Delangis was sentenced.

While Delangis' defence counsel requested a five-year sentence, Justice Sirois of the Court of Québec in St-Jérôme followed the Crown's recommendation to impose a nine-year sentence because of the particular circumstances of the case. The fact that Delangis did not disclose his HIV status was an aggravating factor

in the sentence, as were his attempt to attribute partial responsibility to the complainant and his high risk of re-offending.

— Marie-Ève Lavoie

Marie-Ève Lavoie (marievelavoie@hotmail.com) is a law student at McGill University and worked previously at COCQ-Sida, where she was responsible for its "HIV Info Rights" program.

### **HIV-positive man convicted for sexual crime involving a minor**

In July 2009, Sylvain Dufresne was convicted of sexual interference for having had sexual contact with a 12-year-old boy he met on the Internet. This was Dufresne's third conviction for a sexual crime involving a minor.<sup>20</sup>

The boy, who pretended to be 15, invited Dufresne to his home while his parents were away. Dufresne did not reveal his HIV-positive status and requested that the boy give him unprotected oral sex, which he did. A subsequent HIV test confirmed the boy was not infected.

During sentencing, the Crown argued that the non-disclosure of HIV status was one of the aggravating factors for which Dufresne should be declared a long-term sex offender.

In September 2009, Dufresne was sentenced to three years in prison and a ten-year surveillance period, the maximum for long-term sex offenders.<sup>21</sup>

— Marie-Ève Lavoie

### **Man pleads guilty for failing to disclose his HIV status before unprotected sex**

On 9 June 2009, Fidel Mombomackay pleaded guilty to aggravated sexual assault for failing to disclose his HIV-positive status to a Saskatoon woman prior to having unprotected sex with her.<sup>22</sup> The woman, whose identity is protected by a publication ban, was infected with HIV.

Mombomackay, who was already in prison after being convicted in Ontario in 2007 of knowingly exposing three women to HIV,<sup>23</sup> was reported to have been in a sexual relationship with the Saskatoon woman between 2004 and 2005.<sup>24</sup>

On 11 September 2009, Justice Popescul of the Saskatchewan Court of Queen's Bench sentenced Mombomackay to four years in prison, which he will begin serving upon completion of the 30-month term he is serving for the convictions in Ontario.<sup>25</sup>

### **Hamilton man pleads guilty to aggravated sexual assault for failure to disclose HIV-positive status**

On 5 October 2009, Daniel Edgar Chin pleaded guilty to four counts of aggravated sexual assault for failing to disclose his HIV-positive status to four sexual partners.<sup>26</sup> Two of the complainants contracted HIV.

Chin learned he was HIV-positive in 2005 after being tested at an anonymous clinic in Toronto.<sup>27</sup> By 2007, public health officers had been

alerted that Chin was identified as a sexual partner by several men who had been diagnosed with sexually transmitted infections, including HIV.

Hamilton's public health unit subsequently issued Chin with a Section 22 order under Ontario's *Health Protection and Promotion Act*, which required Chin to refrain from taking certain actions in order to prevent HIV transmission. Chin was arrested in October 2007 after he missed a scheduled appointment with public health nurses.<sup>28</sup>

### **Hamilton woman pleads guilty to aggravated sexual assault for failure to disclose HIV-positive status**

Robin Lee St. Clair was originally charged with sexual assault in March 2007 after a man complained that during their one-night stand, she disclosed her HIV status only after the condom broke.<sup>29</sup> The complainant was not infected with HIV.

After St. Clair was charged, the Toronto Police Service issued a public safety alert featuring St. Clair's photo and HIV status, and advising those who had had sexual contact with her to seek medical advice. According to the police, St. Clair frequented bars in Hamilton, Brantford and Toronto "on a regular basis, and has been sexually active with men she meets at these bars."<sup>30</sup>

St. Clair had tested positive for HIV in 2003, after which police alleged she ignored a 2004 public health order to disclose her condition before sex.<sup>31</sup>

On 17 June 2009, St. Clair pleaded guilty to the more serious charge of aggravated sexual assault.

### **Man sentenced to ten years for aggravated sexual assault involving non-disclosure of HIV status**

On 31 March 2009, the B.C. Supreme Court sentenced Charles Kokanai Mzite to ten years less three days for four counts of aggravated sexual assault.<sup>32</sup> Mzite was found guilty earlier in March 2009 of aggravated sexual assault for having unprotected sex with four Victoria women without telling them he was HIV-positive.<sup>33</sup>

Mzite received a four-year sentence for the woman he infected with HIV, and two years less one day for each of his other three victims. The sentences are to be served consecutively.

Mzite, who has been in jail since September 2007, was credited with 37 and one-half months for time served, meaning he must serve a further six years and 10 months in prison. Mzite was also required to comply with the National Sex Offender Registry and provide a DNA sample.<sup>34</sup>

The B.C. Supreme Court acknowledged that the sentence would affect Mzite's immigration status. He had immigrated from Zimbabwe to Canada in 2001 and is a protected person under the *Immigration and Refugee Act*. As a result of his conviction, Mzite will likely be ordered deported.<sup>35</sup>

### **Imona-Russel sentenced to nine years for assault and sexual assault convictions**

William Imona-Russel was convicted in February 2009 by the Ontario

Superior Court Justice of assault causing bodily harm, assault with a weapon, threatening death, assault, two counts of sexual assault and attempted aggravated sexual assault.<sup>36</sup> The convictions related in part to a sexual relationship Imona-Russel had with a woman, during which time he did not disclose his HIV-positive status to her.<sup>37</sup>

During his sentencing hearing, Prosecutor Julia Forward recommended that Imona-Russel be sentenced for eight to 10 years for his crimes. Lawyer Ferhan Javed, Imona-Russel's court-appointed representative, argued that Imona-Russel should receive four to six years imprisonment.<sup>38</sup>

On 25 September 2009, Ontario Superior Court Justice John McMahon sentenced Imona-Russel to nine years in prison, but awarded him five years and 15 days of "time served" in pre-trial custody.<sup>39</sup>

<sup>1</sup> J. Huber and T. Crawford, "Murder verdict in HIV case sets off alarm; first in Canada," *The National Post*, 6 April 2009, p. A1.

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

<sup>3</sup> *R. v. Aziga*, Charge to the Jury (1–2 April 2009), Court File No. CR-08-1735 (Ontario Superior Court of Justice), pp. 47–48.

<sup>4</sup> *Ibid.*, p. 100.

<sup>5</sup> *R. v. Williams*, [2003] 2 SCR 134, 2003 SCC 41.

<sup>6</sup> *R. v. Aziga*, Charge to the Jury (supra), pp. 100–101.

<sup>7</sup> *Ibid.*

<sup>8</sup> "Johnson Aziga, convicted in HIV sex deaths, due to return to court," *The Canadian Press*, 24 September 2009.

<sup>9</sup> Canadian AIDS Society, *HIV Transmission: Guidelines for Assessing Risk*, Fifth Edition, 2005.

<sup>10</sup> D.K. Smith et al., "Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccu-

pational exposure to HIV in the United States," *MMWR Recomm Rep* 54 (No. RR-2) (2005): 1–20 at 7.

<sup>11</sup> *Ibid.*

<sup>12</sup> *R. v. Aziga*, Charge to the Jury (*supra*), pp. 197–198.

<sup>13</sup> *Ibid.*, p. 240.

<sup>14</sup> *R. v. Mumford*, [2009] O.J. No. 1637 (QL).

<sup>15</sup> *R. v. Iamkhong*, [2009] O.J. No. 2446 (QL).

<sup>16</sup> 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.

<sup>17</sup> T. Blais, "Thief confesses to syringe attack," *The Edmonton Sun*, 13 May 2009, p. 24.

<sup>18</sup> *Ibid.*

<sup>19</sup> See "Sylvain Delangis est condamné à 9 ans de prison pour agression sexuelle," *La Presse Canadienne*, 24 March 2009; "HIV positive man sentenced to nine years of prison for sexual assault," *The Canadian Press*, 24 March 2009; and "9 ans de prison pour un homme qui a agressé sexuellement une adolescente alors qu'il était porteur du VIH," *Branchez-vous*, 24 March 2009.

<sup>20</sup> C. Touzin, "Un pédophile porteur du VIH a eu une rela-

tion non protégée," *La Presse*, 22 July 2009.

<sup>21</sup> J. Morabitos, "La prison pour le cyberpédophile Sylvain Dufresne," *Le Courrier du Sud*, 21 September 2009.

<sup>22</sup> L. Coolican, "Man pleads guilty to infecting Saskatoon woman with HIV; did same thing in Ontario in 2005," *National Post*, 10 June 2009, p. A7.

<sup>23</sup> S. Chu, "Thirty-month sentence for three counts of aggravated sexual assault," *HIV/AIDS Policy & Law Review* 12(2/3) (2007): 46.

<sup>24</sup> L. Coolican (*supra*).

<sup>25</sup> L. Coolican, "Criminal's actions 'despicable'; deliberately hid his AIDS status from victim," *The (Saskatoon) Star Phoenix*, 11 September 2009, p. A16.

<sup>26</sup> B. Brown, "Man pleads guilty to HIV assaults; Chin didn't tell partners," *Hamilton Spectator*, 6 October 2009, p. A3.

<sup>27</sup> *Ibid.*

<sup>28</sup> "Man to stand trial in HIV sex-assault case," *Hamilton Spectator*, 22 July 2008, p. A3.

<sup>29</sup> M. Mandel, "Lovers' lives left in doubt; woman kept HIV status to herself," *Toronto Sun*, 11 September 2009, p. 9.

<sup>30</sup> *Public safety alert: woman arrested for sexual assault*, Toronto Police Service news release, 22 March 2007.

<sup>31</sup> D.A. Freed, "Woman with HIV pleads guilty in sex case," *Toronto Star*, 18 June 2009, p. GT02.

<sup>32</sup> L. Dickson, "HIV man gets 10 years for not telling sex partners," *The (Vancouver) Province*, 1 April 2009, p. A10.

<sup>33</sup> S. Chu, "Man found guilty of four counts of aggravated sexual assault for non-disclosure of HIV status," *HIV/AIDS Policy & Law Review* 14(1) (2009): 42.

<sup>34</sup> L. Dickson (*supra*).

<sup>35</sup> *Ibid.*

<sup>36</sup> Transcript of oral reasons in *R. v. William Imona-Russell*, 23 February 2009, Ontario Superior Court of Justice.

<sup>37</sup> S. Chu, "Man convicted of attempted aggravated sexual assault where evidence indicates condom not worn," *HIV/AIDS Policy & Law Review* 14(1) (2009): 41.

<sup>38</sup> "HIV positive man should serve 10 years for raping, infecting ex-lover; court hears," *The Canadian Press*, 12 September 2009.

<sup>39</sup> B. Powell, "HIV-positive man gets 9 years for sex attack; put power drill against former girlfriend's head and then raped her," *The Toronto Star*, 26 September 2009, p. GT07.

## In brief

### Court strikes down restriction in medical marijuana program

On 2 February 2009, the B.C. Supreme Court convicted Matthew Beren, who produced marijuana for the Vancouver Island Compassion Club, of the production, possession and controlling of marijuana for the purposes of trafficking. However, it also found federal provisions limiting the supply of marijuana available to licensed medical users unconstitutional.<sup>1</sup>

The *Marihuana Medical Access Regulations* (Regulations) makes dried marijuana available to those holding a licence in dosages approved by their physicians. In

defence of the trafficking charges, Beren argued that the practical effect of the restrictive nature of the Regulations made the legal supply of marijuana for most medical cannabis users illusory. In particular, Beren argued that the specific conditions which must be met in order to have access to a legal supply of marijuana for medical purposes were cumbersome, arbitrary, unduly restrictive and acted as a barrier to access.

Beren thus contended that the federal government's policy and operational choices in this area violated his rights to liberty and security, contravened Section 7 of the *Charter of Rights and Freedoms* (Charter) and were contrary to the principles of fundamental justice.

The B.C. Supreme Court held that the requirement in the Regulations that physicians act as gatekeepers for access to legally sanctioned marijuana did not violate the Charter. Although it acknowledged that this might cause some patients delay or even denial of access for the relief sought, the Court found evidence indicating that it was becoming increasingly easy to obtain a physician's support for a licence to possess marijuana. Therefore, the Court said, there was ample justification for the hurdles to access set by the Regulations.

However, the Court found that the provisions of the Regulations restricting persons to only one production licence and prohibiting licence hold-

ers from producing marijuana in common with other licence holders were arbitrary, contrary to Section 7 of the Charter, and not in accordance with the principles of fundamental justice. As such, the B.C. Supreme Court declared those provisions invalid, but stayed the effect of this declaration of invalidity for one year to allow the Crown to respond as required.

With respect to Beren, the B.C. Supreme Court found that the essential elements of the charges against Beren were proven: Beren was producing and trafficking in marijuana for the purpose of supplying a compassion club, which in turn was selling the marijuana to its members, most of whom were not licensed to possess the drug in accordance with the provisions of the Regulations which the Court found to be valid. As such, Beren was convicted of the trafficking charges.

### **Quebec tribunal allows dental assistant to request alternate tasks while breastfeeding to reduce risk of HIV infection**

On 29 April 2009, the Commission des lésions professionnelles du

Québec permitted Stella Gounaris' request for "preventive retreat" from her work in light of the fact that she was breastfeeding.

Because she works as a dental assistant, Gounaris and her baby were exposed to, among other things, the risk of HIV infection. Accordingly, Gounaris argued that, pursuant to the *Loi sur la santé et la sécurité du travail*, she was entitled to another appointment, or in the absence of alternative employment, to paid leave.<sup>2</sup>

In August 2008, the Commission de la santé et de la sécurité au travail had refused Gounaris' claim on the basis that she was not exposed to a risk of HIV infection in the context of employment if universal precautions, such as the wearing of gloves and a mask, were taken.

However, the Commission des lésions professionnelles du Québec held that these measures only reduced the risk of HIV infection. Because Gounaris was exposed to various risks, including the possibility of viral infection, she was entitled to request to be appointed to other tasks and, if these were not available, to paid leave, so as not to endanger her baby.

The Commission also held that Gounaris was entitled to compensation

for the loss of revenue she suffered as a result of her justified retreat.

— *Cécile Kazatchkine and  
Sandra Ka Hon Chu*

Cécile Kazatchkine (ckazatchkine@aidslaw.ca) is a policy analyst with the Canadian HIV/AIDS Legal Network.

<sup>1</sup> *R. v. Beren*, [2009] B.C.J. No. 618 (Q.L.).

<sup>2</sup> *Gounaris et Clinique dentaire l'Acadie Sauvé*, 2009 LNQCLP 118 (Q.L.). Article 46 of the *Loi sur la santé et la sécurité du travail* provides: "Une travailleuse qui fournit à l'employeur un certificat attestant que les conditions de son travail comportent des dangers pour l'enfant qu'elle allaite peut demander d'être affectée à des tâches ne comportant pas de tels dangers et qu'elle est raisonnablement en mesure d'accomplir. La forme et la teneur de ce certificat sont déterminées par règlement et l'article 33 s'applique à sa délivrance." Article 47 provides: "Si l'affectation demandée n'est pas effectuée immédiatement, la travailleuse peut cesser de travailler jusqu'à ce que l'affectation soit faite ou jusqu'à la fin de la période de l'allaitement."

# 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 Patricia Allard (pallard@aidslaw.ca), Deputy Director of the Canadian HIV/AIDS Legal Network and editor of this section. Except where otherwise noted, the articles in this section were written by Ms Allard.

## India: Delhi High Court annuls law criminalizing adult homosexual relations

In what is considered by many to be a landmark decision on equality and non-discrimination in India, the Delhi High Court declared in July 2009 that Section 377 of the *Indian Penal Code*, which criminalizes people who engage in “unnatural offences,” violates the rights to equality, freedom from discrimination, and life and personal liberty, pursuant to the *India Constitution (Constitution)*.<sup>1</sup> The court also agreed with the petitioner in the case that the law severely impairs HIV/AIDS prevention efforts by discouraging men who have sex with men (MSM) from participating for fear of stigma, discrimination and police abuse under the guise of enforcing the Section.

The public interest challenge to the 150-year-old law was brought in 2001 by the Naz Foundation (India) Trust, represented by the Lawyers Collective HIV/AIDS Unit.<sup>2</sup> The Naz Foundation is a non-governmental

organization active in sexual health and HIV/AIDS intervention and prevention, with a focus on marginalized groups such as MSM.

The Foundation argued that Section 377, coupled with the nega-

tive and discriminatory attitudes of state agencies, drives sexual minorities underground, thereby crippling HIV/AIDS prevention efforts among this marginalized and particularly vulnerable community.

The Foundation argued that, in its application to private adult consensual sex, Section 377 violates the rights to equality, freedom from discrimination, freedom of expression, and to life and personal liberty as set out in the Constitution. Specifically, the petitioners contended:

- that the section is arbitrary and unreasonable, and that it disproportionately targets the gay community in violation of the right to equality and equal protection of the law (Article 14 of the Constitution);
- that the section violates Article 15 of the Constitution, which prohibits discrimination on the basis of sex (which includes sexual orientation in addition to gender); and
- that criminalization inhibits self-expression and interferes with the exchange of information on sexuality, thus violating freedom of expression (Article 19 of the Constitution).

Finally, the petitioners argued that criminalization violates individual dignity and inhibits the exchange of information on sexuality which, in turn, interferes with the right to health. They argued that privacy should extend to the protection of sexual orientation, expression and conduct, so long as the conduct causes no harm to others. Privacy, dignity and health all flow from the right to life and personal liberty protected in Article 21 of the Constitution.<sup>3</sup>

Numerous interventions were filed in support of, and against, the petition. Contradictory interventions were filed by two branches of the Indian government. The Ministry of Home Affairs sought to justify and

retain Section 377, arguing that it has not been used only in homosexuality cases, but also in child sexual abuse cases, as well as to fill gaps in the rape laws.

India's National AIDS Control Organization (NACO), backed by the Ministry of Health and Family Welfare, on the other hand, supported the petition and reiterated that the impugned section seriously interfered with HIV/AIDS prevention efforts.<sup>4</sup>

**Public morality and public disapproval cannot justify the curtailment of rights and cannot be used to uphold the constitutionality of the law.**

The Naz Foundation's petition was initially dismissed on the grounds that it had no standing to challenge the law since it had not been prosecuted under it. In 2006, however, the Supreme Court remanded the matter back to the High Court to hear the case on the merits.

In the High Court decision, Chief Justice Shah and Justice Murlidhar declared that "Section 377 IPC, insofar it criminalises consensual sexual acts of adults in private, is violative of Articles 21, 14 and 15 of the Constitution."<sup>5</sup>

The court relied on Indian and foreign case law to find that the right to privacy protects personal autonomy

and space; that protecting the rights of vulnerable persons is vital to HIV prevention; that sex discrimination includes discrimination on the basis of sexuality and sexual orientation; and that public morality and public disapproval cannot justify the curtailment of rights and cannot be used to uphold the constitutionality of the law.

The court concluded by advising the Indian Parliament to amend the law on sexual offences to give effect to the Indian Law Commission's recommendations, which call for Section 377 to be repealed and for rape laws to be made gender-neutral.

With specific reference to the relation between the impugned law and HIV/AIDS, the court referred to numerous international instruments and reports addressing the right to health and ultimately agreed with the petitioners to find that

Section 377 IPC pushes gays and MSM underground, leaves them vulnerable to police harassment and renders them unable to access HIV/AIDS prevention material and treatment. On the other, the extensively documented instances of NGOs working in the field of HIV/AIDS prevention and health care being targeted and their staff arrested under Section 377 IPC amply demonstrate the impact of criminalization of homosexual conduct.<sup>6</sup>

While the decision is being appealed by some groups and individuals, it was also celebrated by many, including numerous gay rights and HIV/AIDS activists, as well as by NACO, which stated that "with criminal sanctions gone, we hope to reach out better to men who have sex with men and encourage safer sex."<sup>7</sup> The UNAIDS Country Coordinator

in India also welcomed the decision, as follows:

We are excited by the Delhi High Court's ruling and hope that it will send a positive signal to many other countries, especially in South and West Asia, where sodomy is punishable by death. Locally, it will give a boost to efforts to prevent HIV among homosexual men, who will no longer be fugitives from the law."<sup>8</sup>

— Celeste A. Skanland

Celeste Skanland is a third year law student at McGill University.

<sup>1</sup> Section 377 states: "Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or for a term which may extend to ten years, and shall also be liable to fine": *Indian Penal Code, Act No.45 of 1860 (IPC)*. The impugned section is ambiguous in itself, but it has been interpreted to mean that anal, oral and other penile-non-vaginal sex, including between consenting adults, is unlawful.

<sup>2</sup> *Naz Foundation (India) Trust v. Government of NCT, Delhi and Others*, (July 2, 2009), WP(C) No.7455/2001 (High Court of Delhi).

<sup>3</sup> See *The Constitution of India* as of 2 July 2008, online: <http://lawmin.nic.in/coi/coiason29july08.pdf>; and The Lawyers Collective HIV/AIDS Unit, *Sodomy Law Declared*

*Unconstitutional*, online: [www.lawyerscollective.org/sites/default/files/Sodomy%20Law%20Declared%20Unconstitutional.pdf](http://www.lawyerscollective.org/sites/default/files/Sodomy%20Law%20Declared%20Unconstitutional.pdf).

<sup>4</sup> Numerous other interested parties intervened in this case, both in support of and against the petitioner's challenge. Some of those who were against it are now appealing the decision. Mr. P.P. Malhotra, Additional Solicitor General (ASG), for example, argued that Section 377 helps to curtail the spread of HIV/AIDS and that decriminalization would cause a decline in public health and foster the spread of AIDS. See *Naz Foundation* (supra), para. 24(ii).

<sup>5</sup> *Naz Foundation* (supra), para. 132.

<sup>6</sup> *Ibid.*, para. 71.

<sup>7</sup> Lawyers Collective, "Indian court decriminalizes homosexuality," news release, Delhi, 2 July 2009, online: [www.lawyerscollective.org/node/1004](http://www.lawyerscollective.org/node/1004).

<sup>8</sup> *Ibid.*

## U.S.: Extended jail sentence of HIV-positive pregnant woman from Cameroon overturned

**In May 2009, a U.S. District Court judge sentenced Quinta Layin Tuleh, a pregnant HIV-positive woman from Cameroon, to 238 days incarceration for the possession of fake immigration documents. The judge defied the extended sentence on the grounds that it was necessary to protect her "unborn child" from contracting HIV.<sup>1</sup>**

Ms. Tuleh arrived in the U.S. from Cameroon in September 2008. She was arrested in Presque Isle, Maine on 21 January 2009 and charged with possession of fake immigration documents (a social security card and a work permit). At her first court appearance, the Magistrate Judge ordered that Tuleh be held without bail pending the outcome of her case. On 26 January 2009, Tuleh waived indictment and pleaded guilty. Tuleh

was pregnant and HIV-positive, both of which she was unaware of at the time of her arrest.

According to the federal sentencing guidelines, Tuleh's recommended sentence was zero to six months. Both the federal prosecutor and the defence attorney asked for 114 days, or time already served.<sup>2</sup>

Judge John Woodcock ignored these requests, as well as the sentencing guidelines, and sentenced

Tuleh to 238 days in federal prison. Woodcock was explicit that the purpose of the extended sentence was to ensure that Tuleh's baby had a good chance of being born free of HIV.

In his reasoning, Woodcock argued that the law required him to consider the defendant's medical condition. Although this is normally used to lower sentences, he found that there was nothing in the guidelines to prevent him from using Tuleh's pregnancy and

HIV status to extend her sentence on the same grounds. He argued:

I'm not doing this to punish you. I'm doing it because under the law I have to take into consideration your medical condition, and the law allows me to do that, and I think it's only fair to your child to make sure that your child, to the extent possible, is ... not born HIV positive....<sup>3</sup>

My obligation is to protect the public from further crimes of the defendant, and that public, it seems to me at this point, should likely include the child she's carrying. I don't think the transfer of HIV to an unborn child is a crime technically under the law, but it is as direct and as likely as an ongoing assault. If ... I were to know conclusively that upon release from imprisonment a defendant was going to assault another person, I would act in a fashion to prevent that, and the transfer of HIV to an unborn child, it seems to me, is similar to an assault, causing grievous injury to a wholly innocent person. And so I think I have the obligation to do what I can to protect that person, when that person is born, from permanent and ongoing harm.<sup>4</sup>

Tuleh requested bail and appealed her sentence to the First Circuit Court of Appeals in Boston. The federal prosecutor also appealed the decision. Both parties requested that the Circuit Court overturn the sentence and return the case to Judge Woodcock for re-sentencing, with the expectation that he would give her time served and release her immediately.

A number of interested individuals and organizations filed a joint *amicus curiae* in support of the appeal and Tuleh's request for bail.<sup>5</sup> The *amici* argued that the sentence could not

be reconciled with "evidence-based medical practices for pregnant women living with HIV," with the Federal Sentencing Guidelines or with the constitutional rights of pregnant women and persons living with HIV.<sup>6</sup>

In particular, the *amici* objected to the judge's analogy of the transfer of HIV to an unborn child as an ongoing assault. They argued that the courts have consistently refused to allow prosecution of pregnant women who endanger the health of their fetus. The *amici* also provided evidence to the effect that the health of pregnant women and treatment for persons with HIV are not well served in prisons where consistent levels of care are not always available.<sup>7</sup>

On 15 June 2009, Judge Woodcock released Tuleh on bail while her appeal was pending.

In granting the motion for bail, Woodcock said that he understood why the case was so controversial but that his intention was only to ensure that Tuleh remained healthy and that the child was born healthy. "At the time of the sentencing, I had no clear understanding of what the community could do, I had no specifics," he said.

Once declared, however, Woodcock had no power to revise the sentence. The Boston First Circuit Court thus agreed to hear the appeal on an expedited schedule and they promptly vacated her sentence and sent the case back to Judge Woodcock for re-sentencing. They offered no detailed reasoning for doing so.

In August 2009, Judge Woodcock re-sentenced Tuleh to 114 days, or time served, plus two years of supervised probation. She was released immediately. The hearing was remarkably short, lasting less than

ten minutes and Woodcock did not elaborate on the reasons for the revised sentence.<sup>8</sup>

— Celeste A. Skanland

<sup>1</sup> *United States of America v. Quinta Layin Tuleh*, Criminal Action Docket No. 09-19-B-W (United States District Court of Maine, May 14, 2009).

<sup>2</sup> Tuleh's defence lawyer argued that "...ultimately, she has the moral agency to decide what to do with her life.... And as attractive as it would be to go around and ... try to get people to do what's right, that's, unfortunately, ... or fortunately, depending on your viewpoint, ... the world that we live in": *United States of America v. Quinta Layin Tuleh* (supra), Transcript of Sentencing Proceedings, p. 26.

<sup>3</sup> *Ibid.*, p. 20.

<sup>4</sup> *Ibid.*, p. 31.

<sup>5</sup> The joint emergency *amicus curiae* challenging the sentence was led by the National Advocates for Pregnant Women, the Center for HIV Law and Policy, and Elizabeth Frankel and Valerie Wright of the Maine law firm Verrill Dana, LLP, on behalf of 28 public health experts, advocates and organizations. See *United States of America v. Quinta Layin Tuleh* (supra), *Amicus Curiae Brief of Medical, Public Health, and HIV Experts and Advocates in Support of Bail Pending Appeal or, in the Alternative, Re-Sentencing*, online: <http://advocatesforpregnantwomen.org/QT%20Amicus%20Brief,%20redacted.pdf>.

<sup>6</sup> *Ibid.*, p. 1.

<sup>7</sup> See also, the declaration of Dr Robert Cohen describing the variability in HIV care in U.S. prisons, which often leads to poor outcomes: "I have seen, and continue to see examples of HIV care in prisons and jails which compromise the health of HIV infected persons. It is common for prisoners to receive inappropriate medications. It is very common for prisoners to have frequent and prolonged interruptions of their anti-retroviral medications": *United States of America v. Quinta Layin Tuleh* (supra), Appendix B: Declaration of Robert L. Cohen, M.D.

<sup>8</sup> J. Harrison, "Judge resents HIV-positive woman to time served," *Bangor Daily News*, 5 August 2009.

## Constitutional Court of South Africa overturns lower court's decision on the right to "sufficient water"

**On 8 October 2009, the Constitutional Court of South Africa overturned the judgment of the Supreme Court of Appeal, which addressed the proper interpretation of Section 27(1)(b) of the *Constitution of South Africa* (Constitution) — namely, everyone's right to have access to sufficient water.**

At issue before the court was whether the City of Johannesburg's Free Basic Water policy of providing six kilolitres of free water per month (25 litres per person per day) infringed residents' right to water under Section 27 of the Constitution or Section 11 of the *Water Services Act*. In addition, the court considered whether the state's use of pre-paid water meters in the Phiri Township — one of the oldest areas of Soweto, composed of a disproportionately poor, black population — was lawful. The pre-paid meter system would require Phiri residents to purchase water credits once they had used up their household's six free kilolitres.

As reported earlier in the *Review*, the initial decision in this matter, delivered by the High Court, found that "pre-paid water meter system infringes national standards, including the requirement that no consumer be without water for more than seven days per year, and violates procedural fairness."<sup>1</sup>

Further, the High Court determined that the pre-paid meter practice was discriminatory when comparing the treatment of Phiri residents with that of other Johannesburg residents, and ordered the city to cover the cost of the installation of

the metered system. Finally, the court found that individual residents required more than the minimum standard (25 litres) of free basic water, and, as such, ordered the state to provide 50 litres per person per day of free basic water.

On appeal, the Supreme Court of Appeal varied the High Court's order, determining "that the quantity of water required for dignified human existence in compliance with section 27 of the Constitution was 42 litres per person per day."<sup>2</sup> Further, the Court of Appeal ruled that the state was not entitled in law to impose a pre-paid meter system that cut off the water supply to residents once they had exceeded the free basic water limit.

On appeal, the Constitutional Court found that the proper interpretation of section 27(1)(b) of the Constitution must be understood in light of Section 27(2), which makes "clear that the right does not require the state upon demand to provide every person with sufficient water ... rather it requires the state to take reasonable legislative and other measures progressively to realise the achievement of the right of access to sufficient water, within available resources."<sup>3</sup>

With respect to the city's legal authority to impose a pre-paid meter system on Phiri residents, the court determined that, under statute, municipalities are entitled "to establish pre-paid systems for the provision of services," and, consequently, the city had a legal right to develop a pre-paid water meter system. Finally, the court found that the practice of the pre-paid meter was neither discriminatory nor unfair to Phiri residents.

<sup>1</sup> A. Symington, "South African High Court defends the right to water," *HIV/AIDS Policy & Law Review* 13(1) (2008): 59.

<sup>2</sup> *Lindiwe Mazibuko & Others v. The City of Johannesburg & Others*, Constitutional Court of South Africa, Case CCT 39/09, 8 October 2009, para. 28.

<sup>3</sup> *Ibid.*, para. 50.

# Rulings in Argentinean and Colombian courts decriminalize possession of small amounts of narcotics

Two recent court decisions in South America have reflected a growing backlash in the region against the so-called, U.S.-led “war on drugs.” In Argentina, the Supreme Court of Justice ruled unanimously on 25 August 2009 that the second paragraph of Article 14 of the country’s drug control legislation, which punishes the possession of drugs for personal consumption, was unconstitutional. In Colombia, the Supreme Court of Justice ruled on 8 July 2009 that the possession of illegal drugs for personal use was not a criminal offence.

## Argentina

In Argentina, the Court said that the unconstitutionality of Article 14 was applicable to cases of drug possession for personal consumption that does not affect others. It noted,

[T]he second paragraph of Article 14 of Law N° 23.737 should be invalidated, since it violates Article 19 of the National Constitution, in the sense that it invades the sphere of personal liberty, which is excluded from the authority of state organs. For this reason, the unconstitutionality of this legal disposition is declared, for it incriminates the possession of drugs for personal use under circumstances that do not bring any concrete danger or harm to the rights and welfare of others.<sup>1</sup>

The law penalizing the possession of drugs for personal consumption affects the right to privacy, which is protected by Article 19 of the *National Constitution of Argentina* and by international human rights instruments. In this regard, the Court noted,

[D]rug possession for personal consumption in itself does not provide any reason to affirm that the accused

have carried out anything more than a private act or that they have offended public morals or the rights of others.<sup>2</sup>

The ruling resolved the cases of five people who were apprehended leaving a house that was under investigation for drug sales. They were arrested by police officers close to the house, and each one of them was found to be in possession of small quantities of marijuana (about three cigarettes each).

Referring to drug use in general, the Court said,

It is clear that definitive answers for these questions cannot be found in the framework of criminal law without jeopardizing possible solutions in other areas. Criminalizing an individual [for drug use] is undeniably inhumane, subjecting the person to a criminal process that will stigmatize him for the rest of his life and subject him, in some cases, to prison time.<sup>3</sup>

The Court urged

all instances of government to ensure a State policy against illicit drug trafficking and to adopt preventative health measures ... geared primarily at vulnerable groups, especially minors, in order to adequately comply with the

international human rights treaties to which our county subscribes.<sup>4</sup>

## Colombia

In Colombia, the Supreme Court of Justice ruled on a case involving a man prosecuted for possession of a small quantity of cocaine. The court, having established that the man did not intend to traffic in the drug, overturned his conviction and ordered him immediately released. “In the exercise of his personal and private rights, the accused did not harm others, so his conduct cannot be the object of any punishment,” the Court found.<sup>5</sup>

The Court cited a 1994 decision by the country’s Constitutional Court, which said that possession of illegal drugs within fixed limits was not subject to prosecution.

The defendant, Ancízar Jaramillo Quintero, had been convicted for possession of 1.3 grams of cocaine, sentenced to 64 months in prison and ordered to pay a fine of 1.2 million pesos (CAN\$664).

The court found that there were no grounds for punishment because the fact that Jaramillo was carrying only a tiny amount over the minimum (one gram) could not be considered a

crime. The Court said that there may be moments in which a drug user possesses quantities a little larger than those permitted without this constituting drug trafficking. In the case of Jaramillo, the Court found that the small amount of cocaine that he had in his possession was not meant to be sold or distributed to other individuals, but rather was for his personal consumption.

The Court recognized that drug consumption is a personal decision of each individual and that it causes addiction. However, the Court said, the problem is not a criminal one that

is resolved with convictions, but rather one that it is “worthy of receiving therapeutic medical treatment before any punishment, sentence or placement in a penitentiary.”<sup>6</sup>

Finally, the Court emphasized that authorities must “tolerate any attitude or behaviour that does not significantly harm or put other people at risk.”<sup>7</sup>

— *David Cozac*

David Cozac (dcozac@aidslaw.ca) is Communications and Development Officer

with the Canadian HIV/AIDS Legal Network.

<sup>1</sup> “Argentina’s supreme court ‘Arriola’ ruling on the possession of drugs for personal consumption,” *Intercambios*, 1 September 2009, online: [www.tni.org/detail\\_page.phtml?&act\\_id=19841](http://www.tni.org/detail_page.phtml?&act_id=19841).

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

<sup>3</sup> *Ibid.*

<sup>4</sup> *Ibid.*

<sup>5</sup> “La Corte Suprema de Colombia despenaliza el consumo de drogas,” *Alma Magazine*, 9 September 2009, online: [www.almamagazine.com/entradas-fallo\\_historico-la\\_corte\\_suprema\\_de\\_colombia\\_despenaliza\\_el\\_consumo\\_de\\_drogas](http://www.almamagazine.com/entradas-fallo_historico-la_corte_suprema_de_colombia_despenaliza_el_consumo_de_drogas).

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

<sup>7</sup> *Ibid.*

## Russia: Despite legislative and procedural barriers, HIV-positive woman fights for custody of ten-year old brother

**Svetlana Izambaeva, a well-known HIV-activist and educator in Russia, is seeking to obtain custody of her ten-year old brother, Sasha. After their mother died, regional official refused Izambaeva custody because of her HIV-positive status. Consequently, the local child custody agency (*organ opeki*) decided to give Sasha to a foster family.**

According to Russian law, people suffering from certain conditions cannot become foster or adoptive parents, or obtain custody of children.<sup>1</sup> The list of conditions includes TB, oncological diseases, drug and alcohol dependence, and infectious diseases “before person is taken off the surveillance registry.”<sup>2</sup> The list does not directly mention HIV/AIDS,

which is, however, considered to be infectious disease.

Without the consent of Izambaeva, who is Sasha’s closest blood-relative, the boy was sent first to an orphanage and then to a foster family. Izambaeva was told that “she cannot bring up children because she has HIV.”<sup>3</sup> (Izambaeva has two healthy children).

On 21 August 2009, Izambaeva asked the Aviastroitelnyi territorial court to find the actions of the regional official who denied her custody unlawful. For procedural reasons, the Judge did not hear the case; rather, she stated that Izambaeva should formally appeal the decision of the child custody agency to give Sasha to a foster family.<sup>4</sup> On 1 October 2009,

the Supreme Court of the Republic of Tatarstan (a region of the Russian Federation), denied an application to appeal the lower court's decision.

Izambaeva's representatives are planning to further appeal the decisions of the court and the child custody agency. According to Pavel Chikov, denying custody to people because they are HIV-positive constitutes discrimination. He said:

Russian law does not directly prohibit adoption and custody by people living with HIV. Bureaucrats cite the Government Resolution of 1996, but it is clear that a person who is HIV positive will never be taken from surveillance. Such a regulatory document cannot limit the human rights and interest that are enshrined in the law of the Russian Federation.<sup>5</sup> By giving custody of Sasha to the foster family, the child protection agency violated the law because it did not obtain relative's written refusal to assume custody.<sup>6</sup>

According to the law, relatives have priority when it comes to the custody of children.<sup>7</sup>

In a later development, the foster family decided to relinquish its responsibilities as foster parents to the child, relegating him to the orphanage.

## Commentary

Being HIV-positive should not be considered a factor that automatically makes a person unfit or unsuitable to become a parent. The habitual assumption that people who are living with HIV cannot be good parents is discriminatory.<sup>8</sup> HIV cannot be spread by casual contact, and persons living with HIV are able to lead long and healthy lives, thus there is no reason why they cannot be adoptive or foster parents or obtain custody of children.

The Russian Constitution contains general guarantees of equality and prohibition against discrimination. Federal law specifically prohibits discrimination against people living with HIV.<sup>9</sup>

— Leah Utyasheva

Leah Utyasheva (lutyasheva@aidslaw.ca) is a senior policy analyst with the Canadian HIV/AIDS Legal Network.

<sup>1</sup> Government Resolution of the Russian Federation, 1 May 1996, No. 542, "On the list of diseases with which a person cannot adopt, obtain custody, or accept in a foster family," amended by Government Resolution, 19 March 2001, No.195. Similar lists are also in place in many other countries of the region.

<sup>2</sup> According to Russian law, people with infectious diseases should be placed on epidemiological surveillance (registry) [диспансерный учет] until full recovery.

<sup>3</sup> A. Bessarabova, "Can an HIV-positive woman adopt a child?," *The World of News*, 14 August 2009, online: [www.mimov.ru/arhiv/mn810/mn/11-1.php](http://www.mimov.ru/arhiv/mn810/mn/11-1.php) (in Russian).

<sup>4</sup> "Refusing the motion to dismiss, the judge left the case of HIV-positive Svetlana Izambaeva without resolution," *Open Information Agency*, 21 August 2009, online: [www.openinform.ru/news/xeno/21.08.2009/13442](http://www.openinform.ru/news/xeno/21.08.2009/13442) (in Russian).

<sup>5</sup> *Constitution of the Russian Federation*, 12 December 1993. Article 55 stipulates that human rights and freedoms can be limited only by federal law.

<sup>6</sup> A. Bessarabova (supra).

<sup>7</sup> *Family Code of the Russian Federation*, No. 223-ФЗ, 29 December 1995, Section VI.

<sup>8</sup> Freedom from discrimination is enshrined in international and regional human rights instruments — e.g., the *Universal Declaration on Human Rights* (Article 2); the *International Covenant on Economic, Social, and Cultural Rights* (Article 2); the *International Covenant on Civil and Political Rights*, Articles 2 and 26; the *Convention on Elimination of All Forms of Discrimination Against Women* (Article 12); the *Convention on the Rights of the Child* (Article 2); and the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (Article 14).

<sup>9</sup> *Constitution of the Russian Federation*: Article 19 guarantees equality and freedom from discrimination; *Federal Law on Prevention of Spreading in the Russian Federation of Disease Caused by Human Immunodeficiency Virus (HIV)*, 30 March 1995, No. 38-ФЗ, Article 17.

## Criminal law and cases of HIV transmission or exposure

### UK: HIV positive woman gets probation for biting best friend<sup>1</sup>

In May 2009, Andrea Chard pleaded guilty to assaulting her best friend, Jade Perry. The Plymouth Crown

Court sentenced Chard to two years' probation, while suspending an eight-month jail sentence.

On 16 April 2009, after Perry intervened to break up an argument, Chard — knowing she was HIV-positive at the time — bit Perry

on the arm, and then proceeded to sink her teeth into the woman's cheek. The assault caused terrible wounds but did not expose Perry to HIV. Chard claims she acted in self-defence, but the prosecutor pointed out that Chard had several previous

convictions in which she spat or bit others.

Judge Francis Gilbert stated, “You have HIV and you knew it at the time. You must be very careful when you lose your temper. You bit your best friend and left her shocked and in pain. You deserve to go to prison.”

Nonetheless, Judge Gilbert acknowledged that the goal in this case was to help the defendant overcome her alcohol addiction and learn to manage her temper. Consequently, he ordered anger and alcohol management classes.

### **Ireland: High Court presented with medical evidence of risk of contracting HIV from saliva**

On 27 July 2009, Justice Mary Irvine of the High Court was presented with medical evidence that showed that the risk of transmission of HIV or hepatitis C from saliva could be as low as one in 100 000. In addition, the Court was also informed that the transmission of these diseases “through contact with blood was also negligible.”<sup>2</sup>

Colm Bergin, a consultant in infectious diseases, who provided evidence before Justice Irvine, testified in court that in 10 years’ practice he had never come across a case of transmission of HIV or hepatitis C through saliva.

The High Court has become increasingly concerned about the high number of HIV occupational exposure claims — for such incidents as biting, spitting and needle pricks — brought before the court for compensation by Garda<sup>3</sup>. While Justice Irvine stated that injured police offi-

cers should be compensated, she also stressed that “the Court needed to be fully informed as to what it was compensating Gardaí for.”<sup>4</sup>

### **Sweden: Man sentenced to an additional eight months for a second HIV exposure conviction<sup>5</sup>**

In October 2009, a Swedish court sentenced a man in his twenties to an additional eight months in prison after he was convicted of failing to disclose his HIV status and having unprotected sexual relations with a 15-year-old girl.

In January 2008, the man had been convicted of engaging in unprotected sex without disclosing his status to seven women, ranging in age from 17 to 25. Subsequently, he was sentenced to two years in prison.

After serving 16 months, the man obtained a conditional release during which time he re-offended. Given he still had eight months left to serve on his 2008 conviction, the new eight-month sentence will be added to it. In addition, the man will also be required to pay approximately 4,000 Euros in damages.

### **UK: HIV-positive man breached order prohibiting contact with people over 60**

In April 2009, Derek Hornett pleaded guilty in court to four counts for breaching a court order that banned him from having contact with people 60 years or older.<sup>6</sup> Hornett had offered his handyman services to four women, ranging in age from 60 to 83, followed which he made “romantic”

overtures to at least one of them. One woman became suspicious and reported Hornett’s behaviour to the police.

The order stems from a 2005 conviction for knowingly infecting an 82-year old woman with HIV. Hornett was the sixth person to be convicted of reckless HIV transmission in England and Wales.<sup>7</sup> Hornett had developed a relationship with the older woman to take advantage of her finances. In addition to the three-year sentence, Hornett received a Sexual Offences Prevention Order prohibiting him from engaging in sexual contact without disclosing his HIV status, as well as from associating with people over 60.

In May 2009, Hornett was convicted and sentenced to three years in prison. He received a two-year sentence for the first breach, plus 12 months for each of the other breaches. The latter will be served concurrently with each other but consecutively with the former.

### **Australia: HIV-positive man gets a prison term for infecting his wife**

In May 2009, a Penrith District Court judge sentenced a man, who pleaded guilty to maliciously inflicting grievous bodily harm after he infected his wife with HIV, to a prison term of four years and three months. The Sydney man will be eligible for parole in April 2012.<sup>8</sup>

It is believed that the man’s wife contracted the disease sometime between January 1994 and December 2003. In 1998, the couple’s youngest child was diagnosed with HIV and passed away three years later due to an AIDS-related illness.

## Update: Swiss court upholds acquittal in HIV exposure case

As reported earlier in the *Review*, in February 2009, the Court of Justice (Criminal Division) of the Republic and Canton of Geneva acquitted a man of attempted spread of a human disease and attempted serious bodily harm (section 231 and 122 of the Swiss Penal Code). Relying on expert testimony, the Court was convinced that HIV transmission is scientifically negligible to nil when an HIV-positive person undergoes treatment, has an undetectable viral load and does not have other infections.<sup>9</sup>

In July 2009, the Federal Court upheld the Court of Justice's acquittal but did not broach the issue of whether an undetectable viral load affects the transmission of HIV. The court found that because the two women who had unprotected sexual relations with the defendant did not contract the virus, pursuing the charges under criminal law was no longer viable since they could not be viewed as victims.<sup>10</sup>

<sup>1</sup> "Woman with HIV bit best friend's face," *The (Plymouth) Herald* (online), 2 May 2009, online: [www.thisisplymouth.co.uk/news/Woman-HIV-bit-best-friend-s-face/article-957003-detail/article.html](http://www.thisisplymouth.co.uk/news/Woman-HIV-bit-best-friend-s-face/article-957003-detail/article.html).

<sup>2</sup> "Medical data sought over Garda claims," *The Irish Times*, 28 July 2009.

<sup>3</sup> "Garda" refers to the law enforcement officers in Ireland.

<sup>4</sup> "Medical data..." (supra).

<sup>5</sup> E. Bernard, "Sweden: 20 year-old man gets another eight months for second HIV exposure conviction," *Criminal HIV Transmission blog*, 13 October 2009; E. Bernard, "Sweden: 20 year-old man previously convicted of HIV exposure arrested again," *Criminal HIV Transmission blog*, 21 September 2009. Both articles are online: <http://criminalhivtransmission.blogspot.com>.

<sup>6</sup> "HIV man who flouted ban is jailed," *The Western Morning News*, 9 May 2009.

<sup>7</sup> E. Bernard, "UK: Man previously convicted of reckless HIV transmission jailed again," *Criminal HIV Transmission blog*, 11 May 2009.

<sup>8</sup> "Man jailed for three year for infecting his wife with HIV," *Australian Associated Press*, 11 May 2009.

<sup>9</sup> A. Symington, "Switzerland: Geneva court finds no risk of HIV transmission, overturns conviction," *HIV/AIDS Policy & Law Review* 14(1) (2009): 47.

<sup>10</sup> "Acquittement définitif pour un séropositif genevois," *20 minutes online*, 8 July 2009, online: [www.20min.ch/ro/news/geneve/story/18627156](http://www.20min.ch/ro/news/geneve/story/18627156).

## In brief

### Iran: Two world-renowned physicians working on HIV prevention incarcerated

In January 2009, Dr Kamiar Alaei and Dr Arash Alaei, two brothers working in Iran on HIV treatment and prevention, were convicted of communicating with "an enemy government"<sup>1</sup> because of the fact that they had attended numerous public health conferences in the U.S.

According to Physicians for Human Rights (PHR), "The brothers traveled the world to share Iran's model of HIV prevention and treatment, not to recruit people to foment

a 'velvet revolution,' as alleged by the Iranian government."<sup>2</sup> PHR said that, in fact, the Alaei brothers' efforts have earned Iran international recognition as a model of best practice by the World Health Organization.

During detention, several of the doctors' due process rights were violated. The doctors were detained two months longer than permitted under Articles 30–34 of Iran's *Code of Penal Procedure*. In addition, they were eligible for bail but never obtained a bail hearing. Finally, the brothers also faced secret charges they were unable to refute as their attorney was never made privy to any information substantiating the charges.<sup>3</sup>

Consequently, on 20 January 2009, Dr Kamiar Alaei and Dr Arash Alaei were sentenced to three and six years, respectively, in prison. They appealed the conviction in February 2009, but their appeal was denied. Over one year since their arrest, the Alaei brothers continue to be imprisoned. Sarah Kalloch, Director of Outreach at PHR, stated:

Iran cannot equate public health diplomacy and the quest for shared solutions to the world's shared disease burden to treason. It is a dangerous and maddening fallacy and a danger to the people of Iran to keep science stifled and scientists in jail.<sup>4</sup>

## South Africa: High Court orders law enforcement to stop arresting sex workers

On 20 April 2009, the Sex Worker Education and Advocacy Task Force (SWEAT), a non-profit organization that promotes the health and human rights of sex workers, won a historic case in South Africa when the Western Cape High Court (Cape Town) ordered the South African Police Service (SAPS) and members of the Cape Town City Police to stop arresting sex workers they knew were unlikely ever to be prosecuted.

SWEAT had requested the High Court to determine “whether it is lawful for members of the SAPS and the City Police to arrest and detain sex workers in circumstances where they know with a high degree of probability that no prosecution will result.”<sup>5</sup>

Law enforcements, the respondents in this matter, admitted that they were well aware that the sex workers who were arrested would not, in all likelihood, be prosecuted. For example, in an affidavit of a former police station commissioner, it was reported that “a copy of the record of arrests of sex workers for the period January to December 2006 in Claremont ... [shows] 106 arrests, of which not one resulted in a prosecution.”<sup>6</sup>

Affidavits from sex workers also confirmed the failure to prosecute those arrested: “One sex worker describes having been arrested approximately 200 times during the last six years, but never prosecuted. Another claims that she has been arrested over a 100 times, without being prosecuted.”<sup>7</sup> Accordingly, the Court found that based on the facts,

“the arresting officers knew with a high degree of probability that no prosecution would result.”<sup>8</sup>

The High Court agreed with SWEAT that the arrests of sex workers were unlawful because “[a] peace officer who arrests a person, knowing with a high degree of probability that there will not be a prosecution, acts unlawfully even if he or she would have preferred a prosecution to have followed the arrest.”<sup>9</sup>

Consequently, the High Court deemed law enforcement’s pattern and practice of arrest of sex workers to be based on ulterior motives — namely harassment, punishment and intimidation of sex workers — and to merely constitute a form of social control, and certainly not a lawful arrest.

## Update: Senegal court overturns convictions against AIDS activists

On 20 April 2009, a Senegalese Court of Appeal overturned jail convictions of AIDS activists and ordered their immediate release.<sup>10</sup> As reported earlier in the *Review*, in December 2008 nine gay men were arrested in a police raid conducted at the home of the head of AIDES Senegal, a non-profit HIV education and counselling organization.

In Senegal, a country where 95 percent of the population is Muslim, gay and lesbian activity is punishable by a prison term of up to five years.<sup>11</sup>

The men were convicted of engaging in “homosexual conduct” contrary to Article 319.3 of the Senegalese *Penal Code*, as well as “criminal association,” and were sentenced to an eight-year prison term — the most severe sentence to

be handed down by a court for an Article 319.3 conviction.

Following the defence lawyers’ argument that the men were not engaged in homosexual acts at the time of their arrest, but rather had been arrested based on anonymous tips, the Court of Appeal vacated the trial court’s decision.<sup>12</sup>

## Australia: Dismissal of gay blood donor complaint

In May 2009, the Tasmanian Anti-Discrimination Tribunal dismissed Michael Cain’s complaint, in which he argued that the Australian Red Cross (ARC) discriminated against him based on his sexual preference. In 2004, Cain attempted to donate blood, but ARC rejected his offer because he had answered “Yes” to the question of whether he had engaged in “homosexual sex” in the previous 12 months.<sup>13</sup>

Cain indicated in his complaint that “homosexual sex” is lawful and argued that people who practice it safely should be allowed to donate blood. However, the tribunal determined that ARC is responsible to ensure that the blood supply remains as safe as possible, and so, is entitled to exclude men who have sex with men, as a group, because they are at a higher risk of transmission.

In an effort to appease the gay community, Dr Philippa Hetzel of ARC’s Blood Service stated that the exclusionary policy is not due to sexual preference but rather due to the difficulty of identifying acute infections, and keeping the risk to the blood supply as low as possible.<sup>14</sup>

*[Editor’s note: A similar case is unfolding in Canada. See the*

*Canadian Developments section of this issue.]*

## Northern Ireland: HIV patient's discrimination case settled

In April 2009, the Southern Health Trust settled a discrimination case brought against it for its refusal to administer a medical procedure because of a patient's HIV status. The Trust apologized to the complainant, Tony Bell, acknowledging that the hospital's refusal to perform an endoscopy because he was HIV-positive was completely inappropriate. Further, the Trust compensated Bell in the amount of £4,000.<sup>15</sup>

Because of the hospital's refusal, Bell underwent an alternative medical procedure, which was delayed by four months.

With the support of the Equity Commission of Northern Ireland, Bell filed the case under the recently reformed *Disability Discrimination Act* (DDA). The changes to DDA, implemented in 2007, sought to increase protection against discrimination in service delivery for people living with HIV, including in such areas as housing, education and medical services. As part of its settlement, the Southern Health Trust will cooperate with the Equity Commission to review its practices and procedures to ensure they are in compliance with the DDA.

<sup>1</sup> Amnesty International, *Amnesty International Report 2009*, online: <http://thereport.amnesty.org/en/regions/middle-east-north-africa/iran>.

<sup>2</sup> PHR, "Factsheet," [undated], online: [www.iranfreethedocs.org](http://www.iranfreethedocs.org).

<sup>3</sup> *Ibid.*

<sup>4</sup> P. Witzler, "Sad Anniversary of Alaeis' Detention," 25 June 2009, online: <http://iranfreethedocs.org/2009/06/25/sad-anniversary-of-alaeis-detention/>.

<sup>5</sup> *The Sex Workers Education and Advocacy Task Force v. The Minister of Safety and Security of South Africa and Others*, High Court of South Africa (Western Cape High Court, Cape Town), Case No. 3378/07, 20 April 2009, para. 5.

<sup>6</sup> *Ibid.*, para. 10.

<sup>7</sup> *Ibid.*, para. 13.

<sup>8</sup> *Ibid.*, para. 15.

<sup>9</sup> *Ibid.*, para. 27.

<sup>10</sup> "Court overturns Senegal jail terms for homosexuality," Agence France Press English, 20 April 2009.

<sup>11</sup> A. Symington, "Senegal: Nine gay men arrested, convicted and given harsh sentences," *HIV/AIDS Policy & Law Review* 14 (1) (2009): 49–50.

<sup>12</sup> "Court overturns..." (supra).

<sup>13</sup> "Gay blood donor complaint dismissed," Australian Associated Press, 27 May 2009.

<sup>14</sup> *Ibid.*

<sup>15</sup> "NHS trust apologises and compensates man with HIV after refusal of treatment," *Aidsmap News* (online), 29 April 2009.



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# FROM EVIDENCE AND PRINCIPLE TO POLICY AND PRACTICE:

## PROCEEDINGS FROM THE 1<sup>ST</sup> ANNUAL SYMPOSIUM ON HIV/AIDS, LAW AND HUMAN RIGHTS

### Introduction

On 12–13 June 2009, the 1<sup>st</sup> Annual Symposium on HIV/AIDS, Law, and Human Rights drew more than 180 participants to downtown Toronto for a packed series of panels and workshops. The Symposium was an opportunity to bring together researchers, lawyers, community organizations, activists and policy-makers to discuss and debate key developments in research and law in a number of HIV-related areas; and to discuss the implications of these developments for public policy and the advocacy that is needed to defend and promote human rights.

One impetus for this initiative was the limited familiarity with HIV/AIDS within the legal profession in Canada. As relatively few lawyers have any substantive knowledge of HIV and

related legal issues, persons living with HIV often lack adequate access to adequate legal services.

Similarly, AIDS service organizations and other community-based

organizations, including groups of persons living with HIV, need legal information so that they can better advocate for the rights of their clients. And they need enhanced advocacy

skills for dealing effectively with the media and policy-makers on often-controversial HIV-related legal issues.

The Symposium opened on the evening of 12 June with a keynote address by the Honourable Justice Edwin Cameron, an internationally-renowned human rights advocate openly living with HIV, author of *Witness to AIDS* and a judge of the Constitutional Court of South Africa.

Justice Cameron spoke eloquently on the growing resort to criminal prosecutions to deal with HIV transmission or exposure, a topic of considerable and growing interest in Canada and internationally.

With the event open to the public, Justice Cameron's lecture drew a full house to Osgoode Hall, home to the Ontario Court of Appeal and the Law Society of Upper Canada.

*[Editor's note: An article containing a near-verbatim transcript of Justice Cameron's address appears in this Special Section. The article starts on the cover of this issue.]*

The following day consisted of four panels and three skills-building workshops.

## Panels

The topics of the panels were as follows:

- the evidence and legal arguments in support of access to HIV prevention and care in Canada's

prisons (moderated by Richard Elliott, Canadian HIV/AIDS Legal Network);

- Canada's Access to Medicines Regime to supply lower-cost medicines to developing countries (moderated by Tenu Afavia, United Nations Development Programme);
- the criminalization of HIV transmission and exposure (moderated by Justice Cameron and building on his remarks from the opening keynote address); and
- drug policy developments affecting HIV prevention and care among people who use illegal drugs, such as litigation over Vancouver's supervised injection facility, and pending legislation on mandatory minimum sentences for drug offences (moderated by David Elby, Canadian HIV/AIDS Legal Network).

The panel on drug policy, which served as the closing plenary of the Symposium, included remarks from Senator Pierre Claude Nolin, former chair of a special committee of the Senate of Canada on illegal drugs, regarding legislative developments in Canadian drug laws.

**This special section of the Review contains a summary of the proceedings of the presentations from the four panels.**

## Skills building

The skills-building workshops focused on providing practical tips on how to do HIV work in prisons, on how to work successfully with the media, and on how to lobby effectively for policy change.

In the prisons workshop, Terry Howard, Coordinator the Prison Outreach Program (POP) of the B.C. Persons with AIDS Society, reviewed the various services provided by the POP, including HIV/AIDS treatment information, harm reduction education and counselling, psychosocial support, advocacy, release planning, assistance with court and parole hearings, and prison staff awareness.

In the media workshop, Chris Holcroft, Principal, Empower Consulting, explained the reporting schedules of different media, and discussed what makes "news," the need to be credible and reliable, and the critical importance of messaging. Chris also reviewed two key components of the media profession — news releases and interviews.

In the policy change workshop, Amanda Sussman, policy advisor and human rights expert, discussed practical techniques for achieving social change and ways to help participants identify the best way to use their time and resources so that they could have the greatest impact on Canadian government policy.

# Criminalization of HIV transmission: poor public health policy

*cont'd from page 1*

right. More important than resisting all prosecutions is to define with care the circumstances in which criminal laws and prosecutions are truly *not* justified.

Following that is the task of understanding and insight. We must try to comprehend why unjustified and unjustifiable laws are enacted and prosecutions pursued, for our arguments and strategic positions must be based on insight.

Finally, there is the job of consolidating forces. We must unite to address the causes of such unjust laws and to resist their effects.

In short, the criminalization debate is about picking our turf, cutting loose from it what is indefensibly beyond it and uniting sensibly to resist encroachments on it.

## The surge of criminalization

When we talk of the “criminalization of HIV,” we mean both enacting laws specifically directed to punish behaviour that may transmit HIV and the application of general laws in a way that targets those with HIV who have acted in that way.

The global trend toward criminalization of HIV is accelerating, with significant human and legal consequences. Canada owns the dark distinction of being a world leader in HIV-related criminal prosecutions: Canada has, per capita, prosecuted more persons with HIV for HIV-related sexual offences than any other country.<sup>1</sup> More than 90 people with HIV have been prosecuted, and

almost 70 convicted, of criminal HIV exposure or transmission in Canada since the late 1980s.<sup>2</sup>

However, Canada is just one of many jurisdictions that seem increasingly to be invoking the criminal law against people with HIV. Since 1997, there have been 16 successful prosecutions in Texas, U.S., for HIV exposure or transmission, the most recent at the end of May 2009.<sup>3</sup> In 2008, a homeless man was sent to jail. He was convicted of committing a serious offence while being arrested for drunk and disorderly conduct — namely, harassing a public servant with a deadly weapon. Because of his past encounters with the law, the system ratcheted up the gravity of what he did, and he ended up being sentenced to 35 years in jail, of which he must serve at least half before he can apply for parole.<sup>4</sup>

The “deadly weapon” the man used was his saliva. It was alleged to be “deadly” because he had HIV. He was jailed because he spat at the officers who were arresting him. According to assured scientific knowledge, after nearly three decades, saliva has never been shown to transmit HIV.<sup>5</sup> The “deadly weapon” was no more than a toy pistol — and it was not even loaded. Increasing the severity of his offence because he had HIV, therefore, was plain wrong.

An earlier case of *Thissen*<sup>6</sup> in Ontario, in 1996, concerned a sex worker with HIV who was sentenced to imprisonment for two years less a day for biting an undercover police

officer on the hand during a scuffle as he arrested her. She pleaded guilty to the offence of aggravated assault — a charge laid on the far-fetched supposition that the bite endangered the officer’s life. Notwithstanding the absence of any significant risk of transmitting HIV via such a route, and the fact that bites have played no role in the spread of the epidemic, the sentencing judge adverted to “the enormity of the consequences [of the epidemic] to individuals and society as a whole,” and concluded that “the incidence of HIV/AIDS is so great that it is a known worldwide health menace.”<sup>7</sup>

The Crown requested imprisonment for three to four years. The judge agreed that such a lengthy sentence was appropriate, but refused to impose a sentence whose length (by virtue of exceeding two years) would require incarceration in the federal correctional system, “because of a lack of facilities in federal institutions in this province for the custody and care of inmates infected with HIV/AIDS.” While the concern for the health of the HIV-positive accused in prison was commendable, it is hard to escape the conclusion that the police, prosecution and sentencing judge overreacted dramatically and with no basis in science, largely because of misinformation and stigma related to HIV.

Elsewhere in the U.S., in April 2009 a gay man in Iowa was sentenced to 25 years in prison, and required to register as a sex offender and undergo a sex offender treat-

ment program for not disclosing his HIV status prior to a one-off sexual contact he had with a man he met online.<sup>8</sup> There was no transmission of the virus.

The police, prosecution and sentencing judge overreacted dramatically and with no basis in science, largely because of misinformation and stigma related to HIV.

In Africa, in 2007, a 26-year-old woman living with HIV from a township near Bulawayo, in Zimbabwe, was arrested for having unprotected sex with her lover. The crime of which she was convicted was “deliberately infecting another person.” Tests on her lover revealed he did not have HIV. The woman was receiving antiretroviral (ARV) therapy.<sup>9</sup> Before sentencing her, the court tried to get a further HIV test from the lover, even though it was reported that he did not want to proceed with the charges.<sup>10</sup> She was eventually sentenced to a suspended term of five years’ imprisonment.<sup>11</sup> The threat of imprisonment, and the shame and ordeal of her conviction, will continue to hang over her.

The statute under which she was convicted, Section 79 of Zimbabwe’s *Criminal Law (Codification and Reform) Act*,<sup>12</sup> is an extraordinary piece of legislation. It does not merely make it a crime for a person

who knows that he or she has HIV to infect another. It makes it a crime for anyone who realizes “that there is a real risk or possibility” that he or she might have HIV to do “anything” that he or she “realizes involves a real risk or possibility of infecting another person with HIV.” Although the offence is termed “deliberate transmission of HIV,” you can commit it even if you do not transmit HIV. In fact, you can commit it even if you do not have HIV.

The wording of the Zimbabwe law is wide enough to cover a pregnant woman who knows she has, or fears she may have, HIV. If she does “anything” that involves the possibility of infecting another person — such as giving birth or breast-feeding her newborn baby — the law could make her guilty of deliberate transmission, even if her baby is not infected and the alternative is to abort or watch the baby starve.<sup>13</sup> In all cases, the law prescribes punishment of up to twenty years in prison.

In Sierra Leone, lawmakers have enacted a statute that requires a person with HIV who is aware of the fact to “take all reasonable measures and precautions to prevent the transmission of HIV to others” — and it expressly covers a pregnant woman.<sup>14</sup> It requires her to take reasonable measures to prevent transmitting HIV to her foetus. This, in a context where medicines that can reduce or prevent transmission are not always made available and where many people do not have control over all aspects of their sexual life.

There is a depressing super-abundance of instances that highlight the ways in which these laws stigmatize and criminalize a status rather than serve any useful public policy function. For example:

- **Egypt:** In February 2008, *Human Rights Watch* reported that men are being arrested merely for having HIV under Article 9(c) of Law 10/1961, which criminalizes the “habitual practice of debauchery [fujur]” — a term used to penalize consensual homosexual conduct.<sup>15</sup>
- **Switzerland:** In June 2008, the highest court in Switzerland held a man liable for negligently transmitting HIV to a sexual partner when he knew that a past partner had HIV, even though he believed, because he experienced no seroconversion symptoms, that he himself did not have HIV.<sup>16</sup> More encouragingly, however, in February 2009 the Geneva cantonal court acquitted a man in a not dissimilar case on the basis of an undetectable viral load (and other pertinent criteria).<sup>17</sup>
- **Singapore:** In July 2008, a man with HIV was sentenced to a year in prison for exposing a sexual partner to the virus. The sex act in question deserves explicit mention: He fellated his “victim.” The risk to the receiving partner was minimal, if not non-existent.<sup>18</sup>
- **New Zealand:** In June 2009, a gay man was charged for wilfully causing or producing a sickness or disease after unintentionally transmitting HIV to his consenting partner. He is the first person ever to be charged solely under section 201 of the *Crimes Act*, which dates back to 1961. He faces up to 14 years in prison.<sup>19</sup>
- **Arkansas, U.S.:** Also in June 2009, a 17-year-old high school student was arrested under an HIV disclosure law for failing to inform his consenting partner of

his status before unprotected sex. He was charged as an adult and faces up to 30 years in prison if convicted. The charge does not appear to relate to transmission, but only to non-disclosure.<sup>20</sup>

- **Washington State, U.S.:** Also in June 2009, a man with HIV was arrested under an HIV exposure and transmission law following a complaint from a bisexual married man whom he had met on the internet for casual sex. The statute criminalizes only the person with HIV. The man has pled guilty and is currently awaiting sentencing. His case likewise does not rest on transmission, but only on exposure.<sup>21</sup>

## Cases in Canada

Johnson Aziga recently became the first person, apparently anywhere in the world, to be convicted of first-degree murder for sexual transmission of HIV. Mr Aziga reportedly had unprotected sex with 13 women after he knew of his HIV status, and seven of those women later tested positive themselves. Two of the women subsequently died from AIDS-related cancers. The women alleged that Mr Aziga had infected them with the virus; that he had not disclosed his status to them before they had unprotected sex, and that, in some cases, he had actively deceived them; and that, had he disclosed, they would not have had sex with him. A jury found him guilty of two counts of first-degree murder and several other counts of aggravated sexual assault.<sup>22</sup>

It is appropriate in an AIDS-rights context to say that *Aziga* may offer a good instance of narrowly-tailored circumstances in which criminal liability is warranted. If it is ultimately

determined that the prosecution has proved, beyond a reasonable doubt, that the defendant *intended* to cause the women bodily harm (that is, infection with HIV) that he knew was likely to cause death and was reckless as to whether death ensued, then he would fall within the UNAIDS delineation, and mine, of a justified prosecution. Whether that formulation ultimately applies in the *Aziga* case may yet be revisited by an appellate court. The trouble is that exceptional cases like that of Mr Aziga — and the sensational murder convictions secured there — may be seized as justification for a broader push for criminalization. And, indeed, in practice, the application of HIV criminalization codes usually has far less warrant.

In this regard, perhaps even more troubling are two very recent cases in Toronto — *Mahmoudi*<sup>23</sup> and *Davis*<sup>24</sup> — in which, as best can be inferred from the evidence currently available on the public record, the police have laid “attempted murder” charges based solely on the allegation of not disclosing HIV-positive status before unprotected (and otherwise consensual) sex. This may be the ripple effect of the murder convictions in *Aziga*, even though it seems questionable whether merely not disclosing HIV status should suffice to draw the conclusion that there was intent to infect another person. That seems a leap of considerable proportions, although too often media reporting on such difficult cases have conveyed such an impression.

If this is, in fact, an indication of the “new normal” practice by police and prosecutors seeking to expand upon the *Aziga* conviction, the worrisome question of over-charging (surely an abuse of process) may

arise, something to which the defendants’ lawyers, and activists — and, one hopes, judges — will no doubt be alert.

Another indication of what Richard Elliott of the Canadian HIV/AIDS Legal Network has dubbed the “creep of criminalization” in Canada may arise from the prosecution of people merely for oral sex without disclosure, another potentially emerging trend that should be resisted. There appears to be at least one case currently before a Canadian court in which the accused is being prosecuted for aggravated sexual assault for allegedly not disclosing his HIV-positive status, even though only acts of oral sex are alleged.

The trouble is that exceptional cases like that of Mr Aziga may be seized as justification for a broader push for criminalization.

Yet oral sex has generally been characterized as carrying at most a “low risk” of transmission, which could be said to fall well below the “significant risk” threshold established by the Supreme Court of Canada some 11 years ago in the leading judgment, *R. v. Cuerrier*. Indeed, I note that a number of years ago, in the *Edwards* case in 2001, a prosecutor and judge in Halifax quite rightly observed that “unprotected oral sex is conduct at a low risk that would not bring it within [the aggra-

vated assault section] of the Criminal Code and had only unprotected oral sex taken place [in that case], no charges would have been laid.” It is disturbing to contemplate that even this sensible limit on the resort to the criminal law may now be at risk from overzealous police and prosecutors.

*R v. Mabior*, a case currently before the Manitoba Court of Appeal, is just as troubling. There, in 2008, the accused was convicted on several charges of aggravated sexual assault, which carries a maximum penalty of life imprisonment.<sup>25</sup> Despite knowing that he had HIV, despite being advised by health care workers of the danger of infection to his sexual partners, and despite being warned that he should disclose his status to them and always practise safer sex, he had unprotected sex with several women.<sup>26</sup> In all cases, the sex was non-coercive. At the time of conviction, none of the complainants had been diagnosed with HIV. The defendant, in other words, was convicted for conduct that was patently reckless toward others, but which had no confirmed deleterious results. The complainants’ freedom from HIV infection is surely significant.

It makes it necessary to ask for what the defendant was being punished: Was it for his bad attitude, his bad deeds or their bad consequences? Convicting a defendant of aggravated sexual assault when the sex acts in question were non-coercive and did not lead to infection seems troublingly excessive, particularly since the *Mabior* approach seems entail that, to escape liability for non-disclosure, the person with HIV must both have an undetectable viral load and use a condom — but is a criminal even when he uses a condom but has detectable virus in his body, or even

when he has an undetectable viral load and fails to use a condom.

The absence of transmission brings to mind broader considerations. Sometimes luck plays a determining factor in the fair application of the law. Two people may engage in the same reckless but unintentional behaviour; one may have the bad luck that accidentally a bad consequence ensues, while the other may have the good fortune to come through without incident. In the first situation, a tragedy ensues and criminal charges can be brought; but in the other, where no harm occurs, there should ordinarily be no charge, unless we now wish to equate non-disclosure of HIV in sex with crimes like drunk driving, which are punished even when no bad consequence ensues. I would suggest that is excessive and unwarranted.

Mr Mabior and his partners, it seems, were fortunate in that no transmission occurred. The charges on which he was convicted fail to reflect that crucial factor, but the implications of his conviction bring to mind broader considerations.

### **HIV prosecutions and “status crimes”: the continually pivotal role of stigma**

Some of the instances I have mentioned bring to mind the statute that California passed in the 1960s that made it a criminal offence for a person “to be addicted to the use of narcotics.” A person was continuously guilty of this crime, even if he had never used or possessed any narcotics within the state, and even if he had not been guilty of any harmful behaviour.

The opinion of Justice Stewart for the majority in the Supreme Court

of the United States in *Robinson v. California* stated,

It is unlikely that any State at this moment in history would attempt to make it a criminal offence for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement or sequestration. However, in the light of contemporary human knowledge, a law that made a criminal offence of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment.<sup>27</sup>

Yet, one wonders how close some of these instances come to what Justice Stewart seems to have thought impossible. It is no great step from punishing conduct by someone with a “venereal disease,” which has no adverse consequence — as many of the statutes and prosecutions I have mentioned do — to punishing the mere status of having the disease. Indeed, some of the sentences I mentioned earlier are shockingly long. It is a matter for dismay that persons who have not actually inflicted physical harm or damaged any property or otherwise caused injury could be locked away for these lengths of time. It must be asked whether sentences as harsh are imposed in other cases of assault, where the complainant consented to the activity, but where serious harm did in fact result. A review of cases in various jurisdictions suggests a disproportionate harshness in sentencing of those convicted of “HIV crimes.”

The inference that undue reaction to the defendants’ HIV status played

a significant, probably pivotal, part in convicting and imprisoning these defendants is unavoidable. In short: They were punished less for what they did than for the virus they carried. A similarly situated person engaging in the same acts, but without HIV, would almost certainly not be charged with any crime. HIV status made the difference.

Stigma and lack of knowledge and plain phobia about AIDS play themselves out repeatedly in the epidemic. For example:

Defendants have been punished less for what they did than for the virus they carried.

- In May 2009, a member of the Swaziland parliament called for people with HIV to be branded on the buttocks after mandatory testing, so that “[b]efore having sex with anyone, people will have to check their partners’ buttocks before proceeding.”<sup>28</sup>
- In December 2007, a trial judge in Barrie, Ontario, upon learning that a witness was HIV-positive and hepatitis C-positive, ordered that he be masked or required to testify from another room. (A complaint to the Ontario Judicial Council has prompted recognition that such orders are unacceptable.)<sup>29</sup>

- In Toronto (and elsewhere in Canada, with apparently distressing frequency), the police release the names and photographs of people suspected of having unprotected sex without disclosing their HIV status. They hold press conferences and issue “public safety alerts,” calling for anyone who has had sexual contact with such persons to contact the police.<sup>30</sup>

One wonders whether the ensuing public debate leaves space for asking who the accused’s sexual partners were and what responsibility they take, 28 years after HIV became a known reality on the continent of North America, for having unprotected sex with him. The mediaeval dynamics of public shaming, of gross but partial community condemnation, and of crudely emotive responses instead of considered reactions do not seem too far away.

### The main arguments against criminalization

There is no doubt that some of the behaviour of those who have been prosecuted is blameworthy. Some of these individuals do not evoke much sympathy. Some may deserve punishment for what they have done. However, policy makers, law enforcement officials, prosecutors and judges must tread carefully. There are profound ethical and legal problems that arise from using the blunt instrument of the criminal law. The central part that stigmatized and stigmatizing reactions to the disease itself — in contradistinction to anything that those with it have done — continue to play in criminalization should be a profound source of worry.

Herewith the central arguments against criminalization:

#### **FIRST: Criminalization is misconceived and ineffective at preventing transmission.**

A motive justification behind many of the laws and prosecutions seems to be the wish to inhibit the spread of HIV. If this is so, the laws and prosecutions are misdirected. They do not prevent the spread of HIV. In the majority of cases, the virus spreads when two people have consensual sex, neither of them knowing that one has HIV. That will continue to happen, no matter which criminal laws are enacted and which criminal remedies are enforced.

It may be that laws of this kind operate to inhibit some risky behaviour on the part of some persons who know that they have HIV. However, the inhibition comes (as the arguments that follow suggest) at profound cost to other goals in HIV prevention because it fuels stigma and inhibits testing.

#### **SECOND: Criminalization is misdirected and should not replace harm reduction.**

A second strong motive in enacting the laws and launching prosecutions seems to be to protect persons from exposure to infection with HIV. If this is so, criminalization is misdirected. It is a misguided substitute for measures that really protect those at risk of contracting HIV — that is, effective prevention, protection against discrimination, reduced stigma, strong leadership and role models, greater access to testing and, most importantly, treatment for those who are unnecessarily dying of AIDS.

AIDS is now a medically manageable condition. It is a virus, not a

crime, and we must reject interventions that suggest otherwise. All public health interventions, including the employment of the criminal law, should be directed to this premise. For the uninfected, we need greater protection for women, and more secure social and economic status, enhancing their capacity to negotiate safer sex and to protect themselves from predatory sexual partners. Criminal laws and prosecutions will not do that. What they do, instead, is to distract us from reaching the goal of protecting people from HIV and expend resources better used elsewhere with greater beneficial impact on HIV prevention.

Criminal laws and prosecutions distract us from reaching the goal of protecting people from HIV.

Criminalization assumes the worst about people with HIV and, in doing so, it punishes vulnerability. The human rights or harm reduction approach assumes the best about people with HIV and supports empowerment. As Justice Michael Kirby, who recently retired from the High Court of Australia, has pointed out, countries with human rights laws that encourage the undiagnosed to test for HIV do much better at containing the epidemic than those that have

“adopted punitive, moralistic, denialist strategies, including those relying on the criminal law as a sanction.”<sup>31</sup>

When condoms are available, when women have the power to use them, when those with HIV or at risk of it can get testing and treatment, when they are not afraid of stigma, ostracism and discrimination — they are far more likely to be able to act consistently for their own safety and that of others. Instead of criminalization we must demand treatment, prevention, education and empowerment.

**THIRD: Criminalization does not protect women, but rather endangers them.**

A seemingly powerful motivation, one often cited by those enacting these laws, is that women need protection. Far from protecting women, criminalization victimizes, oppresses and endangers them. In Africa, most people who know their HIV status are female because most testing occurs at prenatal healthcare sites. The result, inevitably, is that most of those who will be prosecuted because they know — or ought to know — their HIV status will be women.

Many women cannot disclose their status to their partners because they fear violent assault or exclusion from the home. If a woman in this position continues a sexual relationship (whether consensually or not), she risks prosecution under many of these African laws for exposing her partners to HIV. It is callous to propound a doctrine of equal responsibility in autonomous sexual decision-making in situations where women lack the power to make definitive choices about their sexual practice. Where equal status and bargaining power do exist in the bedroom, then respon-

sibility should fall equally on both partners.

**FOURTH: Criminalization misplaces the moral onus of self-protection and shifts the burden of preventing transmission to one person instead of recognizing it as shared by two.**

This is a hard, but necessary, thing to say. HIV has been around for nearly three decades, during which the universal public information message has been that no one is exempt from it. So the risk of getting HIV must now be seen as an inescapable facet of having unprotected sex. This seems to me to be true both in a country like my own of South Africa, where HIV is a disease of mass prevalence, and in Canada, where largely it remains limited to defined vulnerable groups — although I note the growing proportion of new infections attributable to heterosexual encounters, reflected in the steadily increasing infection rate among women.

We cannot pretend that the risk is introduced into an otherwise safe encounter by the person who knows or should know he has HIV. The risk is part of the environment, and practical responsibility for safer sex habits rests on everyone who is able to exercise autonomy in deciding to have sex with another. The person who passes on the virus may indeed be “more guilty” than the person who acquires it, but criminalization unfairly places the blame solely on the person with HIV. Unprotected sex always entails risk of transmission of a range of sexually transmitted infections (STIs). Can it be right in these circumstances to expect a person to inform a partner of the person’s status if the partner does not enquire? Where there are moderately

equal levels of sexual autonomy and decision-making, it is surely the responsibility of both partners to ask, to tell, to protect and to prevent.

It is true that the subordinate position of many women, particularly in Africa, makes it difficult if not impossible for them to negotiate safer sex. When a woman has no choice about sex, and her partner, despite knowing he has HIV, infects her, he unquestionably deserves blame. However, the fact is that criminalization does not help women in this position. It simply places them at greater risk of victimization. Criminalization singles one sexual partner out. All too often, despite her greater vulnerability, it will be the woman. Criminalization compounds the evil, rather than combating it.

**FIFTH: Criminalization tends to be unacceptably vague.**

Many of these laws are extremely poorly drafted. For instance, under laws based on a poorly-drafted “model law” that many countries in East and West Africa have adopted, a person who is aware of being infected with HIV must inform “any sexual contact in advance” of this fact. However, the laws do not say what “any sexual contact” is. Is it holding hands? Kissing? Or only more intimate forms of exploratory contact? Or does it apply only to penetrative intercourse? Nor does it say what “in advance” means. No transmission is required and no intent is required, making it extremely difficult for the average person to determine precisely what behaviour is subject to prosecution. The “model” law would not — nor should not — pass muster in any constitutional state where the rule of law applies. The rule of law requires clarity in advance on the meaning of

criminal provisions and the boundaries of criminal liability.<sup>32</sup>

Moreover, these laws are difficult and degrading to apply. They intrude on the intimacy and privacy of consensual sex. (We are not talking about non-consensual sex; that is rape, and rape should always be prosecuted.) But where sex is between two consenting adult partners, the apparatus of proof and the necessary methodology of prosecution degrade the parties and debase the law. The Zimbabwean woman again springs to mind: Her lover wanted the prosecution withdrawn, but the law vetoed his wishes. It also countermanded her interests. The result is a tragedy for all and a severe setback to HIV prevention and treatment efforts.

The rule of law requires clarity in advance on the meaning of criminal provisions and the boundaries of criminal liability.

Where there is deliberate intention to pass on the virus and the person succeeds in passing it on, there can be no difficulty about prosecuting such a person and no objection to it, but we do not need HIV-specific statutes for that. In cases where there is no deliberate intent, the categories and distinctions of the law become unavoidably fuzzy. They become incapable of clear guidance either to those subject to them or to prosecu-

tors. Those laws that target reckless, negligent or inadvertent transmission of HIV serve only to introduce uncertainty into an area that is already difficult to police.

The combination of vagueness of the statutes and the difficulty in their application contributes to the unfair and selective enforcement of criminalization. Such laws create at least the risk that prosecutors may single out already vulnerable groups — like sex workers, men who have sex with men and, at least as seen in European countries, black males. The risk of selective enforcement arises precisely because the behaviour the laws target is extremely common: consensual sex.

**SIXTH: Criminalization fuels stigma.**

From the first diagnosis of 28 years ago of what eventually came to be called AIDS, HIV has carried a mountainous burden of stigma. Stigma has, in fact, been the predominant feature of the social and political response to AIDS. No other infectious disease is viewed with as much fear as is HIV. In fact, diseases far more infectious than HIV are treated with less repugnance. There have been two over-riding reasons for this: the fact that HIV is sexually transmitted and the fact that it is predominantly found in groups that are already socially disfavoured or marginalized: gay men, the poor, black Africans, women, those who use drugs, sex workers.

It is stigma that makes those at risk of HIV reluctant to be tested; it is stigma that makes it difficult, and often impossible, for them to speak about their infection; and it is stigma that continues to hinder access to the life-saving ARV therapies that are

now increasingly available across Africa. It is also stigma that lies primarily behind the drive to criminalization. Cases like those from Iowa and Singapore, and cases where serious charges are laid for conduct that carries no significant risk — such as the charges recently in Hamilton, Ontario, against an HIV-positive gay man for performing fellatio — highlight the persistence and the prominence of HIV/AIDS stigma. It is stigma, rooted in the moralism that arises from the sexual transmission of HIV, that too often provides the main impulse behind the enactment and enforcement of these laws.

#### **SEVENTH: Criminalization may discourage testing.**

Criminalization is radically incompatible with a public health strategy that seeks to encourage people to come forward to find out their HIV status. AIDS is now a medically manageable disease — I am living proof of that fact. But why should anyone want to find out their HIV status, when that knowledge can only expose them to risk of prosecution? By reinforcing stigma, by using the weapons of fear and blame and recrimination, criminalization makes it more difficult for those with or at risk of HIV to access testing, to talk about diagnosis with HIV and to receive treatment and support.

It is regrettable that, in *Cuerrier*, the majority of the Court rejected the proposition that extending the crime of sexual assault to encompass undisclosed HIV status would discourage testing.<sup>33</sup> It did so without citing any evidence. Ordinary human experience suggests the opposite.<sup>34</sup> (It is a fair observation that, even as the Court in *Cuerrier* rejected this concern about deterring testing as unev-

denced, it accepted, in the absence of evidence, that criminalization would deter risky behaviour.)

We therefore have a dire but unavoidable calculus: Inappropriate criminalization is costing lives. The International Community of Women Living with HIV and AIDS (ICW) has rightly described laws like this as part of a “war on women.”<sup>35</sup> They are not just a war on women; they are a war on all people living with HIV.

There has, of course, been some opposition. One academic called the argument that criminalization will not prevent transmission “silly,”<sup>36</sup> pointing out that traffic regulations do not prevent speeding but nonetheless serve valuable social purposes including the reduction of accidental deaths. Of course, but traffic regulations do not stigmatize any socially vulnerable group nor do they have dire consequences for the lives of those subject to them; and traffic regulations are generally narrowly tailored to road conditions and based on vast accumulations of data. HIV criminalization statutes, by contrast, are overly broad, ignore a wealth of medical science, and have grave consequences for our effective management of the epidemic as a whole.

#### **Why the surge in criminalization?**

The surge in prosecutions and new enactments is in some ways surprising. This is for two reasons. First, the global population living with HIV has levelled off.<sup>37</sup> While there are places where the epidemic is still expanding (in Eastern Europe and North America’s inner cities), and while some communities at special risk (such as gay men) are showing increased prevalence, in global terms the epidemic seems to have reached its

apogee. It is no longer thought of as a potentially Malthusian blight. One would have hoped for a corresponding abatement in alarmist reactions.

Second, HIV is recognized more widely as a fully medically manageable disease. It is no longer the dreaded fatal “scourge” it once was. This, too, one would have expected to enter public and official consciousness and, thus, to lead to less pressure for criminal laws and enforcement.

So it seems odd that laws and prosecutions targeting people with HIV should be spreading. In other ways, it is not odd. I have puzzled about why this rash of criminalization is happening right now. And I have concluded that the reasons may not be profound.

**HIV criminalization statutes are overly broad, ignore a wealth of medical science, and have grave consequences for our effective management of the epidemic.**

Some reasons lie in circumstance. The model law for Africa, which has been enacted in more than a dozen countries in West and Central Africa, was intended as a beneficial intervention to protect people with HIV: Its provisions on criminalization, which are truly frightening, were added almost as an afterthought.

In Western Europe and North America, the seeming upward burst of prosecutions may stem either from

the fact that more heterosexuals are affected by the epidemic, or from the welcome fact that, despite the persistence of stigma, being infected with HIV may no longer be so unspeakable that those who consider themselves to have been victimized by heartless predators are no longer too scared or ashamed to speak out.<sup>38</sup>

If the reasons for increased criminalization are local, contingent and perhaps even haphazard, that is important information that should inform our tactical and strategic responses, for it would help us underscore our arguments that misplaced criminalization is counterproductive and ill-advised.

### **The core debate: aiming at “normal” responses to AIDS**

This brings us to the core debate: What is it that AIDS activists seek to achieve? For quite some time, the AIDS-rights community has enjoyed a supportive relationship with liberal and civil rights commentators. The drive to criminalization has introduced complication into the relationship. The honeymoon is over. Reasonable people ask, quite reasonably, why risky conduct by those who know they have HIV should not be punished. Their concern is understandable — and our responses must match it.

From the start of the epidemic, the social and political response to AIDS has been deeply marked by stigma. In many societies, stigma has, perhaps, been the preponderant determinant of social and legal responses.

Accordingly, the struggle has been to secure rational and just responses to HIV. In saying this, we must bear in mind, always, both for tactics and strategy, and at a level of deep principle, what we wish to achieve.

Our objectives are two-fold: On the one hand, it is to achieve a world in which all disease and all vulnerable populations are treated justly, fairly and rationally. On the other, it is to achieve a world in which HIV is dealt with no differently — no better and no worse — than other diseases and in which those at risk of HIV are dealt with no better and no worse than other vulnerable groups.

**Denouncing improvident prosecutions and unjust sentences should not prevent us from recognizing the legitimacy of some applications of the criminal law.**

In the end, we want a world in which AIDS is a merely normal condition — frightening, life-threatening and requiring just and sane interventions; but demanding these in the same way that any comparable condition would. These objectives should determine policy. There are cases in which risky conduct by a person with HIV that leads to transmission should be criminally charged, provided only that the generally applicable tests for criminal liability apply. And criminalization should be limited to the actual transmission of an incurable, life threatening disease.<sup>39</sup>

Advances in HIV treatment and prevention make it questionable whether criminal codes can ever be justified in treating HIV differently from other transmissible infections, such as hepatitis. The counterpart

consideration for AIDS-rights activists is that this accords with the struggle that has lain at the centre of the social contest about the epidemic: that AIDS should be treated no worse than other diseases (“normalization”). The AIDS community must be clear about distinguishing behaviour that ought not to be criminalized from conduct that deserves prosecution and punishment. We must carefully define the “turf” and be clear why we are defending it. Many AIDS activists have in fact taken a nuanced position, even though this has seemingly been ignored on occasion in representing their stand.

The fact is that prosecutions like Mr Aziga’s and Mr Mabior’s, with their dismaying facts, are a setback for everyone with HIV. That does not lessen the duty to support the consistent application of rational and fair-minded principles of criminal law. Denouncing improvident prosecutions and unjust sentences should not prevent us from recognizing the legitimacy of some applications of the criminal law. And a position of principle and nuance — such as that which the Canadian HIV/AIDS Legal Network has sought to adopt — will enable us to call with authority for appropriate education on HIV and AIDS to be provided to judges, prosecutors and all those dealing with (and writing about) the epidemic.

### **Applying the principle of “normalization” to the criminal law debate**

From a firm basis of principle, we can proceed confidently to challenge many forms of HIV criminalization.

#### **Consent**

The principle I have mentioned also colours our response to the debate

about disclosure and consent. We can broadly accept, for example, that consent is vitiated “if someone has deliberately deceived a person about the nature and the quality of the act and by doing so, has put that person at a risk of harm.”<sup>40</sup> “A consent that is not based upon knowledge of the significant relevant factors is not a valid consent.”<sup>41</sup> According to this line of reasoning, consent is “invalid” if it can be proved that the complainant would have refused to have unprotected sex with the accused if he or she knew that the accused had HIV<sup>42</sup> and if there is a “significant risk of serious bodily harm” arising from the deception.

This is essentially the law established by Section 265(3)(c) of the Canadian *Criminal Code*, as interpreted by the majority of the Supreme Court of Canada in *Cuerrier* in 1998, which held that in such circumstances what appeared to have been consensual intercourse becomes sexual assault. The judgment makes “clear that failure to disclose that one is HIV-positive constitutes fraud negating consent” where there exists a significant risk of transmission. None of the three justices who wrote opinions in the case “explicitly drew a distinction between non-disclosure and deliberately lying about one’s HIV status.”<sup>43</sup>

Despite the statute-specific context of the Canadian decision, I endorsed the outcome in *Cuerrier* as part of a successful strategy in the South African Law Reform Commission to resist the enactment of a criminal law specially targeting HIV. When pressed as to why the ordinary criminal law was sufficient, I would answer that undisclosed exposure to deadly peril would void consent, leaving the person with HIV liable to

prosecution for rape. No special law was therefore required.

As the years have passed, the question as to whether this was right has troubled me more and more. Failing to tell a sexual partner that you’re infected with a potentially deadly disease, and then exposing him or her to it, is a grave ethical lapse. Nevertheless, is it conceptually accurate, and helpful, to categorize ensuing intercourse as *sexual assault*? This seems questionable.

For long, the law has recognized that what constitutes a significant relevant factor in evaluating the reality of sexual consent is very narrow.<sup>44</sup> For example, we accept that most of the frauds, tricks and stratagems employed in bars, clubs and on first dates the world over do not vitiate consent to sex. Provided there is consent to sexual congress, there is no rape, no matter how despicable the fraud. I appreciate the force of the contention that, where the fraud or the suppression of information creates a material risk of serious harm, it should be held to vitiate consent. However, to hold that the non-disclosure turns consensual intercourse into rape seems a misconstruction of criminal categories and an abuse of terminology. To find the non-disclosure unethical is correct, but to hold that it makes consent to intercourse disappear seems like a clever lawyer’s stratagem to reconstruct the real world.

If it were so, then the exception should not be limited to HIV. It should rather be expanded to include contagious diseases such as hepatitis C. While the holding in *Cuerrier* specifically expanded the exception to include other STIs that cause “serious bodily harm,” in practice the case has been used in virtually no prosecu-

tions for STIs other than HIV.<sup>45</sup> It should perhaps include even a case where a man pretends to a woman for whom pregnancy is a high risk to health that he has had a vasectomy. And what of withholding the fact that one is under-age in sex that may make the partner liable to statutory rape charges?

For these reasons, as a non-Canadian person living with HIV, for whom *Cuerrier* was previously an article of faith, I have come to have severe misgivings about it. Non-disclosure of HIV status should be criminal only if intentional behaviour actually led to a HIV transmission.

### **Risk/endangerment — another look at Mabior**

Mr Mabior’s case in Winnipeg, currently before the Manitoba Court of Appeal, also warrants further analysis, given its troubling approach to applying the *Cuerrier* test. Among other charges, Mr Mabior was accused of 10 counts of aggravated sexual assault. Consider the offence of aggravated sexual assault in Canadian law. The elements of the crime are: (a) that the accused intentionally applied force to the complainant; (b) that the force intentionally endangered the life of the complainant; (c) that the force was applied in sexual circumstances; (d) that the complainant did not consent to the force that the accused intentionally applied; and (e) that the accused knew that the complainant did not consent.<sup>46</sup>

In several cases, people with HIV have been charged with this crime for engaging in anal or vaginal sex without disclosing their HIV status. In some cases, this may be an unobjectionable application of the ordinary criminal law, provided it involves the

actual transmission of HIV. As Isabel Grant points out, there is a curious anomaly under *Cuerrier*: Prosecution is easier where the complainant never tests positive and thus there is definitively no transmission because of the difficulty of ascribing a seroconversion to the defendant at trial.<sup>47</sup>

A major shift has taken place: HIV treatment is now a proven means of effective prevention.

The *Mabior* court's approach to the question of endangerment leaves me, as someone living with HIV, filled with misgiving. As a foreign judge, I am respectful of a colleague's decision. As someone who is living with HIV, I must be frank in describing the grave concern the decision causes me. The willing exposure of a sexual partner to HIV is viewed by the Canadian courts as tantamount to endangering life.<sup>48</sup> It is not necessary to establish that the partner was in fact infected.<sup>49</sup> The risk of harm cannot be trivial; it must have the effect of exposing the person supposedly consenting "to a significant risk of serious bodily harm."<sup>50</sup>

The burning question today, under current Canadian law, is, what constitutes a significant risk of serious bodily harm in HIV? According to a 2008 statement on behalf of the Swiss Federal Commission for HIV/AIDS authored by four of Switzerland's foremost HIV medi-

cal experts, individuals with HIV on effective antiretroviral therapy and without sexually transmitted infections (STIs) are sexually non-infectious. The statement says that "after review of the medical literature and extensive discussion," the Swiss Federal Commission for HIV/AIDS resolves that "[a]n HIV-infected person on antiretroviral therapy with completely suppressed viraemia ('effective ART') is not sexually infectious — i.e., cannot transmit HIV through sexual contact."<sup>51</sup>

Some consider that this goes too far. A recent statement by the French AIDS Council nuances the Swiss position, and eludes its pitfalls: It offers an up-to-date medical framework for normalizing the ethical debate about AIDS.<sup>52</sup> While there may always be some residual risk of transmission, no matter how low the viral load, the central point is that a major shift has taken place: HIV treatment is now a proven means of effective prevention.

Higher rates of testing and diagnosis, earlier treatment initiation and higher treatment success rates can all make significant contributions to prevention. Putting more people on antiretrovirals could considerably reduce HIV transmission.<sup>53</sup> Indeed, scientific evidence about the impact of antiretrovirals on viral load and hence on the possibility of transmission was presented in the *Mabior* case.

Yet, it seems open to question whether it was accorded its just force and significance. The accused was convicted for instances of sex in which he had worn a condom and at times at which his viral load was reduced due to his medication but still detectable, despite the fact that none of his partners became infected.

It is to the judge's credit that where there was both condom usage and an undetectable viral load, the defendant was acquitted.<sup>54</sup> Yet, the force of logic elsewhere seemed weaker, including the court's refusal to accept that condoms alone would suffice to reduce the risk of transmission such that it is no longer "significant" as required by the *Cuerrier* decision.

The court accepted evidence that condoms only have an 80 per cent success rate<sup>55</sup> — and concluded that endangerment of life was proven even where condoms were used. This finding seems at odds with scientific authority and seems to mis-state the risk factors. The court seems to take the statistic that condoms have a 20 per cent failure rate to mean that there is a 20 per cent risk of transmission. This is wrong. Depending on the particulars of the sexual encounter, transmission rates are often already significantly lower than one per cent without using a condom. Thus, even if true, the fact that condoms "only" have an 80 per cent success rate would make the risk of transmission with a condom virtually zero.

The extremely low viral load of the accused during many of the encounters may in fact have made the chance of transmission zero. However, the court did not accept that evidence of a low viral load sufficiently reduced the risk of endangerment of the lives of the complainants.<sup>56</sup> It held that "the potentially lethal consequences of unprotected sexual contact leave room for no other conclusion than that endangerment of life has been substantiated."<sup>57</sup>

Despite evidence that the accused's viral load was extremely low during treatment — indeed, the medical

expert testified that, in at least some of the instances, there was a “very high probability that the accused was not infectious and could not have transmitted HIV” — and the fact that condoms were used in some instances and the fact that the virus was not transmitted, the accused was sentenced to 14 years in jail on several charges of aggravated sexual assault.

The AIDS-rights movement should differentiate between just applications of criminal laws as opposed to targeted prosecution based on stigma.

How should we, who hold ourselves concerned to secure justice and rationality in the epidemic, engage with a case like this? We should grant that prosecution should occur when there is intent — which, in my legal system, includes reckless conduct heedless of the prospect of harm — to transmit the virus, coupled with actual transmission. On this point I am in disagreement with some of my distinguished colleagues and allies, including Dr Mark Wainberg, a former President of the International AIDS Society, who is a clinician and activist with a deep record of commitment in the field and who has passionately raised the broader concern, which I share, that the harm of criminalization may outweigh its benefits.<sup>58</sup>

*Mabior* and some of the other recent cases are deeply disturbing. They embody vaguenesses and an absence of scientific rigour that invite a downwards slide to making HIV a status crime. With a principled grounding in mind, the AIDS-rights movement should differentiate between just applications of criminal laws as opposed to targeted prosecution based on stigma. If our resistance to criminalization is too broad, it runs the risk of dissipation. If AIDS activists use all their political credibility denying that criminal prosecution is ever appropriate, they:

- lose public support for more significant battles against injustice, because all cases of criminalization are cast in the same light, and the public rightly believes at least some prosecutions are justified;
- feed into AIDS exceptionalism, which is part of what perpetuates stigma; and
- undermine the ability of people living with HIV to be autonomous, responsible adults and perpetuate the mentality of victimhood and powerlessness.

In short, if we expend all our energy defending the indefensible, we will be unable to sustain the nuance and moral authority we need to resist the spitting cases from Texas and from Canada, the internet sex cases from Iowa, the no-transmission case from Zimbabwe and the terrifyingly vague African “model” legislation.

## Conclusion

The global trend toward criminalization of HIV manifests itself in differing ways, but there seems to be a common thread. In Africa, the

“model” legislation is crudely over-inclusive and, in my view, radically averse to enhanced access to testing. In North America and Western Europe, it is mainly prosecutorial and judicial discretion that invites questions whether HIV could be turned into a status crime. In both contexts, from Cape Town to Calgary, the common theme seems to be still overly averse, and insufficiently informed, reactions to AIDS.

The Canadian trend towards broader and inappropriate prosecutions is regrettably spurring. This domestic national practice will surely encourage other countries, which have looked up to Canada’s human rights record, to broaden their own laws and prosecution policies. Canada will, in effect, export heightened stigma and discrimination. Amid this, we must keep in mind that the struggle for rationality in the epidemic has always been to secure equivalent treatment for those with and at risk of HIV. If we do so, our task becomes clearer.

In this context, “normalization” of HIV embraces, on the one hand, the application of ordinary rules of criminal law to conduct that by any reckoning deserves prosecution; but on the other, equally, resistance to exceptional prosecutions and enactments targeting HIV status alone. For a world without HIV seems, for now, just as far distant and unattainable as a world without irrational prejudice against HIV.

The strength in our position as proponents of rational and just action in the epidemic is that our fight against the latter continues to provide us with the surest guide to achieving the former.

– Edwin Cameron

Edwin Cameron  
(cameron.edwin@gmail.com) is a Justice of  
the Constitutional Court of South Africa.

<sup>1</sup> E.J. Bernard, "Guilty verdict in first ever murder trial for sexual HIV transmission," *Aidsmap News*, online: [www.aidsmap.com/en/news/779517F3-B26C-473F-B809-58C1548E4A91.asp](http://www.aidsmap.com/en/news/779517F3-B26C-473F-B809-58C1548E4A91.asp).

<sup>2</sup> George House Trust, "Canada — HIV Transmission 'Murders,'" online: [www.ght.org.uk/news/article/38384/08/04/2009/Canada\\_-\\_HIV\\_Transmission](http://www.ght.org.uk/news/article/38384/08/04/2009/Canada_-_HIV_Transmission); Canadian HIV/AIDS Legal Network, "Cases of Criminal HIV Transmissions and Exposures" (last updated 1 June 2009), data on file.

<sup>3</sup> See <http://criminalhivtransmission.blogspot.com/>.

<sup>4</sup> G. C. Kovach, "Prison for man with H.I.V. who spit on a police officer," *New York Times*, 16 May 2008.

<sup>5</sup> Centers for Disease Control, "Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV," (last reviewed and modified 20 October 2006) online: [www.cdc.gov/hiv/resources/qa/qa37.htm](http://www.cdc.gov/hiv/resources/qa/qa37.htm).

<sup>6</sup> *R v. Thissen* [1996] O.J. No. 2074; see also, R. Elliott, "Sex trade worker sentenced to two years for biting," *Canadian HIV/AIDS Policy & Law Newsletter* 3(1) (1996).

<sup>7</sup> *Ibid.*

<sup>8</sup> See materials posted by E.J. Bernard at <http://criminalhivtransmission.blogspot.com/2009/05/iowa-gay-man-gets-25-years-for-one-time.html>.

<sup>9</sup> See P.Vernazza et al., "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle," *Bulletin des médecins suisses* 89(5), 2008.

<sup>10</sup> Reported in the (Zimbabwe) *Herald*, 2 April 2008.

<sup>11</sup> *Herald*, 8 April 2008.

<sup>12</sup> Zimbabwe, *Criminal Law (Codification and Reform) Act [Chapter 9:23]* (No. 23/2004).

<sup>13</sup> Contrast *Johnson v. State*, 602 So.2d 1288 (Fla. 1992) (holding that a mother may not be convicted of delivering narcotics to children through the umbilical chord), which runs counter to the apparent effect of the Zimbabwean law.

<sup>14</sup> Sierra Leone's *Prevention and Control of HIV and AIDS Act of 2007*, s. 21, online: [www.sierra-leone.org/Laws/2007-8p.pdf](http://www.sierra-leone.org/Laws/2007-8p.pdf).

<sup>15</sup> For details of these allegations, see the letter of protest at [www.hrw.org/english/docs/2008/04/07/egypt18439.txt.htm](http://www.hrw.org/english/docs/2008/04/07/egypt18439.txt.htm).

<sup>16</sup> See materials posted by E.J. Bernard at <http://criminalhivtransmission.blogspot.com/>.

<sup>17</sup> See E.J. Bernard, "Switzerland: Geneva Court of Justice accepts 'Swiss statement,' quashes HIV exposure conviction," online: at <http://criminalhivtransmission.blogspot.com/2009/02/switzerland-swiss-courts-accept-swiss.html>; and *Procureur Général c. "S," Arrêt, Cour de Justice (Chambre pénale), République et canton de Genève*, 23 février 2009, online: <http://criminalhivtransmission.blogspot.com>.

<sup>18</sup> *Ibid.*

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

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

<sup>21</sup> *Ibid.*

<sup>22</sup> J. Huber and T. Crawford, "Murdrick verdict in HIV case sets off alarm; first in Canada," *National Post*, 6 April 2009, p. A1.; E.J. Bernard, "Guilty verdict in first ever murder trial for sexual HIV transmission," *Aidsmap News* (online), 7 April 2009; S. Chu, "Criminal Law and cases of HIV transmission or exposure," *HIV/AIDS Policy & Law Review* 13(2/3) (2008): 33–39 at 33–34.

<sup>23</sup> "Police accuse man of unprotected sex without revealing HIV status," *CBC News* (online), 8 May 2009; D. Black, "HIV carrier charged in sex case," *Toronto Star* (online), 8 May 2009.

<sup>24</sup> J. McLean, "HIV-positive man faces attempted murder charge," *Toronto Star* (online), 4 June 2009; A. Minsky, "HIV-positive Toronto man charged with attempted murder," *Canwest News Service*, 4 June 2009.

<sup>25</sup> A. Symington, "Criminalization confusion and concerns: the decade since the *Cuerrier* decision," *HIV/AIDS Policy & Law Review*, 14(1), (2009): 1, 5–10 at 5.

<sup>26</sup> *R v. Mabior*, 2008 MBQB 201, para. 42.

<sup>27</sup> *Robinson v. California* 370 U.S. 660; 82 S. Ct. 1417; 8 L. Ed. 2d 758; 1962 U.S. LEXIS 850. The defendant was convicted on basis of a police officer's testimony that he had scar tissue and discoloration on the inside of his arm, as well as needle marks and a scab below the crook of the elbow, which the officer believed was the result of injections by hypodermic needles. The officer also testified that he admitted to occasional use of narcotics — but at the time of his arrest, the defendant was not engaged in any illegal conduct, and there was no proof that he had actually used narcotics within California.

<sup>28</sup> "Brand HIV-positive people on the buttocks," originally published on page 1 of the (Johannesburg) *Sunday Independent*, 24 May 2009. The MP has since apologised and withdrawn the remarks. Online: [www.iol.co.za/index.php?set\\_id=1&click\\_id=68&art\\_id=vn20090524074908246C297054](http://www.iol.co.za/index.php?set_id=1&click_id=68&art_id=vn20090524074908246C297054).

<sup>29</sup> T. Tyler, Judge's ignorance of AIDS draws fire," *Toronto Star* (online), 30 January 2008, online: [www.thestar.com/News/Ontario/article/298672](http://www.thestar.com/News/Ontario/article/298672).

<sup>30</sup> *CTV News*, "Man accused of not disclosing HIV status to partner," 7 May 2009, online: [http://toronto.ctv.ca/servlet/an/local/CTVNews/20090507/police\\_accused\\_090507/20090507?hub=TorontoNewHome](http://toronto.ctv.ca/servlet/an/local/CTVNews/20090507/police_accused_090507/20090507?hub=TorontoNewHome).

<sup>31</sup> "Australian judge slams HIV criminalization," *Poz*, 18 July 2008.

<sup>32</sup> See, for example, *Chicago v. Morales*, 527 U.S. 41 (1999) (holding that a law cannot be so vague that a person of ordinary intelligence cannot figure out what is innocent activity and what is illegal).

<sup>33</sup> *R v. Cuerrier* (1998), 127 C.C.C. (3d) 1, [1998] S.C.J. No.64 (S.C.C.) (Q.L.), para. 74.

<sup>34</sup> I. Grant, "The boundaries of the criminal law: the criminalization of the non-disclosure of HIV," *Dalhousie Law Journal* 123 (2008): 123–180 at 140.

<sup>35</sup> Email communication from Beri Hull of ICW.

<sup>36</sup> U. Schuklenk, "Why some HIV transmissions should be punished," *Bioethics and the Law* 31 (2008), online: [www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=2684](http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=2684).

<sup>37</sup> UNAIDS, "The 2008 Report on the Global AIDS epidemic. According to the report, "The global percentage of adults living with HIV has leveled off since 2000." Online: [http://data.unaids.org/pub/GlobalReport/2008/jc1510\\_2008\\_global\\_report\\_pp29\\_62\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp29_62_en.pdf).

<sup>38</sup> Indeed, Grant (supra) at 179 points out that "a large majority of Canadian prosecutions involve heterosexual couples, and not gay men, IV drug users, or women involved in prostitution.... Cases in which complainants represent middle-class Canada are more likely to be prosecuted and more likely to result in a conviction. In some ways HIV/AIDS may be more frightening now precisely because the 'us' and 'them' dichotomy has broken down."

<sup>39</sup> S. Burris and E. Cameron, "The case against criminalization of HIV transmission," *Journal of the American Medical Association* 300(5) (2008): 578–581.

<sup>40</sup> *R v. Mabior*, para. 12.

<sup>41</sup> *R v. Cuerrier*, para. 127.

<sup>42</sup> *Ibid.*, para. 130.

<sup>43</sup> Grant (supra), pp. 136–137.

<sup>44</sup> *People v. Evans*, 85 Misc. 2d 1088, 379 N.Y.S.2d 912 (N.Y. Sup. Ct. 1975).

<sup>45</sup> Grant (supra), p. 140.

<sup>46</sup> *R v. Mabior*, para. 9.

<sup>47</sup> Grant (supra), p. 137.

<sup>48</sup> *R v. Cuerrier*, para. 8.

<sup>49</sup> *Ibid.*, para. 95.

<sup>50</sup> *R v. Cuerrier*, para. 128.

<sup>51</sup> P.Vernazza et al (supra).

<sup>52</sup> F. Bourdillon et al., "Statement followed by recommendations on the appropriateness of treatment as an innovative tool for fighting the epidemic of HIV infections," *Conseil national du sida (France)*, 9 April 2009. .

<sup>53</sup> This is a contentious area. See R. Granich et al., "Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model," *The Lancet* (online), 26 November 2008: doi:10.1016/S0140-6736(08)61697-9; and J. Montaner, "Clinical principle of treatment as prevention; benefits of earlier treatment to the individual and the community," 5<sup>th</sup> IAS Conference on HIV Pathogenesis, Treatment and Prevention, Cape Town, satellite presentation SUSAT0501, 2009.

<sup>54</sup> *R v. Mabior*, para. 143.

<sup>55</sup> *Ibid.*, para. 104.

<sup>56</sup> *Ibid.*, para. 105.

<sup>57</sup> *Ibid.*, para. 100.

<sup>58</sup> M.A. Wainberg, "The Johnson Aziga case: HIV transmission should not be a crime," *McGill Reporter*, 1 December 2008, online: <http://reporter.mcgill.ca/2008/12/the-johnson-aziga-case-hiv-transmission-should-not-be-a-crime/>.

## Panel: Canada's law on global access to affordable medicines

This article provides summaries of the four presentations made during this panel. Tenu Avafia describes the evolution of international agreements concerning intellectual property rights, which formed the basis of Canada's Access to Medicines Regime (CAMR). Cailin Morrison describes how the CAMR works, outlines the limitations of the CAMR, and discusses recent attempts to reform the CAMR. Bruce Clark, whose company, Apotex Inc. has provided a generic ARV drug to Rwanda under the only compulsory licence issued to date under the CAMR, discusses the challenges of the current CAMR and outlines what improvements are required. Finally, Jillian Clare Kohler describes recent development in India, which amended its patent law in 2005, and how this relates to what is happening with the CAMR.

### Why is the CAMR so important in the context of access to medicines in developing countries?

*Tenu Avafia, Policy Specialist (Trade and TRIPS), United Nations Development Programme*

Most recent estimates are that there are 33 million people in the world living with HIV, and that:

- Sub-Saharan Africa, with 10 percent of the world's population, is home to more than two-thirds of all cases of HIV/AIDS and three-quarters of the deaths attributed to AIDS.
- There were 2.7 million HIV infections and two million AIDS-related deaths in 2007 alone.
- In 2002, 300 000 persons living with HIV were on antiretrovirals (ARVs).
- An estimated 3.4 million persons living with HIV would be on treatment by 2009, but this would represent only about 31 percent of all persons living with HIV.
- Only 34 percent coverage has been achieved globally with treat-

ment to prevent mother-to-child transmission of HIV.

Over the period 1970–2010, the impact of AIDS in Southern African Development Community countries classified as “hyper-endemic” by UNAIDS has been striking, with a marked decrease in life expectancy since the early 1990s.

At the start of this decade, the lowest cost for combined ARV treatment was over US\$10,000 per patient per year. By the end of 2007, the cost of ARV treatment using generics had dropped dramatically to under US\$100 per patient per year.

#### Intellectual property and the price of medicines

Before the advent of the World Trade Organization's *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS),<sup>1</sup> countries had greater policy space to use intellectual property as a tool to facilitate and regulate access to medicines by encouraging generic entry points, and hence market competition, to lower prices.

This changed in 1995 with the creation of the World Trade Organization

(WTO), within which TRIPS is one of three cornerstone agreements. TRIPS imposes a minimum twenty-year term of patent protection for products in all fields of technology, including pharmaceuticals.

Within that protection, there are flexibilities for WTO Members, including developing countries. Yet, between 1994 and 2001, when developing countries attempted to use these flexibilities, they were met with extreme acrimony on the part of the pharmaceutical industry as well as governments such as that of the U.S.

The *Doha Declaration on the TRIPS Agreement and Public Health* (Doha Declaration),<sup>2</sup> adopted by WTO Members in 2001, re-affirmed the rights of developing countries to issue compulsory licences and to use TRIPS flexibilities to reduce the price of medicines. The declaration stated that TRIPS does not, and should not, prevent WTO Members from taking measures to protect public health. It also said that each country had the right to determine the circumstances under which compulsory licences would be issued.

One issue not resolved by the Doha Declaration was what to do

about countries that lacked the manufacturing capacity to fulfill their needs for medicines. Article 31(f) of TRIPS says that any medicine produced under compulsory licence must be predominantly for the domestic market, thus impeding the use of compulsory licensing to export generic medicines from countries with manufacturing capacity to countries in need of those medicines.

Countries like Canada have generic manufacturers but don't have the same extensive epidemics of diseases, such as HIV, when compared with some developing countries that require access to large quantities of medicine — and at much lower prices than generally available from originator pharmaceutical companies in the absence of competition.

This is where the WTO General Council's Decision of 30 August 2003 (WTO Decision)<sup>3</sup> comes in, as a means of overcoming the Article 31(f) restriction and facilitating the use of compulsory licensing to export less expensive generic medicines to countries in need. That Decision then formed the basis of the CAMR.

## Canada's Access to Medicines Regime (CAMR): failing the most vulnerable

*Cailin Morrison, Legal Advisor (Trade and Intellectual Property Law), Canadian HIV/AIDS Legal Network*

In August 2003, responding to demands from civil society groups, then-Prime Minister Jean Chrétien announced that Canada would implement the WTO Decision into Canadian law. The objective of the

WTO Decision and the Canadian legislation was to enable developing countries with insufficient or no manufacturing capacity in the pharmaceutical sector to “make effective use of compulsory licensing” to respond to their public health needs and in particular to “provide access to medicines for all,” [emphasis added] as was explicitly stated in the Doha Declaration.

The CAMR has been used only once. The process is laborious.

The *Jean Chrétien Pledge to Africa Act* (now referred to as “Canada's Access to Medicines Regime” or CAMR)<sup>4</sup> was passed unanimously in Parliament in May 2004. It was proclaimed in force in May 2005, with the accompanying regulations published on 1 June 2005. Its stated purpose is to permit “the use of patents for international humanitarian purposes to address public health problems.” Since the legislation was enacted, it has only been used once. This is explained, in large part, by the fact that the legislation is too cumbersome.

### CAMR: How does it work?

The process under the CAMR is laborious. First, a generic manufacturer and developing country purchaser strike a tentative deal on the specific drug and quantity.

The importing developing country must then notify the WTO's Council for TRIPS (if a WTO member) or the Canadian government (if not a WTO Member) of its intention to use the system set out in the WTO Decision, and of its lack of manufacturing capacity (which is presumed in the case of “least-developed countries”). The importing country must also state that either there is no patent on the product in its territory, or that it intends to issue a compulsory licence to permit import and sale of the drug.

If an NGO is the purchaser of the product, the CAMR requires that it obtain “permission” from the government of the importing country before the generic drug manufacturer may be granted a licence to produce and export the drug for the NGO's use in that country.

Then, the generic manufacturer of the drug undergoes review by Health Canada's Therapeutic Products Directorate (this review, incidentally, is only required for drugs exported under the CAMR).

Next, the manufacturer must request a voluntary licence from the patent-holder(s). It must disclose the importing country and the quantity of the drug to be exported to that country. This must be followed by a 30-day period of negotiation with the patent-holder(s) for a voluntary licence on “reasonable commercial terms and conditions.”

However, this 30-day period, which must expire before any application can be made for a compulsory licence, does not start running, for legal purposes under the CAMR, until the name of the importing country and quantity of the drug sought are disclosed to the patent-holder(s).

If the negotiation for a voluntary licence is unsuccessful, the

generic company can then apply to the Commissioner of Patents for a compulsory licence. If the statutory conditions are satisfied, the Commissioner “shall” issue a non-exclusive licence to the applicant.

When a compulsory licence is issued, the royalty that must be paid to the patent-holder(s) is set by regulation adopted under the *Patent Act* as part of the CAMR: The royalty is determined on a sliding scale based on the importing country’s ranking on the U.N.’s Human Development Index, with a maximum cap of four percent of the value of the contract between the generic manufacturer and the importing country. (However, the patent-holder(s) may apply to the Federal Court of Canada for a higher royalty.)

The licence permits the generic manufacturer to export only the quantity of the product set out in the compulsory licence application (i.e., the quantity originally negotiated by generic manufacturer with the purchaser and notified to the WTO or the Canadian government). There is a maximum two-year term for a compulsory licence.

### Limitations of the CAMR

The CAMR presents a “chicken-or-egg” problem: The agreement between the Canadian generic manufacturer and would-be purchaser serves as the basis for seeking a voluntary or compulsory licence to export; but, at the time of needing to make such an agreement, there is no guarantee that the generic manufacturer will be able to supply the drug because the licence must still be obtained under the CAMR.

In addition, NGOs require the “permission” of the importing country government, which must also be

given before any compulsory licence can be obtained by the generic manufacturer to supply that product.

Developing countries that are neither “least-developed” nor WTO members face unjustified, additional conditions in order to be eligible importers, such as declaring a “national emergency or other circumstances of extreme urgency” and filing a pledge not to permit “commercial use.” The latter term is not defined anywhere; this lack of definition could raise questions about distribution of imported generics through channels such as commercial pharmacies.

The CAMR requirements expose importing countries to pressure from patent-holders and even possible retaliation.

The pre-condition of trying to negotiate a voluntary licence, and the requirement that the name of the importing country be disclosed to the patent-holder(s) at that time, exposes importing countries to pressure from patent-holders and others to refrain from pursuing the purchase of generics through compulsory licensing, and may expose them to retaliation as well. (Consider, for example, the history of pressure, including threats of trade sanctions, brought to bear in recent years on developing countries contemplating the use of compulsory licensing.)

Another limitation is that the compulsory licence is for a single specific contract and authorizes only a pre-specified quantity of a product only to a single country or purchaser. Finally, there is an arbitrary two-year limit on compulsory licences; after that, a new application is required. This limits commercial viability and economies of scale.

Far from being an “expeditious solution” providing quick, reliable and affordable medicines to people in the developing world, in five years the CAMR has resulted in the export of one drug to one country (Rwanda).

An estimated 2.3 million children under the age of 15 are infected with HIV. Of this number, 34 percent (780 000) are believed to be in need of ARVs. Yet, globally, only 15 percent are on treatment. In sub-Saharan Africa, this falls to less than six percent. Without access to ARVs, half of these children will be dead before their second birthday.

### Reforming the CAMR

As it stands, the CAMR is failing the most vulnerable. However, there is an opportunity to fix the law and use an amended CAMR to export affordable ARVs for people in developing countries.

During the spring 2009 session of Canada’s Parliament, Liberal Senator Yoine Goldstein and the New Democratic Party Member of Parliament and Health Critic, Judy Wasylycia-Leis, recognizing the limitations of the CAMR, introduced separate private members’ bills to amend the legislation.

On 31 March 2009, Senator Goldstein introduced Bill S-232 in the Senate to amend provisions of the CAMR.<sup>5</sup> The purpose was to simplify the process for obtaining

a compulsory licence in order to deal with the problems faced by developing countries in obtaining lower-cost, generic versions of patented medicines to address public health problems, including, but not limited to HIV/AIDS, tuberculosis and malaria.

On 25 May 2009, Wasylycia-Leis introduced Bill C-393 in the House of Commons.<sup>6</sup> The two bills are almost identical, with some minor differences. Highlights of both bills include:

- abolishing Schedule 1 (the limited list of drugs subject to compulsory licensing for export), and instead more closely reflecting the WTO Decision that authorizes compulsory licensing of “any pharmaceutical product”;
- eliminating additional requirements for developing countries that are not “least-developed” and not WTO members to be eligible to import Canadian-made generics;
- eliminating the unnecessary requirement for NGOs to obtain “permission” to import from the government of the country to which the generics are to be sent;
- eliminating the requirement that only Health Canada can conduct the quality review which is a precondition for obtaining a compulsory licence for export —and, instead, accepting approval by Health Canada *or* a similarly stringent drug regulatory authority in another country *or* the WHO Prequalification Project, *or* simply letting the importing country decide which standard it will require; and
- eliminating the arbitrary two-year limit on the term of the compulsory licence.

Furthermore, both bills incorporate what CAMR reform advocates such as the Canadian HIV/AIDS Legal Network have dubbed the “one-licence solution.” This is a simplified process that would eliminate the need for separate negotiations with patent-holders for each order placed by each importing country. Under this process, a compulsory licence would be applied for and granted at the outset (assuming the generic manufacturer satisfied the minimal conditions of the statute).

**It is time that Canada use the flexibility it has under TRIPS to legislate changes to the CAMR so that it will be a simple, workable system.**

The licence issued by the Commissioner of Patents would authorize the manufacture for export to any eligible importing country without limiting the maximum quantity that may be exported. The licence would include the condition that the generic manufacturer disclose, and pay royalties on, any contracts subsequently negotiated with eligible importing countries (in accordance with the existing formula in the law, which would not be changed.)

Under the one-licence system, over the longer term, multiple-purchaser contracts would enable economies of scale, and there would be flexibility for manufacturers and

purchasers (e.g., to adjust quantities and supply additional eligible countries as needed).

Bills S-232 and C-393 are both TRIPS-compliant. In almost all respects, they satisfy the conditions of the WTO Decision, albeit with a somewhat different — and simpler — process for obtaining a licence to export to eligible importing countries. Furthermore, it should be recalled that the WTO Decision says explicitly that it was adopted “without prejudice” to other flexibilities that WTO Members have under TRIPS. Article 1 of TRIPS states that WTO Members are free to determine the appropriate method of implementing TRIPS within their own legal systems and practice. Note, as well, that Article 30 of TRIPS states,

Members may provide limited exceptions to the exclusive rights conferred by a patent, provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties.

In the Doha Declaration, WTO Members unanimously agreed that TRIPS “can and should be interpreted and implemented so as to protect public health and, in particular, to promote access to medicines for all.” Furthermore, they unanimously agreed that WTO members have the right “to use, to the full, the provisions in the TRIPS Agreement which provide flexibility for this purpose.” It is time that Canadians demand that Canada use the flexibility it has under TRIPS to legislate changes to the CAMR so that it will, in fact, be a simple, workable system of compulsory licensing to export more affordable medicines

to developing countries, as was originally promised by Parliament more than five years ago.

## **CAMR: from principle to practice**

*Bruce Clark, Vice-President of Regulatory Affairs, Apotex Inc.*

The premise of the CAMR was that high-quality medicines, with Health Canada approval, would be available for developing countries facing serious diseases. However, the reality was that Apotex had to undergo a years-long odyssey (2004–2008) to get its generic ARV drug to Rwanda under the only compulsory licence issued to date under CAMR.

Apotex's decision to get involved in the first attempt to use the CAMR rested on a core value — access to affordable medicines — and meeting a critical unmet need: Millions of people have no access to effective, high-quality, affordable medicine.

### **CAMR weaknesses**

Apotex, Canada's largest generic pharmaceutical manufacturer is the only company to date to have used the CAMR to obtain a compulsory licence to supply a developing country with a less expensive generic medicine — and, hence, also the only generic manufacturer in the world to have made use of the mechanism set out in the WTO Decision.

Responding to a request from Médecins Sans Frontières (MSF), Apotex produced Apo-Triavir, a generic fixed-dose combination tablet consisting of the ARVs zidovudine (AZT), lamivudine (3TC) and nevirapine (NVP). A compulsory licence to supply over 15 million tablets of

the product to Rwanda was issued in September 2007; the first shipment of the product arrived in Rwanda in September 2008.

Under the current legislation, there are three primary challenges in making the CAMR work. First, there are process “gaps” and resulting delays because the requirement for a country to first make a formal request (i.e., notification to WTO and then disclosure of this country's name and request to patent-holders in seeking a voluntary licence) delays negotiations and implementation (including the application for a compulsory licence).

Second, the licence is only for a specific quantity and lasts only two years at most, even though requirements change and costs — and, hence, final price to developing country purchasers — are driven by volume.

**The current approach consumes too many resources and compromises the ability to meet the objective of the CAMR.**

Finally, the licence is country-specific. Because of this, it is difficult for multi-country programs, including NGOs procuring and distributing to treatment initiatives in multiple countries, to use the legislation.

In addition, the CAMR's effectiveness is compromised by a lack of clarity: Actual operational provisions

are at odds with its stated objective. The process needs to be streamlined, particularly with regard to the licensing negotiations required before a compulsory licence can be sought.

The current approach, which tries to balance a humanitarian objective with the interests of the patent-holding pharmaceutical industry, has ended up consuming too many resources and compromising the ability to meet the objective.

A June 2009 opinion piece by Russell Williams, President of Rx&D: Canada's Research-based Pharmaceutical Companies, the industry association for patent-holding pharmaceutical companies,<sup>7</sup> contained several statements that were misleading.

For example, the claim that patent-holding “companies stepped forward promptly and decisively” is incorrect. Not one patent-holding company stepped forward. Furthermore, one patent-holding company refused to initially grant a royalty-free licence, claiming that it was unreasonable. (One year later, it offered to grant a voluntary licence, but the terms were unreasonable.)

All of the patent-holding companies concerned refused to engage in dialogue before the Apotex product received approval by Health Canada. They stated that requests for a voluntary licence were premature because no specific importing country had been identified.

Elsewhere in the article, Williams claimed that three companies “gave authorization to manufacture product royalty-free,” implying that these companies had agreed to issue a voluntary licence. In fact, no companies gave any such authorization and no companies agreed to issue a voluntary licence. Rather, Apotex obtained

a compulsory licence by application to the Commissioner of Patents.

Two companies indicated they would not oppose the issuing of a compulsory licence — which they had no legal basis for doing in any event — but said that they would not grant a voluntary one. Another company imposed unmanageable requirements for a voluntary licence, and asserted copyright in its letter and proposal in an effort to prevent the proposal from being disclosed.

Williams' claim that "it took almost a year for Apotex to produce and send" the ARV to Rwanda is misleading. The tender from Rwanda had been awarded to Apotex in July 2008 (after a bid submitted by Apotex several months earlier in accordance with Rwanda's government procurement process). The Apotex product was received in Kigali on 25 September 2008. We could have started the process much earlier, possibly a full year earlier, if patent-holders had been willing to engage in licence discussions without insisting on delaying any negotiations until a specific importing country was identified.

Williams claimed that "Rx&D members have provided more than \$225 million in donated medicine since 1990." In those 19 years, 50 companies were involved, making for an average of \$11 million of donations per year or approximately \$200,000 per company.

Yet, the quantity of Apo-Triavir being provided by Apotex to Rwanda over the two-year period of the compulsory licence has a value of \$20 million, based on the lowest reported prices of the brand-name medicines constituting Apo-Triavir that are on offer to the developing world, and a value of \$234million, at current

Canadian pricing for those brand-name medicines — all from one generic company.

The companies holding the patents on the originator drugs combined in Apo-Triavir have not provided a combination pill, despite the fact that the developing world has been asking for one.

### Improving the CAMR

The CAMR needs to look after the interests of those affected. The regime is weighted toward protecting industry interests at the expense of the humanitarian objective is it supposed to achieve. It needs a model that prioritizes the need, instead of the current model, which perpetuates the human crisis.

The regime is weighted toward protecting industry interests at the expense of the humanitarian objective is it supposed to achieve.

Indeed, the CAMR made sense only in the developed world: it is overly complex, and most potential importing countries do not have the expertise or resources to initiate the request and deal with the bureaucracy involved.

The CAMR process for licensing also needs to be streamlined. The process should move directly to issuing a compulsory licence for export upon regulatory approval. This would expedite the process and limit

costs; the legal costs are particularly substantial.

Ownership of technology should be transferred, where possible, to developing countries. This means that the Government of Canada needs to move from facilitator to implementer. A profit-based industry is constrained by costs, and industry priorities compromise a long-term view. Moreover, established government agencies (e.g., the Canadian International Development Agency, or CIDA) could play a role in this process.

Not-for-profit development and manufacturing of these products could be done at existing government-sponsored, university-based facilities under compulsory licence agreements. If this were to happen, industry collaboration could support development, training and production at these facilities. The products would be approved by Health Canada with subsequent WHO pre-qualification. CIDA or another agency could manage the supply agreements.

### Global comparisons with the CAMR: India's Story

*Jillian Clare Kohler, Faculty of Pharmacy, University of Toronto*

As part of its obligations as a WTO Member, in 2005 India adopted the *Patents (Amendment) Act*<sup>8</sup> in order to bring its intellectual property law into compliance with WTO standards.

Previously, Indian patent law only provided for patenting of processes for inventions in the pharmaceutical sector, not pharmaceutical products themselves; this enabled "reverse engineering" so that equivalent generic products could lawfully be manufactured in and exported from

India. The *Patents (Amendment) Act* introduced pharmaceutical product patents in the country.

Thus, medicines patented after 1 January 2005 are now eligible for patent protection in India. This is significant because India is a major supplier of the world's generic medicines, and there is concern about how the new Indian legislation will affect access to affordable medicines from Indian generic manufacturers.

The *Patents (Amendment) Act* has been criticized for incorporating ambiguous language and including loopholes that may benefit litigious patent holders.

### The case of Nepal

What happened in Nepal is an example of the impact of the Indian patent law amendments on access to essential medicines.

In September 2007, the Indian generic pharmaceutical company, Natco, filed an application with India's Patent Controller for a compulsory licence to produce two anti-cancer drugs for export to Nepal: erlotinib (patented by Roche under the brand name Tarceva) and sunitinib (patented by Pfizer under the brand name Sutent). Both drugs were granted patents in India in 2007.

Based on an import licence issued by Nepal, Natco intended to produce 30 000 tablets of erlotinib and 15 000 tablets of sunitinib.

This was the first test case using Section 92A of India's *Patent Act*, inserted by the 2005 amendments. Section 92A consists of three paragraphs allowing for export of generic versions of patented medicines to any country provided the country has allowed importation of the drug. According to Section 92A,

Compulsory licences shall be available for manufacture and export of patented pharmaceutical products to any country having insufficient or no manufacturing capacity in the pharmaceutical sector for the concerned product to address public health problems, provided compulsory licence has been granted by such country or such country has, by notification or otherwise, allowed importation of the patented pharmaceutical products from India.

Lawyers for the patent-holders argued that, under fundamental common-law principles of "natural justice," an opportunity to be heard was required before any action adverse to the patent-holder's interest was taken by the state.

Legal ambiguity in legislation creates obstacles.

The patent-holders distinguished the comprehensive nature of Canada's legislation from the sparse nature of Section 92A in India's *Patent Act*. They argued that, in the absence of comprehensive safeguards, in order to ensure that a patentee is treated fairly, India's Patent Controller should allow the patentee the opportunity to be heard prior to the issuance of a compulsory licence.

The patent-holders also argued that the "notice" given by the government of Nepal, upon which Natco was relying, was insufficient to demonstrate Nepal's intent to utilize the

mechanism in the WTO Decision to import drugs produced under a compulsory licence. The patent-holders contrasted this to the formal notification provided to the WTO by Rwanda of its intent to use Canada's regime.

Legal ambiguity in legislation creates obstacles. Uncertainty in the interpretation of Section 92A of India's *Patent Act* opened the door for heightened politics, including litigation by the patent-holders. While Canada's legislation has been the subject of much warranted criticism for being too cumbersome, the sparse language contained in India's *Patent Act* has also proven to be contentious.

This case raises two main issues under Indian patent law. First, should a hearing be granted to the patent-holder before a compulsory licence authorizing export is issued? Second, what constitutes sufficient "notification" by an importing country of its intent to utilize the WTO Decision to import under a compulsory licence?

The answers are critical for global access to medicine because India is a major producer of generic drugs for developing countries. Indeed, a judgment in favour of Natco would set a global example.

### The Cipla case

On 14 January 2008, in India, Cipla announced its intention to manufacture a generic version of Roche's erlotinib. Roche proceeded to sue Cipla in the Delhi High Court (court papers filed on 19 January 2008). However, Cipla claimed that erlotinib was a derivative of an earlier, patented substance, and should not have been granted a patent.

On 24 April 2009, the Delhi High Court ruled that Cipla should be restrained from manufacturing and selling the generic drug until the

issue of patent rights was decided through litigation.

The legislative models among the handful of countries that have amended their domestic legislation to implement the WTO Decision have features that both facilitate and hinder effective utilization of that decision.

Countries may want to follow India's example and allow for any country having insufficient manufacturing capacity in the pharmaceutical sector to serve as eligible importers, regardless of WTO membership. (Canada's legislation also allows this to some degree, but imposes additional requirements not faced by WTO Members.)

Unlike Canada, the Netherlands sets a positive example by allowing for NGOs to act for an importing country without requiring some unde-

finied "permission" from the government of that country.

The European Union establishes a 30-day period for negotiating a voluntary licence, but waives the need to negotiate with the patent-holder in the event that the generic product is needed for an emergency or other circumstance of extreme urgency, or for public non-commercial use in the importing country — something explicitly allowed by TRIPS but not currently reflected in Canada's legislation.

The importing country should have the right to determine whether it wishes to avail itself of the regulatory approval process of the exporting country or of the WHO's pre-qualification program. Additionally, the long-term sustainability of using such regimes requires that there be

sufficient commercial incentive for generic manufacturers to participate.

<sup>1</sup> *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS), 15 April 1994, Annex 1C of the *Marrakesh Agreement Establishing The World Trade Organization*, Legal Instruments — Results of the Uruguay Round, Vol. 31, 33 I.L.M. 1197 (1994).

<sup>2</sup> Declaration on the TRIPS Agreement and Public Health, Ministerial Conference, Fourth Session, Doha, 9–14 November 2001, WT/MIN(01)/DEC/2.

<sup>3</sup> WTO General Council, *Decision on the Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. IP/C/W/40 (30 August 2003).

<sup>4</sup> *An Act to Amend the Patent Act and the Food and Drugs Act* (Jean Chrétien Pledge to Africa), S.C. 2004.

<sup>5</sup> Bill S-232, *An Act to amend the Patent Act (drugs for international humanitarian purposes) and to make a consequential amendment to another Act*.

<sup>6</sup> Bill C-393, *An Act to amend the Patent Act (drugs for international humanitarian purposes) and to make a consequential amendment to another Act*.

<sup>7</sup> R. Williams, "Canada's Access to Medicines Regime: not a panacea to developing world," *The Globe and Mail*, 5 June 2009.

<sup>8</sup> *The Patents (Amendment) Act No. 15 of 2005*, 4 April 2005.

## Panel: Rights of people in prison to HIV prevention, treatment and care

This article contains summaries of the five presentations made during this panel. Ralf Jürgens provides an overview of the issue of needle exchange programs in prisons, and reviews the international experience with such programs. Sandra Ka Hon Chu advances the legal and human rights arguments for establishing needle exchanges in Canadian prisons. Giselle Dias describes the inter-sectoral strategy for HIV/AIDS in prisons being developed by the Prisoners HIV/AIDS Support Action Network (PASAN). Finally, two former prisoners turned activists, James Motherall and Greg Simmons, provide their personal perspectives on prevention and treatment behind bars.

### Needle exchange programs in prisons: an overview

*Ralf Jürgens, HIV/AIDS, health, policy and human rights consultant*

In Canada, needle exchange programs have still not been implemented in prisons, even though the Expert Committee on AIDS in Prisons recommended as far back as February 1994 that such programs be established.<sup>1</sup> This reluctance to move forward on one of the Expert Committee's most important recommendations has had a negative impact not only for Canadian prisoners, but also for those in other countries — particularly ones in Eastern Europe and the former Soviet Union — since prison systems in resource-poorer countries look to Canada for leadership on prison policy.

Prevalence of HIV infection among prisoners in many countries, including Canada, is significantly higher than in the general population.<sup>2</sup> Hepatitis C virus (HCV) prevalence is even higher.<sup>3</sup> Most prisoners living with HIV contract their infection prior to imprisonment. However, the risk of being infected in prison,

specifically through the sharing of contaminated injecting equipment, is high. Outbreaks of HIV infection in prison associated with shared injecting equipment have been documented in a number of countries.<sup>4</sup>

In many countries, a substantial proportion of prisoners are drug dependent. Estimates of drug use or dependence in male prisoners (eight studies, n=4293) range from 10 percent to 48 percent; in female prisoners (six studies, n=3270), from 30 percent to 60 percent.<sup>5</sup> For injecting drug users, imprisonment is a common event. Studies report that between 56 percent and 90 percent of people who inject drugs had been imprisoned.<sup>6</sup>

Prisons around the world have been unable to stop drugs from coming into their institutions. People who used drugs prior to imprisonment often continue using drugs while imprisoned, although for most people the prevalence and frequency of drug use declines during imprisonment.<sup>7</sup> Some people discontinue using drugs while in prison, while others start using drugs, often as a means to release tensions and to cope with being in an overcrowded and often violent environment.<sup>8</sup>

Injecting drug use in prison is of particular concern given the potential for transmission of HIV and other blood borne infections, including HCV. Those who inject drugs in prisons often share needles and syringes and other injecting equipment, which is an efficient way of transmitting HIV.

Studies show that the extent and pattern of injecting and needle sharing vary significantly among prisons; that many people who inject before imprisonment reduce or stop injecting when they enter prison, but many resume injecting upon release; that some people start injecting in prison; and that those who inject in prison will usually inject less frequently than outside, but are much more likely to share injecting equipment than are drug injectors in the community.<sup>9</sup> Furthermore, they are sharing injection equipment with a population — fellow prisoners — that often has a high prevalence of infections.

The first prison needle and syringe program (PNSP) was established in Switzerland in 1992. Since then, PNSPs have been introduced in over 50 prisons in 12 countries in western and eastern Europe and in central Asia. In some countries, only

a few prisons have PNSPs, but in Kyrgyzstan and Spain PNSPs have been rapidly scaled up and operate in a large number of prisons.

Only in one country, Germany, have PNSPs been closed. At the end of 2000, PNSPs had been successfully introduced in seven prisons and other prisons were considering implementing them. However, since then, six of the programs were closed down as a result of political decisions by newly elected state governments.

The decision to cancel the programs was made without consultation with prison staff. Since the programs closed, prisoners have gone back to sharing injecting equipment and to hiding it, increasing the likelihood of transmission of HIV and HCV, as well as the risk of accidental needle stick injuries for staff.<sup>10</sup> Staff have been among the most vocal critics of the governments' decision to close down the programs, and have lobbied the governments to reinstate the programs.<sup>11</sup>

Several models for the distribution of sterile injecting equipment have been used, including distribution by prisoners trained as peer outreach workers.

Systematic evaluations of the effects of PNSPs on HIV-related risk behaviours and of their overall effectiveness in prisons have been undertaken in 10 projects. With the exception of one prison in which sharing continued because of insufficient supply with needles and syringes,<sup>12</sup> all available evaluations have shown that sharing of injecting equipment either ceased after implementation of the PNSP,<sup>13</sup> or significantly dropped.<sup>14</sup> Prisoners who inject drugs in Moldovan prisons with PNSPs also reported few incidents of sharing injecting equipment.<sup>15</sup>

No new cases of HIV were reported in any evaluation. In five of the six prisons in which blood tests were performed for HIV or hepatitis infection, no seroconversion was observed,<sup>16</sup> and self-reports in other prisons also indicated no new cases of infection. In another prison in which the incidence of HIV, hepatitis B (HBV), and HCV was determined through repeated testing, no HIV and HBV seroconversions were observed, but there were four HCV seroconversions, one of which had definitely occurred in prison.<sup>17</sup>

**The availability of sterile injecting equipment has not resulted in more prisoners injecting drugs, or an increase in overall drug use or the amount of drugs in prisons.**

In addition, there is evidence of ancillary benefits associated with the implementation of PNSPs, including increased staff safety, due to the fact that accidental injuries from hidden injecting equipment during cell searches decreased.<sup>18</sup>

There have been no reports of syringes having been used as weapons in any prison with an operating PNSP. The availability of sterile injecting equipment has not resulted in an increased number of prisoners injecting drugs, an increase in overall drug use or an increase in the amount of drugs in prisons.<sup>19</sup>

Ensuring that prisoners have easy and confidential access to PNSPs has been shown to be a key factor in ensuring their success. Prisoners are reluctant to use PNSPs if they fear negative consequences, either because they could be seen using a dispensing machine,<sup>20</sup> or because they could only access the PNSP through health care or other staff.<sup>21</sup>

When prisoners have limited access to the program, are not provided the right type of syringes, or lack trust in the program, benefits for staff are also reduced, as some prisoners will continue to hide needles and syringes, thus increasing the risk of needlestick injuries for staff.<sup>22</sup>

Once in place, acceptance of PNSPs is generally high among staff and prisoners.<sup>23</sup>

Therefore, the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and UNAIDS recommend that prison authorities introduce PNSPs urgently and expand implementation to scale as soon as possible.<sup>24</sup>

The rationale for establishing needle exchange programs in prisons is even stronger than in the community. Although people dependent on drugs inject less frequently during incarceration, each episode involves more risk due to the scarcity of sterile injecting equipment and the high prevalence of sharing of injecting equipment.

Furthermore, the rapid turnover of prison populations means that there are potentially more changes in injecting partners than in community settings; and results in considerable interaction between prison- and community-based populations of people who inject drugs.

Since most prisoners leave prison at some point to return to their

community, implementing needle exchange programs in prisons benefits not only prisoners and prison staff, but also people in the sexual and drug injecting networks in which prisoners participate after their release.

Rather than providing PNSPs, many systems continue to provide bleach or other disinfectants. Such an approach is not supported by evidence.<sup>25</sup> Because of their limited effectiveness in decontaminating injecting equipment, particularly in prisons, bleach programs should be regarded as a second-line strategy to PNSPs.

Finally, “[a]ction to reduce the size of prison populations and prison overcrowding should accompany — and be seen as an integral component of — a comprehensive strategy to prevent HIV transmission in prisons, to improve prison health care, and to improve prison conditions.”<sup>26</sup>

According to U.N. agencies, this should include legislative and policy reforms aimed at “reducing the criminalization of non-violent drug offences and significantly reducing the use of incarceration for non-violent drug users,” and “developing alternatives to prison and non-custodial diversions for people convicted of offences related to drug use so as to significantly reduce the number of drug users sent to prison, the overall prison population, and levels of prison overcrowding.”<sup>27</sup>

Canada seems to be going exactly in the opposite direction. Bill C-15 — a law currently being debated in the Canadian parliament that would institute mandatory minimum sentencing for minor drug offences — would increase the size of prison populations and increase, rather than reduce, incarceration of people who use drugs, thus

further increasing the risk of HIV and HCV transmission in prison.

### **Clean switch: the case for prison-based needle and syringe programs**

*Sandra Ka Hon Chu, Senior Policy Analyst, Canadian HIV/AIDS Legal Network*

The rates of HIV and HCV in prisons are 10 times higher and 30 times higher, respectively, than in the general population. As well, there is a high rate of injection drug use in prison. In one study, eighty percent of people incarcerated in federal institutions were identified upon admission as having a substance use problem connected to criminal activity.

Underpinning the legal basis for prison needle exchange and syringe programs (PNSPs) are two guiding principles as they relate to access to health in prison:

- The principle of retaining all rights: People in prison retain all human rights except those necessarily removed or restricted as a consequence of imprisonment.
- The principle of equivalence: People in prison should have access to a standard of health care equivalent to that available outside prisons.

According to Canada’s *Corrections and Conditional Release Act* (CCRA), Correctional Services Canada (CSC) must carry out sentences “through the safe and humane custody and supervision of offenders” and must “take all reasonable steps to ensure that penitentiaries ... are safe, healthful and free of practices that

undermine a person’s sense of personal dignity.”<sup>28</sup>

The CCRA and several Commissioner’s Directives (CDs) affirm the principles of retaining all rights and of equivalence by stipulating that “[h]ealth care shall conform to professionally accepted standards” and be “in keeping with community practice,” as well as by recognizing that harm reduction measures are necessary.

People in prison should have access to a standard of health care equivalent to that available outside prisons.

CSC provides bleach to people in prison, but stops short of providing clean needles.

#### **Charter protection**

The Canadian *Charter of Rights and Freedoms* (Charter) features several provisions that support the right of people in prison to PNSPs.

#### **Section 7: right to life, liberty and security of the person**

The right to life, as provided in Section 7 of the Charter, concerns state activity that can cause death. With respect to a supervised injection site, a court has found that criminal law that impedes access to health services for people who use drugs is

unconstitutional because “it prevents healthier and safer injection where the risk of mortality resulting from overdose can be managed, and forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death.”

Courts have also applied Section 7 to invalidate conditions imposed by criminal justice systems that interfere with a person’s access to health care services. For example, the prohibition on marijuana to alleviate pain has been found to be a violation of an individual’s liberty to choose a medically suitable course of treatment.

Similarly, a blanket imposition of a “red zone” as a condition of probation for all people convicted of drug offences has been found to violate individual liberty under Section 7 because individuals “are effectively forbidden from accessing necessary health and other social services.... [I]t is apparent that a lot of people who need The Needle Exchange’s services are either not getting them or are violating the ‘red zone’ condition to do so.”

The right to security of the person encompasses individuals’ physical and psychological integrity. Accordingly, violations of this right have included the following:

- state action that increases “anxiety as to state of [a person’s] health” and “is likely to make illness worse by depriving [a person] of access to adequate medical care”;
- delays in access to health services that materially increase risks to health;
- preventing access to treatment by threat of criminal sanction; and

- denial of timely health care for a condition that is clinically significant to current and future health.

### Section 15: right to equality

Section 15 is intended to prevent discrimination, promote equality and remedy disadvantage. The Supreme Court of Canada recently set out the analytical framework to assess Section 15 claims in *R. v. Kapp*. In order to find a violation of the Charter’s equality rights clause:

- there must be a distinction based on an enumerated or analogous ground; and
- the distinction must create a disadvantage by perpetuating prejudice or stereotyping.

Community-based needle and syringe programs (NSPs) have enjoyed the support of the Canadian government at all levels, and are a benefit available to people injecting drugs outside prison. Denying clean needles to incarcerated people exposes them to increased risk of HIV and HCV infection, and reflects a clear distinction in treatment between people who inject drugs in the community and people who inject drugs in prison.

With respect to the grounds listed in the Charter and analogous grounds, people in prison can be said to constitute an analogous ground on which discrimination is prohibited. In 2003, the Canadian Human Rights Commission said, “Federally sentenced offenders have a right to treatment that is consistent with the *Canadian Human Rights Act* [legal protection against discrimination].”

On the other hand, in *Sauvé*, a minority of the Supreme Court of Canada stated that the “status of being a prisoner does not consti-

tute an analogous ground.” In my opinion, the reasoning in *Sauvé* was flawed because it was contrary to principles of retaining all rights and equivalence; it ignored the fact that people in prison manifest factors (e.g. social marginalization, poverty) that should be considered in determining an analogous ground under Section 15; and it ignored the reality that there are multiple intersecting grounds of disadvantage reflected in who is harmed by the denial of PNSPs.

In any event, a majority of the Supreme Court of Canada has never stated that being a prisoner does not constitute an analogous ground. Neither has any provincial appellate court.

CSC’s exclusion of people in prison from the full range of health benefits available to people in the general community creates an environment in which it is acceptable to treat people who inject drugs in prison as second-class citizens and to subject them to risks of irreparable harm. People who inject drugs are already identified with numerous negative stereotypes, including the view that drug users are of lesser moral value and, therefore, are less worthy of health care, a perception that is exacerbated by incarceration.

CSC’s distinction in treatment reinforces this disadvantage, increases the vulnerability of people in prisons to disease and infection, and subjects them to pernicious prejudice and stigmatization.

### Section 12: right to not be treated to cruel or unusual treatment or punishment

In the context of prisons, the right not to be treated to cruel or unusual treatment or punishment refers to

treatment or punishment that would be “grossly disproportionate” for the incarcerated person, and that Canadians would find abhorrent or intolerable. It also refers to treatment or punishment that would be so excessive as to “outrage [public] standards of decency.”

Denial of full health services creates an environment where it is acceptable to treat people who inject drugs in prison as second-class citizens and to subject them to risks of irreparable harm.

In general, this right must have regard to all contextual factors, including the personal characteristics of people in prison; the gravity and particular circumstances of the offence; the actual effect on the individual; and the existence of valid alternatives to the treatment imposed.

In fact, various conditions of incarceration have been held to violate Section 12 — for example, lobotomization, castration, limitations on visitation and access to open-air exercise, and methods of searching incarcerated people.

In particular, a court has found that Section 12 was violated as a result of a failure to provide adequate medical care for detained people with HIV. In another case, a court held that segregation of a prisoner with mental illness would violate Section

12 because, in the circumstances, it would contribute to deterioration of health.

Current policies on needle exchange ignore the contextual factors of people in prison. Denying access of people in prisons to equivalent health services is not a legitimate objective of imprisonment and the harm inflicted as a result would be grossly disproportionate to any purported benefit.

A determination of what violates “public standards of decency” is informed by the principles of retaining all rights and of equivalence. A critical factor here is the fact that governments support and fund NSPs outside prisons.

The contextual factors that are relevant to the denial of the rights of people in prison include the extent of their marginalization and vulnerability, the effects of denying NSPs to them and the fact that there is an available alternative — i.e., implementing PNSPs consistent with the CCRA and international human rights principles.

### Justifying Charter violations

Even if Charter violations have been established, governments can try to prove that the violations are justified. They can point to Section 1 of the Charter, which allows for justifiable limits to be placed on Charter rights.

However, in fact, prohibiting PNSPs does not relate to “pressing and substantial” government concerns of preventing prison drug use and protecting prison safety, but rather undermines these objectives. Prohibiting PNSPs constitutes more than minimal impairment of the rights of people in prisons, given the evidence of potential harms (e.g., HIV or HCV infection).

Not only is prohibiting PNSPs ineffective in achieving government objectives, but it is also harmful. The harms to people in prison of such a policy considerably outweigh supposed “benefits” that are not supported by evidence.

### Inter-sectoral strategy for HIV/AIDS in prisons

*Giselle Dias, prisoners’ rights advocate, Prisoners’ HIV/AIDS Support Action Network (PASAN)*

In 1991, a coalition of prisoners, ex-prisoners, activists, agencies and individuals formed to write *HIV/AIDS in Prison Systems: A Comprehensive Strategy*.<sup>29</sup> This was the first comprehensive strategy to address the growing epidemic of HIV/AIDS in prisons.

The strategy, which was submitted to the Minister of Correctional Services and the Minister of Health in June 1992 on behalf of PASAN, focused on HIV/AIDS education and prevention; injection drug use; human rights, compassionate release and confidentiality; anonymous HIV testing; aftercare for people living with HIV/AIDS; and female prisoners.

In 2007, Peter Collins, a federal prisoner serving a life sentence at Bath prison, and I, a former policy analyst at PASAN, were hired on contract to update the strategy. The updated strategy, which will be called “An Inter-Sectoral Strategy on HIV/AIDS and Hepatitis C in Ontario Prisons,” has been particularly challenging. There have been several documents already written to try and address the issues of HIV/AIDS and Hepatitis C prevention, care, treatment and support in prisons. Peter and I did not want to continue to reiterate the same discourse.

What will make this document different from others is that while most of the literature on HIV/AIDS in prisons has focused on epidemiology, risk behaviours in prison and some issues related to care, treatment and support of prisoners, the inter-sectoral strategy intends to shine the light on areas that have previously not been addressed — such as systemic issues that lead people to prison, and prison conditions that exacerbate the transmission of HIV/AIDS and hepatitis C (HCV) in prison.

Up until now, groups have tried to mirror community programming to fit into the prison environment, without recognizing all of the barriers that prisoners face while in prison, such as the constant surveillance, lack of freedom, deprivation and lack of humanity.

One cannot look at prisons as if they existed on their own. Prisons are a part of our community and people in prison are often there as a result of not having access to the basic rights that all people should be entitled to — for example, housing, mental health services, employment.

There is a significant over-incarceration in our prisons of indigenous people, people from racialized communities, women, people who use drugs, sex workers and the homeless. There is also the recent phenomenon of the criminalization of people living with HIV/AIDS. The inter-sectoral strategy hopes to make connections between systemic issues (mentioned above) and the rates of HIV and HCV transmission in prisons.

There is a need for people to collaborate and connect projects that address key issues, such as the decriminalization or legalization of drugs and the decriminalization of sex work. The reality is that most people who use drugs, work in the sex trade

or are homeless end up in prison. These are also the same people who are at higher risk of the transmission of HIV and HCV. Ultimately, groups need to be working to address (a) policies that contribute to the over-incarceration of certain populations; and (b) the various ways in which the prison system exacerbates rates of HIV and HCV infection.

One cannot look at prisons as if they existed in isolation.

### Prison environment

Some of the risk factors that the inter-sectoral strategy will address are typical of what we have seen in other documents including; injection drug use, sexual activity, tattooing / piercing and education.

Additionally, the strategy will also address several other risk factors that exist within the system that are rarely (if ever) discussed. Aside from overcrowding and ventilation, which have already been widely documented, these risk factors include:

- the distant locations of some prisons;
- issues related to multiple levels of security;
- deprivation and what this means for people who literally have nothing;
- the lack of meaningful work within the prisons, and non-existent pay that fuels the underground economy in prisons;

- the lack of accountability from correctional staff; and
- how security, which governs all facets of the prison, often overrides everything and anything from access to pain management, to jobs, to possible release from prison.

### Best practice programs

A report released in 2007<sup>30</sup> identified best practice prevention policies and programs in an attempt to assist prison systems, other sectors of government, community organizations and prisoners to respond to the challenges of HIV/AIDS in prisons. It was the first report to do this kind of analysis in Canadian prisons.

In terms of best practice programming, there are several that have had positive impact on prisoners' health.

### Community health centres

Community health centres have set up offices within at least two provincial prisons in Quebec. Established by the *Centres locaux de services communautaires* (CLSC), the offices are comprised of two nurses, one social worker and one sexual health counsellor. They deal with issues pertaining to drug use, HIV/AIDS and HCV. They also provide hepatitis A and B vaccinations, and conduct education sessions with prisoners during which they distribute condoms, bleach, gloves and alcohol swabs.

The offices maintain their own filing system, which is kept separate from the prison health care facilities. This service helps bridge the health services gap for prisoners once they are released from prison. Often, once released, prisoners will maintain their relationship with the health centre and seek services from them.

### Direction 180

Direction 180 is a community methadone clinic in Nova Scotia. On rare occasions, clinic staff have gone to the local prison and initiated methadone for prisoners. Unfortunately, there is a serious lack of funding for the clinic. Nevertheless, similar programs could be very beneficial in provincial prisons in Ontario, where methadone is not initiated within the system. In Nova Scotia, once an individual has been initiated, the prison will continue with methadone maintenance therapy.

### Public health partnerships within Corrections

An example of public health partnerships can be found in the federal corrections system, where a public health nurse has an office within the prison and offers anonymous HIV antibody testing, as well as testing for hepatitis A, B and C, syphilis and gonorrhea. The nurse will see prisoners about any health issue in order to build a relationship. All blood work leaves the institution and no results are reported back to Corrections Canada unless permission is given by the prisoner. This confidentiality is essential to the program; it has increased the number of prisoners who will seek testing.

In Manitoba, five of the nine provincial prisons have public health nurses going into the prison to work. These nurses provide a “needs assessment” of the prison by speaking with staff and prisoners concerning sexual health. They also provide one-to-one or group education and counselling for prison staff and prisoners on a variety of sexual and reproductive health topics. As well, the nurses offer individual appointments for HIV, hepatitis A, B, C, gonorrhea, chlamydia and

syphilis testing. Providing education to staff has resulted in less security concerns overall.

### The way forward

Prison health is public health and — equally — public health is prison health. There is a need to provide better care to the under-served by addressing the determinants of health. One of the easiest ways of doing this is to reach into the prison system and make connections with prisoners while they are there. As the examples cited above demonstrate, there are some very exciting partnerships between prisoners, community groups, community health centers, public health, methadone clinics and Corrections, all of which can make a significant difference in prisoners’ lives.

Prison health is public health and — equally — public health is prison health.

Currently, in Ontario, there are very few people going into the prisons to support prisoners. There appears to be an expectation that Corrections are solely responsible. Although Corrections do have significant obligations regarding prisoners’ health — ones for which they should be held accountable — there is also a role for community groups to reach into prisons so that people know where to go when they get out. This way, prisoners would have service providers with whom they know they can connect.

In order to do this, however, more resources, money and collaboration are required. Funding bodies need to see the importance of community going into prisons to bridge the gaps that exist for so many prisoners.

People currently in prison need to take a larger part in these discussions. There are ways to include people who are in prison in conferences and other public events. While the work may be difficult, it is essential to make these opportunities available to people in prison, whether it be through voice recordings, academic papers, poetry, artwork or trying to get prisoners out on passes. These are ways of getting prisoners’ voices heard on the outside.

Additionally when we ask prisoners to participate in advocacy or public education, we need to be sure to create an effective support system around them in case they face ramifications from the prison system. People in the drug using community argue that it is not enough to have people who no longer use illicit drugs in the harm reduction movement: We have to get to the point where people who are actively using drugs are leaders in that movement.

Although it is important to utilize ex-prisoners at conferences and community events, it is not enough. We need to find ways of including prisoners and then pay them for their participation.

### Two perspectives from behind bars

*James Motherall, former prisoner, now turned activist*

There is a large disparity between federal and provincial prisons regarding how the issue of HIV prevention

and treatment is addressed, which raises the question of accountability. Prisons are dedicated to taking hope away from prisoners. The logic is simple: Where there is no hope there is no opposition.

If the same infection rates existed in the general population that currently exist in prison, there would be a public outcry.

I became active in harm reduction and HIV education in response to the suicide of a prisoner who took his own life when he found out he was HIV-positive. Little was known about HIV then and this prisoner was devoid of any hope. A few prisoners formed a group which became known as the Stony Mountain Health Awareness Group to learn more about HIV and to provide education and support to other prisoners. This group provided hope and was not liked by the system.

When condoms were introduced to prisons the plan was that those who needed them would ask a guard, which is just another form of control. It took activism on the part of prisoners to ensure that condom distribution was out of sight of cameras and guards, and was private.

The Correctional Service of Canada (CSC) tattoo pilot project was too controlled, and was rolled out without input from prisoners.

The types of tattoos permitted under the program were too restrictive. Because prisoners could not get what they wanted, they continued to engage in unsafe tattooing.

There is a real problem with HIV in prison. If the same infection rates existed in the general population that currently exist in prison, there would be a public outcry. In prisons, some statistics have shown that the rates of infection are 10 to 17 times higher than the general population.

With respect to drug use, the guards need to be challenged because they are the only ones who could get into a facility without being searched. If guards are the only group of people entering and leaving prisons without being searched, is it not reasonable to think this just might be a way that drugs are still getting in?

The bottom line is that prisons do not want to stop the flow of drugs. While the official mandate of the prison system is to protect the public, the prison system needs people coming back for repeated incarceration. It needs drugs in the system because drugs aid in the desire to create hopelessness. Those who leave prison with no hope are likely to return, and full prisons guarantee job security

*Greg Simmons, former prisoner, now turned activist*

In the early years of my time in prison, drug use was not condoned among prisoners. This has changed a great deal. I have seen prisoners sticking their arms in bars to get a hit and using pens to inject. There are no other options for injecting in prison.

In a sense, you use drugs to block out what is happening to you, the amount of time you are doing, and all

the other negative stuff that has happened to you in your life.

Prisoners did not tell each other if they were HIV-positive. There was a lot of stigma around the disease when I was a prisoner. The CSC's position is reactive, not proactive. In my prison, when the CSC found out that one inmate was positive, everyone else was tested.

Officials instituted a methadone program, but that was done just to keep people quiet.

Inmates were moved around so that the CSC did not have to deal with the problem. The CSC needs to change its position on harm reduction.

Finally, prisons have to stop being warehouses and start to become places where people can change their lives.

<sup>1</sup> *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Minister of Supply and Services Canada, 1994).

<sup>2</sup> J. Dolan et al, "HIV in prison in low-income and middle-income countries," *Lancet Infectious Diseases* 7 (2007): 32-43; WHO/UNODC/UNAIDS, *Interventions To Address HIV in Prisons: Comprehensive Review, Evidence for Action* Technical Paper; 2007.

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- <sup>9</sup> WHO/UNODC/UNAIDS, *Interventions* (supra).
- <sup>10</sup> Lines R et al., *Prison Needle Exchange: A Review of International Evidence and Experience*. Montreal: Canadian HIV/AIDS Legal Network, 2004.
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# Panel: Emerging issues in Canada's drug policy — implications for HIV prevention and health promotion for people who use drugs

This article contains summaries of the three presentations made during this panel. Carol Strike discusses various strategies that have been used to prevent HIV transmission among people who use drugs. Richard Elliott reviews the implications of the 2008 judgment by the British Columbia Supreme Court on *Insite*, the supervised injection facility in Vancouver. Finally, Senator Claude Nolin provides some observations on legislating in the area of drug law.

## Implications for HIV prevention

*Carol Strike, Senior Scientist, Centre for Addiction and Mental Health; and Associate Professor, Dalla Lana School of Public Health at the University of Toronto*

There are three ways in which HIV and hepatitis C (HCV) can be transmitted among drug users. Injection-related risk comes through the multi-person use of contaminated needles and drug preparation equipment.

Non-injection-drug-related risk arises through the sharing of non-injection equipment such as pipes, stems, straws and similar paraphernalia. Sexual behaviour among drug users enhances risk through unprotected oral, anal or vaginal sex.

The World Health Organization (WHO) has recommended nine comprehensive prevention strategies, as follows:

- needle and syringe programs
- opioid substitution treatment
- HIV testing and counselling
- antiretroviral therapy

- prevention and treatment of sexually transmitted infections
- condom distribution programs for injection drug users and their sexual partners
- targeted information, education and communication for injection drug users and their sexual partners
- vaccination, diagnosis and treatment of viral hepatitis
- prevention, diagnosis and treatment of tuberculosis

Safe injection facilities are not on the list. Nor are prescription heroin programs, despite the fact that they are noted for their effectiveness.

The characteristics of effective programs are as follows:

- They are evidence-based and sustainable.
- They are supported, funded and protected by decision makers.
- They are accessible, affordable, equitable and non-discriminatory.
- They are comprehensive and coordinated, and the services are flexible.
- They place no restrictions by age, gender, sexual orientation,

citizenship, race or ethnicity, employment type, confinement in a facility, insurance status, substance use, or location (e.g., not just urban centres).

- They include target setting to ensure availability, coverage, quality and potential impact.

Drug users must be included in all aspects of the design, delivery and evaluation of prevention programming.

## Prevention strategies

### Needle exchange

There is ample evidence from many jurisdictions to support needle exchange programs, including a high level of uptake. These programs succeed if they have an accessible and affordable supply of equipment, as well as supportive and knowledgeable decision-makers.

### Mandatory treatment

Three decades' worth of evidence have provided mixed, inconsistent and inconclusive results about the success of this measure. While it is possible to force drug users to partici-

pate in treatment, it is more difficult to engage them. Mandatory treatment can motivate some people, but not all. Moreover, it is not possible to predict who coercion motivates. Internal motivation is more effective than coercion. The 2008 principles of drug dependence treatment advise against mandatory treatment.<sup>1</sup>

### **Opioid Substitution Treatment**

The WHO has stated that methadone constitutes an essential medicine. Methadone is a very inexpensive drug, with a large portion of the cost having to do with how the drug is dispensed.

There has been a rapid expansion of this form of treatment, particularly in Ontario where, as of 2009, there were 250 methadone management therapy physicians and 21 000 patients. There is limited availability of buprenorphine, a newer drug substitution option, and it remains expensive.

The use of methadone treatment has proven to be accessible, affordable and properly managed. Dosage is the single best predictor of outcome. However, other factors influence outcome, including, for example, accessibility, quality of the therapeutic relationship between patient and health care professional, patient motivation, concurrent mental health problems, employment status and social supports.

### **Heroin and hydromorphone prescriptions**

In addition to trying to prevent HIV and HCV, this type of supervised treatment aims to reduce mortality and morbidity risks; improve social functioning and well-being; reduce arrests and incarcerations; provide a point of contact or referrals for social,

health and other drug treatment services; and reduce public order problems — e.g., drug use in public and discarded needles. Only patients who have failed at treatment on several occasions are eligible for this type of treatment.

Evaluations of heroin prescription treatment have revealed the following outcomes: high retention rates (greater than 50 percent); improved physical and mental health status; increased admission to other treatment programs; reduced consumption of heroin and benzodiazepines; decreased homelessness; reduced illegal income, criminality and arrests; and increased income from legal sources. The results are mixed, however, with respect to employment and social support outcomes.

### **Glass stem kit distribution: stimulant smoking**

This form of prevention program was designed for people who smoke crack and methamphetamine (i.e., crystallized forms of drugs). The multi-person use of smoking equipment, which is very common, is a likely route of HIV and HCV transmission, because pipes can cause injuries, such as cuts and burns, and blood from cuts can contaminate pipes.

Also, many injecting drug users also smoke crack or crystal methamphetamine. Moreover, the frequent use and sharing of such equipment leads to repeated exposures to risk. This activity takes place in an environment in which crack users are typically very marginalized.

The goals of glass stem kit distribution are to reach marginalized and disconnected users; provide referrals for health and social services; reduce the spread of HCV and HIV; and provide education and resources.

Evaluations of stem kit distribution have demonstrated reductions in the frequency of sharing. As well, evidence demonstrates that some people who inject drugs switch to only smoking drugs and thereby reduce their exposure to injection-related health problems.

### **Safe injection facilities**

Currently, there are over 50 supervised consumption sites, including in Australia, Austria, Canada, Germany, Luxembourg, Netherlands, Spain and Switzerland, all of which aim to reduce mortality and morbidity risks for injecting drug users, provide referrals for social, health and drug treatment services, and reduce public order problems.

Vancouver's Insite facility, which attracts users at risk for HIV, overdose and public injecting, has demonstrated many benefits including reductions in needle sharing, overdose risk and violence against women. Insite has resulted in an increased uptake of detoxification services, and has not resulted in any increase in drug dealing near the facility or in initiation of injection or relapse into injection. Insite has become a key referral source for medical care. Indeed, Vancouver police now refer public injectors to Insite.

### **Insight in the court: the Insite judgment and its implications**

*Richard Elliott, Executive Director, Canadian HIV/AIDS Legal Network*

The case of *PHS Community Services Society v. Canada (Attorney General)*<sup>2</sup> centred on the *Controlled Drugs and Substances Act* (CDSA), Section 4(1) of which prohibits unau-

thorized possession, and Section 5(1) of which prohibits trafficking of controlled substances. Section 56 of the CDSA also states,

The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of the Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

An exemption for Insite under Section 56 would mean that, within the facility, site users would not be liable for prosecution for possession and staff would not be liable for trafficking. Insite received its first exemption, for three years, from 12 September 2003 to 12 September 2006.

Following extensive public pressure, the federal government extended the exemption to 31 December 2007 and then again to 30 June 2008. However, given manifest government opposition to Insite, there were growing concerns that the exemption would be discontinued, thereby exposing Insite users and personnel to criminal prosecution for drug offences.

Therefore, the Portland Hotel Society, which operates the health facility, as well as the Vancouver Area Network of Drug Users (VANDU) and two individual site users, Dean Wilson and Shelly Tomic, pre-emptively initiated court proceedings seeking to prevent this possibility. Collectively, they advanced two key arguments:

1. Insite is a health care undertaking within provincial authority and therefore immune to interference

by federal criminal law under Canada's constitutional division of powers between different orders of government.

2. Sections 4(1) and 5(1) of the CDSA are unconstitutional in that they violate the rights of Insite users to life, liberty and security of the person under the *Canadian Charter of Rights and Freedoms* (the Charter).

In the end, the British Columbia Supreme Court (the court of first instance) rejected the first argument, ruling that federal law was "paramount" in a case where both the province and the federal governments had legitimate authority to legislate in relation to different aspects of a matter (i.e., health and crime). However, the Court agreed that Canada's laws against possession and trafficking of drugs were unconstitutionally overbroad.

### A vulnerable population

The federal health minister's Expert Advisory Committee (EAC) on Supervised Injection Sites reported in March 2008 that, of approximately 1000 people who use drugs surveyed in Vancouver's Downtown Eastside:

- the average length of injection history is 15 years;
- the majority (51 percent) inject heroin, and 32 percent inject cocaine;
- 87 percent are infected with the hepatitis C virus, and 17 percent with HIV;
- 18 percent are aboriginal;
- 20 percent are homeless, and many more live in single resident rooms;
- 80 percent have been incarcerated;

- 38 percent are involved in the sex trade;
- 21 percent are using methadone; and
- 59 percent reported a non-fatal overdose in their lifetime.

### Constitutional federalism analysis

A significant question is one of jurisdiction. The *Constitution Act, 1867* states that health care is a provincial undertaking (Section 92(16)) and that criminal law falls within federal powers (Section 91(27)).<sup>3</sup>

The plaintiffs argued that the application of CDSA prohibitions on possession and trafficking "materially intrudes" on a provincial undertaking (i.e., health care) and that the doctrine of "interjurisdictional immunity" makes these CDSA sections inapplicable to Insite users and staff, who are receiving and delivering health care. They argued the Court should "read down" these sections of the CDSA as not applying to Insite's users and staff.

The trial judge came to the following "incontrovertible conclusions":

- Addiction is an illness. One aspect of the illness is the continuing need or craving to consume the substance to which the addiction relates.
- Controlled substances, such as heroin and cocaine, that are introduced into the bloodstream do not cause hepatitis C or HIV. Rather, the use of unsanitary equipment, techniques and procedures for injection permits the transmission of those infections, illnesses or diseases from one individual to another.
- The risk of morbidity and mortality associated with addiction and

injection is ameliorated by injection in the presence of qualified health professionals.

Therefore, the trial judge was clear that Insite is a health care facility and, as such, it was within the province's legislative jurisdiction. However, some laws have a "double aspect": both federal Parliament and provincial governments may legislate on different aspects, within their spheres of authority. Because legislation may touch on matters that cross jurisdictional lines, according to the trial judge,

[t]he question then is whether the purpose and object of Insite are immune from the reach of criminal law because of interjurisdictional immunity, or whether, because the provincial policy conflicts with a federal power, the federal law will prevail because of the doctrine of paramountcy.

The plaintiffs argued that providing effective and responsible health care to local populations was part of the "basic minimum and unassailable content" of provincial power over delivery of health care, and that "turning injection drug users away from the health care door intrudes upon the province's core responsibility."

For its part, the federal government argued that Parliament had a compelling state interest in prohibiting injection of controlled substances, partly because of harms to individual and community health. It argued that criminalizing injection had only an incidental effect on provincial domain of health care and that permitting Insite to continue "will create a safe haven from the criminal law and undermine its national objective and importance."

The court said that it was a case of "double aspect" — specifically,

that federal power to legislate in an area of criminal law that indirectly controls injection has incidental effect upon a "vital part" of provincial health care undertaking. The CDSA prohibits possession in all circumstances, while a central feature of Insite as a health facility aimed at reducing harms associated with illegal drug use is that it permit possession of those drugs on the premises.

**"I cannot agree with Canada's submission that an addict must feed his addiction in an unsafe environment."**

In the result, the trial judge ruled that where there is a "double aspect," the doctrine of federal paramountcy applies (i.e., criminal law prevails): "[T]he Province has no capacity to override the criminal law by creating an environment in which individuals can conduct themselves free of its constraints." Therefore, he dismissed the argument that Insite's users and personnel were immune from the criminal prohibitions on possession and trafficking of illegal drugs.

### **Charter issues**

The plaintiffs fared better, however, with their Charter arguments.

### **Section 7**

Section 7 of the Charter protects everyone's right to "life, liberty and security of the person, and the right

not to be deprived thereof except in accord with principles of fundamental justice."<sup>4</sup>

According to the plaintiffs,

While users do not use Insite directly to treat their addiction, they receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid the risk of being infected or of infecting others by injection, and they gain access to counselling and consultation that may lead to abstinence and rehabilitation.

The court considered that Section 4(1) of the CDSA (possession),

which prohibits injection within the confines of Insite, engages the right to life because it prevents healthier and safer injection where the risk of mortality resulting from overdose can be managed, and forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death.

Rejecting the federal government's argument that such risks arise from the choices made by individuals to use drugs, the trial judge further observed,

With respect, the subject with which these actions are concerned has moved beyond the question of choice to consume in the first instance. As I have said elsewhere in these reasons, the original personal decision to inject narcotics arose from a variety of circumstances, some of which commend themselves to choice, while others do not. However unfortunate, damaging, inexplicable and personal the original choice may have been, the result is an illness called addiction.

The failure to manage the addiction in all of its aspects may lead to death,

whether from overdose or other illness resulting from unsafe injection practices. If the root cause of death derives from the illness of addiction, then a law that prevents access to health care services that can prevent death clearly engages the right to life.

With respect to security of the person, the judge concluded,

Section 4(1) of the CDSA threatens security of the person. It denies the addict access to a health care facility where the risk of morbidity associated with infectious disease is diminished, if not eliminated.... Denial of access to Insite and safe injection for the reason stated by Canada [use of Insite merely to satisfy drug cravings], amounts to a condemnation of the consumption that led to addiction in the first place, while ignoring the resulting illness....

[T]here is much to be said against denying addicts health care services that will ameliorate the effects of their condition. Society does that for other substances such as alcohol and tobacco. While those are not prohibited substances, society neither condemns the individual who chose to drink or smoke to excess, nor deprives that individual of a range of health services.... Simply stated, I cannot agree with Canada's submission that an addict must feed his addiction in an unsafe environment when a safe environment that may lead to rehabilitation is the alternative.

As for the requirement that an infringement of these Charter rights may be constitutionally acceptable if it accords with "principles of fundamental justice," the court stated that even if it accepted the government's arguments about the compelling state objectives underlying the CDSA, a law's infringement of Charter rights cannot be considered to comply with

principles of fundamental justice if it is arbitrary. The judge said,

In my opinion, s. 4(1) of the CDSA, which applies to possession for every purpose without discrimination or differentiation in its effect, is arbitrary. In particular it prohibits the management of addiction and its associated risks at Insite. It treats all consumption of controlled substances, whether addictive or not, and whether by an addict or not, in the same manner.

Instead of being rationally connected to a reasonable apprehension of harm, the blanket prohibition contributes to the very harm it seeks to prevent. It is inconsistent with the state's interest in fostering individual and community health, and preventing death and disease. That is enough to compel the conclusion that s. 4(1), as it applies to Insite, is arbitrary and not in accord with the principles of fundamental justice. If not arbitrary, then by the same analysis, s. 4(1) is grossly disproportionate or overbroad in its application.

The trial judge noted that this conclusion applies equally to the prohibition on trafficking under CDSA Section 5(1):

It is possible that staff at Insite who handle used equipment contaminated by controlled substances, or staff who take possession of any controlled substance for delivery to police, could be alleged to be engaged in "trafficking," which is broadly defined by the CDSA to [sic] the administration or transfer of a controlled substance. Failure to protect the staff against such an allegation would negative the utility of any determination that s. 4(1) is contrary to s. 7.

### Section 1

Having found that these provisions of the CDSA infringed the Charter

rights of those using Insite, the court was required to consider whether the infringement could be justified by the government. Section 1 of the Charter "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

The judge concluded,

"The principles of fundamental justice are among the most important in society. Any law that offends them will not ordinarily be saved by s. 1.... Given what is at stake, the present case is no exception."

### Remedy ordered

As a result, the court ruled that Sections 4(1) and 5(1) of the CDSA were inconsistent with the Charter and of no force and effect. The declaration of constitutional invalidity was suspended until 30 June 2009. In the interim, the court granted Insite staff and users, acting in conformity with current operating protocol, a constitutional exemption from Sections 4(1) and 5(1).

The federal government appealed to the British Columbia Court of Appeal (BCCA), and the appeal was argued in late April 2009. A ruling from the appellate court was still pending at time of publication. In the interim, all parties have agreed that:

- Insite's exemption from the CDSA sections, and the trial judge's suspension of his declaration that these sections are invalid, will continue until the BCCA issues its decision.
- If the BCCA rules in favour of Insite, the exemption and the declaration of invalidity will continue pending resolution by the Supreme Court of Canada, to

which the government will apply for leave to appeal.

- If the BCCA rules against Insite, the judgment will not be effective for 60 days, allowing the plaintiffs to apply for a stay of this decision and leave to appeal to the Supreme Court of Canada.

## Concluding remarks

*Hon. Pierre-Claude Nolin, Senator, Senate of Canada*

In spite of a lack of sufficient information, the Senate accepted Bill C-15 — which proposes mandatory minimum jail sentences for drug offenders. But the Senate also issued a lengthy report discussing how prohibition would not necessarily work.

Our colleagues in the House of Commons did not want to participate in researching a solution to the matter. So, a five-Senator committee was created that put partisanship aside in order to look for rigorous evidence about this issue.

The courts have come to play an activist role in the area of drug law, as politicians refuse to take responsibility for the issue. Every few years, the public ask politicians to defend their platforms, which are often blindly supported by people who do not understand, in this case, the consequences of criminal laws. More incarceration with fewer restrictions will not lead to a freer or safer society.

Creating law must be the result of a large and fruitful discussion that involves public, civic and political engagement. Since the 1980s, Canadian courts have been left to deal with this problem because governments have not wanted to do so. However, the problem cannot be dealt with in the courts alone. Trying to find a federal, provincial and municipal solution around issues of drug use is a big challenge. Mistakes will be made, but they can be corrected.

The Senate committee tried to reflect on how to create a public policy that is loyal to the Charter. It

could be useful to think of the international context, but it is difficult to predict. It is possible, however, that the election of Barack Obama to the U.S. presidency might herald some changes in the U.S. government's perspective on drug use. Past speeches by Obama referenced his support for harm reduction and for framing drug policy in terms of public health rather than criminalization.

<sup>1</sup> United Nations Office on Drugs and Crime, and WHO, *Principles of Drug Dependence Treatment: Discussion Paper*, 2008.

<sup>2</sup> 2008 BCSC 661. All quotations in this article are from this trial judgment.

<sup>3</sup> *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5.

<sup>4</sup> *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11. While recognizing that the right to liberty was engaged because of the risk of criminal prosecution and punishment, the Court declined to consider that issue in detail, saying that the infringement on the rights to life and to security of the person were of considerably greater importance in this case.

## Panel: Challenging criminal charges for HIV transmission and exposure

Justice Edwin Cameron, of the Constitutional Court of South Africa, served as moderator. He said that this topic was particularly relevant for “an African/Canadian setting” because African countries may use Canadian developments as justification for their efforts to address HIV transmission and exposure through criminal law. Justice Cameron said that Canada is internationally perceived as a human rights-respecting state and, thus, sets an example, particularly for African nations, on how to comply with human rights issues. He added that in this particular case, however, Canada was sending the wrong message.

This article contains summaries of the four presentations made during this panel. Marlys Edwardh reviews how the Supreme Court of Canada in *Cuerrier* interpreted the concepts of “endangering life” and “fraud.” Barry Adam discusses the notion of a “duty to disclose” and how this affects HIV prevention. Lucie Joncas examines how the Supreme Court defined “fraud” in *Cuerrier* and describes a case before the Quebec Court of Appeal which may turn on whether the use of a condom or having a low viral load is considered not to constitute a significant risk of transmission. Finally, Michaela Clayton describes the trend in Southern African countries to adopt laws criminalizing HIV transmission or exposure, and explains that criminalization endangers women’s health and lives.

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

*Marlys Edwardh, Partner,  
Ruby & Edwardh*

There are tensions between the approaches that were being followed at the time of the *Cuerrier* decision in 1998 with regard to HIV testing and transmission. On the one hand, public health initiatives encouraged the groups most vulnerable to infection to undergo an HIV antibody test in their own interest. At the same time, courts argued that society needed criminal law protection against individuals who tested positive and did not disclose their HIV status.

Two requirements of the majority *Cuerrier* decision concerning aggravated sexual assault are particularly

germane: the element of endangering life, and the new definition of fraud.

With respect to endangering life, the Court decided that the accused had indeed exposed the complainant to HIV infection that was potentially lethal, and that the Crown need not prove that the complainant was ever infected.

The second requirement, the definition of fraud, was more difficult. What the court had to do was reverse 100 years of common law and interpret the statute as requiring an open-ended, more flexible interpretation of the language of fraud. To do so, they reached into the world of “criminal fraud,” and adopted the models used to understand fraud in respect of economic crimes.

For that, two prongs are needed: dishonesty and (risk) deprivation. Transposing those criteria to

*Cuerrier*, the Court concluded that a sufficient case had been made to vitiate the consent of the complainants — i.e., that either a deliberate deceit or deliberate non-disclosure of a person’s HIV status that was related to the obtaining of consent would provide the requisite dishonesty.

Furthermore, there had to be exposure to a significant risk of serious bodily harm that would satisfy the requirements of deprivation. The Court made it clear that a dishonest act causing trivial harm would not suffice. Other types of dishonesty would not suffice, either.

Counsel for the complainants took the position in court that, if there was a role for a criminal sanction, it belonged to a charge with a more nuanced analysis of what the person was told, and of what the person

might reasonably have been expected to understand.

When can one have sex that does not present a significant risk to transmission? If one has protected sex without disclosing, would that constitute a crime? For that matter, if an HIV-positive mother has a vaginal delivery or provides breast milk to her baby, would that constitute a crime?

There is no clarity on the definition of “significant risk” of serious bodily harm, and so courts are struggling with it.

The absence of a clear line from *Cuerrier* has sowed this doubt. There is no clarity on the definition of “significant risk” of serious bodily harm, and so courts are struggling with it. In 1998, one could make a clear argument that HIV infection was lethal. But that is not the case today.

In general, the criminal law is the bluntest area of law and, therefore, not the most appropriate means to deal with HIV transmission. There was a recent case in Hamilton, Ontario, in which an HIV-positive mother who refused treatment during her pregnancy pled guilty and was convicted for exposing her child to a significant risk of transmission by having a vaginal delivery and breastfeeding the infant.

There is a need for increased activism among the public health, social,

legal and civil society sectors against the increased recourse to criminal law in cases of non-disclosure of one’s HIV-positive status.

### What effect is the criminal justice system having in HIV prevention?

*Barry Adam, University Professor,  
Department of Sociology, University  
of Windsor*

My comments are based on a review of the social science research literature relevant to criminalization of HIV and on a study, for which I was lead investigator, on the impacts of criminal prosecutions for HIV exposure and transmission on people living with HIV.<sup>1</sup> I come at this from a sociological, not juridical, perspective.

Courts are becoming actors in the field of HIV prevention, whether they know it or not. The judicial system is operating based on a model of human behaviour that holds that HIV-positive people can and should assume the responsibility for warning others of the potential for infection, and that prospective partners, once informed of that potential, will act appropriately to avoid infection. Courts have elevated disclosure as a primary requirement.

The study set out to determine:

- how people living with HIV/AIDS perceive the law and the legal obligation to disclose;
- how they are affected by changing public climate of increasing prominence of criminal discourses;
- the sources of legal information available to persons living with HIV/AIDS, including how they

have been advised by AIDS service organizations, health providers and other relevant agencies;

- how criminal prosecutions, and media coverage of these legal proceedings, affect the understanding of rights and responsibilities of self and others;
- how the public climate is affecting the perceptions, treatment and possible stigmatization of persons living with HIV/AIDS; and
- how legal proceedings and associated public discourse affect decisions to test for HIV, disclosure practices of self and sexual partners, and safer sex practices of self and others.

In a follow-up study still underway, interviews were conducted with 100 persons living with HIV/AIDS, broadly representative of the demographics of HIV in Ontario. In particular, investigators met with HIV-positive persons who have experienced a threat of legal consequences from a partner, family member or employer in relation to their HIV status (e.g., non-disclosure); have been served with a public health order; have been processed by the criminal justice system in connection with their HIV status; or have complained to criminal justice or public health authorities about having been exposed or infected by HIV.

### Effectiveness of disclosure

The disclosure requirement is premised on the idea that permission to engage in sex is inextricably bound up with disclosure. This is a prevention message that creates a double bind for people and, therefore, is unlikely to be consistently translated into practice or to be effective in preventing HIV transmission. Research

shows that disclosure prior to sex acts is not associated with higher rates of protected sex among gay and bisexual men.<sup>2</sup>

At any rate, consistent practice of safer sex usually does not require discussion and proceeds without it. Those people who decide from encounter to encounter whether to disclose or not, and who then disclose inconsistently, have higher rates of unprotected sex than either those who disclose consistently or those who do not disclose.

To reveal one's HIV status puts persons living with HIV/AIDS in a double bind. Disclosure will always risk stigmatization or rejection. Indeed, HIV-positive people have reported that rejection from partners following disclosure takes many forms, including refusal to have sex, unwillingness to engage in particular sex practices, emotional distancing, abrupt or longer term relationship dissolution, and even (although rarely) acts of violence.

### Personal politics of disclosure

The legal duty to disclose one's HIV status does not take into account social factors such as dependency. This is particularly difficult for women in relationships with men on whom they are dependent, and for those who feel disadvantaged by their age, attractiveness or ethno-cultural background. Participants in the study expressed such concerns as follows:

- "I do worry that, you know, I might disclose to someone even before sex and then it becomes his word against mine later — right? — and if I go to court, ... I'd probably lose my job."
- "What if one that's negative makes a decision to ... have sex

without a condom, and then he gets infected and then it all comes back to me and then I'm charged? I'm in jail ... so I'm really careful around that."

Other participants disclosed in an indirect manner. Some conveyed their serostatus to their partners by mentioning or exhibiting various embodiments of their serostatus: that they received disability payments, worked in HIV/AIDS services, lived in an HIV/AIDS residence or had visible HIV/AIDS symptoms. However, this form of disclosure does not meet the requirements of the legal duty of disclosure; it has to be explicit.

The legal duty to disclose one's HIV status does not take into account social factors such as dependency.

The dilemmas in disclosure are many. For one, it presumes that both partners are certain of their serostatus. It also shifts responsibility back towards HIV-positive people. Furthermore, there is a need to test the presuppositions underlying the obligation to disclose as an HIV prevention strategy and public policy by examining their operationalization in everyday life.

The legal duty to disclose should require the knowledge of the HIV status of all involved parties; oth-

erwise, this preventive measure would provide individuals with a false sense of safety. The particular public health message to the gay and bisexual communities has long been, "You do not need to disclose if you practice safe sex." Yet, this message contradicts the legal duty to disclose.

## Exposure to HIV and the criminal law

*Lucie Joncas, barrister and solicitor, Desrosiers Joncas Massicotte*

Ever since the outbreak of HIV and its disastrous consequences for public health, the criminal courts worldwide have been called upon to intervene in society's global response to the disease. As a consequence of the judiciary's involvement, the criminalization of what is basically a public health problem is steadily increasing.

This situation evolved because legislators abrogated responsibility to the courts rather than enact clear laws formulated as the result of democratic debate. Thus far, the judicial approach has been primarily a repressive one, involving a reinterpretation of the legal definitions of sexual and physical assault.

### Sexual assault and HIV

To intentionally apply force against another person, and to do so without that person's consent, are two elements common to the definition of sexual and physical assault. How, then, can consensual sex constitute assault? It all turns on the word "consent," and on the notion, recently adopted by the courts, that a person can commit fraud by falsely representing his or health status or by failing to disclose a health problem to his or her sexual partner.

The courts have been criticized for misrepresenting the concept of fraud and consent in the context of sexual assault. The rule had been that for sexual intercourse or a consensual sexual act to qualify as a crime, the courts required a determination that the sexual partner's consent was fraudulently obtained. But the fraud had to pertain to the nature of the sexual activity or the identity of the partner.

Take the following example. A woman, believing that she is dealing with a physician, agrees to undergo a gynecological examination by a person who is not a physician at all, but rather someone unlawfully seeking sexual gratification. The physician has misrepresented the nature of the act. The woman's assailant has misled her into believing that she is undergoing a medical procedure by misrepresenting his status as a professional.

The legal exception regarding vitiated consent was therefore very limited. Indeed, the law does not seek to castigate all false representations designed to persuade the partner to have sex. Regardless of the underlying motivation, once consent was given to having sex, the courts have held that sexual assault had not been committed.

### Re-defining fraud

In the early 1990s, the courts were faced with deciding whether or not a person's failure to reveal his or her HIV-positive status constituted fraud that vitiated consent. The Supreme Court of Canada answered that question in the affirmative in *R. v. Cuerrier*.<sup>3</sup>

According to the Court, the accused's failure to disclose his HIV-positive status put the complainant's

life in danger, regardless of whether the complainant was actually infected with the virus. The failure to disclose amounted to fraud that vitiated consent to having sexual intercourse.

With that decision, the Court changed the secular interpretation of fraud in the context of sexual assault by holding that it was no longer necessary when considering if consent is vitiated to ponder whether the fraud related to "the nature and quality of the act." In the Court's view, the concealment of important facts amounts to vitiated consent where sexual intercourse would create a significant risk for the partner's health.

The Court was saying that true consent pertained not only to the nature of the sexual relations, but also to knowledge of the significant relevant factors. However, the Court still added that "the Crown needs to prove that the dishonest act had the effect of exposing the person consenting to a significant risk of serious bodily harm."<sup>4</sup> And that the Crown must also prove beyond a reasonable doubt that the complainant would have refused to have unprotected sex had he or she been advised that the accused was HIV-positive.

It is important to note that the *Cuerrier* case involved unprotected sex.

### Significant risk

The split (four to three) decision in *Cuerrier* raises several important issues, including the Court's failure to define "significant risk" and "dishonest act." However, the Court did issue the following reservation:

Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not

be either deprivation or risk of deprivation.<sup>5</sup>

This is exactly the issue in a case in the Québec Court of Appeal, *R. v. D.C.*

Moreover — and this is the situation in *D.C.* — the efficacy of triple therapy in counteracting production of the virus has made such advances to the point that HIV is undetectable in blood. In other words, where the viral load is very low, so is the risk of transmission. Thus, the question arises whether the provability of a crime is limited where the risk of contamination is low.

Canada needs legislation that recognizes the liability and responsibility of two consenting adult partners.

This was the issue that the Court of Justice, Penal Division of the Canton of Geneva had to address in *S. v. R. and the Attorney General of the Republic and Canton of Geneva*. In that case, a professor of medicine, summoned by the Public Prosecutor, testified that according to current scientific research, the risk of contamination presented by a patient undergoing AIDS treatment, whose viremia is undetectable, was too low to be scientifically quantified.

In other words, there was no risk of contamination. Consequently, the Court acquitted the accused

because the complainant had not been exposed to bodily harm putting her life in danger.

Scientific evidence was also submitted to the Québec Court of Appeal in *D.C.* It remains to be seen whether Canadian courts will follow that line of reasoning.

It is abundantly clear that Canada needs legislation that recognizes the liability and responsibility of two consenting adult partners, and that the criminal law, with its accompanying stigma, can never be an adequate response to this particular public health problem.

More importantly, associating crimes of violence, like physical or sexual assault, with consensual sex is inappropriate and misconstrues the very nature of the behaviour that is being reproached. Does a mother who transmits HIV to her child commit sexual assault or a crime of violence? Is a person infected with HIV as the result of a blood transfusion the victim of a crime of violence?

The defendant cannot control whether or not the virus is transmitted to the victim. The scientific evidence tells us that where an HIV-positive woman with a high viral load has unprotected sex, the risk of transmission is only one in 1000. How can that fact be reconciled with a crime defined by the intentional application of force? In *Cuerrier*, none of the complainants had been infected despite their high frequency of unprotected sexual encounters with the accused.

Canada should re-examine whether it needs to criminalize all HIV-related behaviour, and needs to have due consideration for the men and women who bear the daily burden of this tragic illness. Unambiguous legislation focussed on public health and

prevention would be preferable to the added stigma of criminalization.

### **Women and HIV transmission in the Southern African context**

*Michaela Clayton, Director, AIDS and Rights Alliance for Southern Africa*

In 2004, the N'Djamena “model” HIV law was created to provide a good model for HIV laws for countries in West Africa. Whilst it does provide some useful provisions, and whilst it emphasizes in the introductory clauses the need for human rights protections, this model law also, disturbingly, broadly criminalizes transmission and exposure.

In spite of this, the model law has been adopted by 15 countries in West Africa, and others may do the same. The law requires people who know they have HIV to inform “any sexual contact” in advance — without defining “sexual contact.” (Does the definition, for example, include kissing?)

Sierra Leone’s version of the law expressly brings a pregnant mother within its terms. She can be jailed if she does not “take all reasonable measures and precautions to prevent the transmission of HIV” to her unborn baby.

A model HIV law has also been developed in the Southern African Development Community (SADC), which comprises 15 countries. Rather than criminalizing HIV transmission, the SADC Model Law seeks to address the root causes that drive the demand for criminalization of HIV transmission in the first place. It places the emphasis on removing barriers to accessing prevention, treatment and care services, and

specifically addresses the particular vulnerability of women to HIV in Southern Africa as a result of gender inequality and gender based violence.

The SADC Model Law provides Members of Parliament sitting to review laws with a framework for placing their focus where it should be: on removing legal barriers to HIV prevention, treatment and care, and on effectively addressing the very factors that make women and other vulnerable groups — such as injecting drug users, men who have sex with men and sex workers — more vulnerable to HIV.

Many laws in the region were enacted with specific, troubling transmission and disclosure provisions.

Despite this model law having been adopted by SADC, many individual countries in the region have ignored it and have drafted their own legislation, which closely resembles the West African N'Djamena model law. In Southern Africa, such laws have been adopted in Tanzania, Madagascar, Mozambique and the Democratic Republic of Congo, and are being considered in Uganda and Malawi.

As a result, many laws in the region were enacted with specific, troubling transmission and disclosure provisions.

### Role of women's groups

The push for these kinds of laws has come largely from women's groups, which were understandably upset over the number of women who become infected with HIV in their relationships — particularly in parts of Southern Africa where multiple, concurrent partners are common. The rationale of the legislation was to protect those most vulnerable to infection. While the intentions were good, the laws were bad public policy.

Far from protecting women, criminalization endangers them. In sub-Saharan Africa, 61 percent of people living with HIV/AIDS are women. These women are often the first to know their HIV status, because most testing occurs at natal health care sites.

The material circumstances in which many women find themselves — especially in Southern Africa — make it difficult for them to negotiate safer sex, or to discuss HIV at all. These circumstances include social subordination, economic dependence and traditional systems of property and inheritance that make women dependent on men. Women are condemned for bringing HIV into

the home. They are often unable to disclose because of fear of physical harm and eviction.

In most cases, women are unable to enforce safer sex. At the same time, women living with HIV/AIDS are liable for prosecution for wilful transmission if they do not disclose to their partner.

Levels of domestic and gender-based violence are high, and fear of violence is a real barrier to disclosure. Gender-based violence is a horrible reality in sub-Saharan Africa, and young HIV-positive women are ten times more likely to have experienced violence than their HIV-negative counterparts.

### Criminalizing women

Although criminalizing HIV transmission or exposure is often positioned as protection for women, the reality, however, is that women are more likely to be arrested and prosecuted. As a result, women are deterred from accessing testing and treatment. Criminalization will make them more vulnerable to HIV, not less.

Criminalizing HIV transmission does not stop new HIV infections. Instead of adopting these criminal-

ization policies, the root causes that drive the demand for criminalization should be addressed.

There is a need for adequate law, policies and enforcement mechanisms that protect women against violence. It is essential to promote the equal status of women in marriage, inheritance, access to credit and to employment. Finally, the cultural practices that render the women more vulnerable to HIV need to be addressed.

Rather than criminalizing HIV transmission, we should focus on revising laws to remove legal barriers to HIV prevention, treatment and care services, and on using the law to fight discrimination and stigma, and to protect women and other vulnerable groups from infection.

<sup>1</sup> B.D. Adam et al, "Effects of the criminalization of HIV transmission in Cuerrier on men reporting unprotected sex with men," *Canadian Journal of Law and Society* 23 (1-2) (2008):137-153.

<sup>2</sup> B.D. Adam, "Research on HIV risk among gay and bisexual men," in AIDS Bureau, Ontario Ministry of Health and Long-Term Care, *Ontario Gay Men's HIV Prevention Strategy*, 2006, pp. 14-15.

<sup>3</sup> *R. v. Cuerrier*, [1998] 2 S.C.R. 371.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*, para. 129.